

*MODEL ETHICAL
PROTOCOLS
for
OTHER EMPLOYED CARERS*

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 Other Employed Carers

The *Ethical Protocols for Other Employed Carers* express the ethical responsibilities of other employed carers,* employed to provide personal care to residents. Other employed carers (other carers) form part of a multidisciplinary team. They work under the direction and supervision, either directly or indirectly, of a qualified nurse or another supervisor.

* Other employed carers includes those carers employed by the home and referred to by RCNA and the ANF as “unlicensed nursing and personal care assistants”, that is those engaged in the care of residents other than qualified nurses and attending health care practitioners.

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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

Residents of aged care homes rely on the staff to meet their needs. The expectations and specific personal, cultural and religious needs that the resident has in relation to the care being offered were documented before or on admission. Other carers need to be aware of these specific expectations in relation to the care they provide and in assisting the resident to settle into the home.

1.1.2 Procedure

On admission, other carers are able to assist the resident to adjust to a new environment by:

- a. providing the resident with an orientation of the environment and making him or her as comfortable as possible;
- b. attending to any immediate physical, emotional and safety needs of the resident within their level of responsibility;
- c. providing appropriate explanation of any admission process with which they are involved;
- d. introducing the resident to other residents as appropriate;
- e. enabling the resident to access those facilities within the home that the resident might require; and
- f. knowing what action is required in the circumstances of a medical emergency within their level of training.

1.1.3 Documentation

Other carers are able to, and should provide information for documentation of care needs.

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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 discomfoting 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 other carers 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

In responding to the issue of unjust discrimination, other carers:

- a. refer complaints about unjust discrimination or harassment (on the basis of race, sex, disability or any other factor) to the person designated to receive complaints. (see Protocol 1.16 on *Complaints*).
- b. treat residents and other staff justly;
- c. respect people who make complaints, or witnesses, so that they are not victimised;
- d. treat seriously reports of unjust discrimination or harassment; and recognise sexual harassment as illegal and subject to disciplinary action.

* 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 at the time of admission. 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

Others carers are positioned to meet many needs of residents, and to observe and promote residents' rights in relation to consent by:

- a. providing adequate explanation for any care they are proposing, eg showering, feeding, and allowing time for the resident to have input into the process and to agree or disagree with that treatment;
- b. referring to the nurse where available, or other immediate supervisor, any situation in which a resident might refuse treatment or where the others carers believe that the resident does not fully understand the implications of any treatment offered;
- c. respecting the resident's right to refuse any intervention which he or she judges to be futile, overly burdensome or morally unacceptable;
- d. complying with any refusal of treatment by a competent resident who is not assessed by a medical practitioner to be mentally disturbed, clinically depressed

* for accommodation or for medical treatment decisions

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or suicidal, irrespective of whether or not the other carers agree with the resident's refusal; and

- e. reporting any intervention that is contrary to the legally recognised wishes of the resident, of which the other carer is aware.

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.

1.4.2 Procedure

Residents are in need of, and have a right to, nutritious food and fluids, with which other carers can assist by:

- a. offering a variety of fresh foods from the five food groups and monitor *actual* intake when directly involved;
- b. reporting to the nurse or immediate supervisor any concerns about a resident's reduced food or fluid intake;
- c. taking time and avoiding distraction when assisting residents to eat, ensuring they receive adequate nutrition in a safe way;
- d. taking appropriate precautions to ensure safe handling of food when directly involved;
- e. respecting the resident's special dietary requirements, reasonable food preferences and cultural requirements;
- f. being aware of, and adhering to directions if a resident has swallowing difficulties.

1.4.3 Documentation

Other carers will contribute to documentation of actual food and fluid intake by residents 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) or other pathologies, 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, the resident is in an immediately terminal state, or the only mode of delivery would impose unreasonable 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

Other carers can contribute to and are able to support the nutritional status of residents by:

- a. ensuring that they understand any artificial nutrition and hydration program if directly involved;
- b. applying appropriate hygiene precautions when directly dealing with artificial hydration and nutrition apparatus;
- c. providing artificial nutrition and hydration in accordance with the directions of the health professional who ordered it, and according to the needs of the resident, when directly involved;
- d. reporting to the nurse or immediate supervisor, any side effects and observed response to artificial nutrition and hydration; and
- e. identifying to the nurse or immediate supervisor, if not adequately trained to care for those residents requiring artificial nutrition and hydration;

1.5.3 Documentation

Other carers will contribute to the documentation of a resident receiving artificial nutrition and hydration, as directed.

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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 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

Other carers are part of a multidisciplinary team that provides palliative care to residents as required. Other carers assist in the provision of that care and therefore should :

- a. develop knowledge and understanding of palliative care as it applies to older persons within their level of training and experience;
- b. contribute, within their level of responsibilities, to palliative care practice;
- c. report unrelieved pain and symptoms to the nurse or immediate supervisor.

1.6.3 Documentation

Contribute to the documentation of the palliative care needs of residents who are suffering pain or discomfort.

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1.7 Care of the dying

**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 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

Other carers aim to provide for the needs of dying residents (and their families) for respect, compassion and care. They should seek to give 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

When a resident is dying other carers should provide care that best meets the needs of the resident, and as directed by the medical practitioner and the nurse.

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 family, carers and healthcare practitioners. When caring for a dying resident, other carers seek to establish a relationship of trust with those residents for whom they provide care.

b. 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 effects - anxiety, fear and distress, but also with its spiritual effects. Other carers should support residents to the level of their ability and training and work under the guidance of other health care practitioners to assist residents where possible.

c. Report Incidences

Report to the nurse or immediate supervisor any episodes of unrelieved pain, discomfort, or distress.

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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 other carer's aim is to assist 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 other carers 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

Other carers may at times be put in a difficult position when a resident is dying. By recognising their legal and ethical responsibilities, other carers can best support the resident and protect themselves by:

- a. Ensuring that they comply with the law and are not a participant in the practice of euthanasia;
- b. reporting any such incidents to the nurse or other supervisor;
- c. providing care as directed to relieve discomfort and to give emotional and social support; (see Protocol 1.16 on *Palliative Care*) and
- d. making decisions about care according to the agreed plan of care.

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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, other carers will initiate those resuscitative measures which are within their training and competence and call for emergency assistance unless there is an adequately documented decision, issued within the past six months following consultation, and authorised by the resident's own doctor, instructing that the resident is not for resuscitation.

1.9.2 Procedure

Other carers 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.

c. Documentation

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

- i. date of the order

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- 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)
- 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. On admission and when indicated, discussion should take place concerning the level of risk-taking that the resident (or representative) considers appropriate and a plan of care developed to ensure the safety of residents whilst respecting their wishes and right to choose to participate in activities which involve a degree of risk.

1.10.2 Procedure

Although not usually directly involved in discussions in which agreement is reached concerning risk-taking activities, other carers can contribute to and support residents in this regard by:

- a. assisting residents where and when appropriate according to the plan of care and being mindful of the right of individual residents to participate in risk-taking activities;
- b. observing for any situations that might be harmful to the resident or to other residents; and
- c. reporting to the nurse or immediate supervisor any adverse or potentially adverse situations.

1.10.3 Documentation

Contribute to the documentation of a resident's participation in potentially risky activities.

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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 living with mental illness or dementia, including those who are aged, have the same rights as every other member of the community. Other carers have a responsibility to ensure that residents who have a mental illness or who have dementia are offered appropriate assistance. 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 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. Other carers are able to meet some of these needs within their level of education and training, and should do so by:

- a. respecting the dignity of all residents who have a mental illness and providing care according to the individualised care plan;
- b. reporting to the nurse or immediate supervisor any behaviour of concern exhibited by the resident;
- c. protecting the privacy and confidentiality of a resident in respect of their behaviour or treatment;
- d. contributing to the development of, or changes to, a care plan that is founded upon medical, nursing, occupational therapy and other professional advice;
- e. developing knowledge within their level of responsibility to be able to provide appropriate care;
- f. being aware of the physical and social environment in which the resident lives and that it may require adjustment to maximise the capacity of the resident to function normally; and
- g. report to the nurse or immediate supervisor, concerns related to issues of safety and any contributing factors.

1.11.3 Documentation

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- 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; and
- c. safety measures and any documentation relating to restraint.

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 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 as a resident, 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, other carers need to 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 other carers 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 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, legally, 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; 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 authorised persons including persons outside of the home;
 - ii. refraining from discussing a resident with another resident unless specific permission is provided by the resident;
 - 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.

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- 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.

1.13.3 Documentation

Healthcare and other personal information about residents should be protected from unauthorised persons.

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1.14 Conscientious objection

**Based on values from the Code of Ethics,
Especially
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 carer has a deeply held personal moral objection to a particular procedure

1.14.1 Policy

Other carers 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 other carers 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 these are known to be safe and that they are administered according to any safety information provided.

1.15.2 Procedure

Other carers may assist a resident with the use of a complementary therapy if the following precautions are taken:

- a. seek informed advice from the resident's doctor, pharmacist and/or nurse as to the safety of the therapy, especially when used in conjunction with conventional medication, and explain to the resident why they are not obliged to assist with any complementary therapy, if advised that it is considered to be unsafe;
- b. report if the resident has any effects that could be related to the therapy;
- c. seek information from the nurse if there are any possible adverse effects to other residents, such as odour, or risk of injury;

1.15.3 Documentation

The use of complementary therapies, safety issues addressed, and monitoring processes 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. Other carers seek to support residents in a home in which they can function freely and as well as their health permits. In the event that the residents' rights and freedoms or their enjoyment of the home may be in any way compromised, other carers support residents to complain without fear of reprisal.

1.16.2 Procedure

- a. Other carers are able to, and should, support the resident or family to make a legitimate complaint by:
 - i. making available information about internal and external complaints 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 other carers believes that he or she has a legitimate concern about personal or care issues, they should report it to the person designated to receive complaints.

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1.17 Religion

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

1.17.1 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.

1.17.2 Procedure

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

1.17.3 Documentation

Other carers should assist with and refer to documentation about the religious preferences and needs of the residents.

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1.18 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**

1.18.1 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, other carers will encourage and assist with residents' safe enjoyment of their independence in living conditions, lifestyle, cultural and social activities.

1.18.1 Procedure

On admission, a social history is prepared of resident lifestyle choices and other carers will support residents in these choices, when directly involved, by:

- a. encouraging and assisting contact with family and friends, and participating community and cultural activities of the resident's own choosing;
- b. respect the right of married couples to live a married life;
- c. supporting the resident's privacy within the limitations of the home;
- d. making available appropriate seating to meet different needs;
- e. accepting the resident's choice of activities in which they participate;
- f. altering the environment as required so as to facilitate interaction among residents;
- g. respecting the cultural nature of activities in the home;
- h. providing the opportunity for, and assisting residents to change their circumstances and environment during the day, and encouraging them to do so;
- i. facilitating communication with non-English speaking residents;
- j. making accessible to residents information about current affairs and events;

1.18.3 Documentation

Other carers are able to contribute to documentation which should reflect the choices of residents, how these will be implemented and any changes made over time

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.

1.19 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**

1.19.1 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. Other carers 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.

1.19.2 Procedure

- a. In response to requests from residents or their legally recognised representative(s) to become involved with financial or legal matters, other carers should inform the resident or their representative of the processes established to deal with those matters, or refer the matter to the nurse or immediate supervisor.
- b. Other carers should participate in meeting accountability requirements where they are involved in assisting residents with their day-to-day finances.
- c. Requests made to other carers to witness wills or any other documents pertaining to the financial affairs of residents, are to be referred to the person designated to assist in this regard, or information provided to the resident or their representative(s) about seeking independent assistance.

1.19.3 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.

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.

1.20 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.

1.20.1 Policy

Other carers should be vigilant in recognising incidents of abuse to residents. Where they have reasonable suspicion of abuse, they should protect the resident by reporting their suspicions or the incident of abuse to the nurse or immediate supervisor. 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.

1.20.2 Procedures

- a. Where a carer is concerned about abuse to a resident he or she should protect the resident by reporting to the nurse or immediate supervisor, knowledge of or suspicion that a resident is the subject of abuse. If the other carer is unable to make a report to the nurse or other supervisor, or the senior person does not act on the report, the other carer needs to consider reporting any suspicions or knowledge of abuse to the police.
- b. If a carer 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 carer, other residents or further endanger the resident being harmed. Whether able to personally intervene or not, the other carer should call the police immediately.

1.20.3 Documentation

Other carers should assist in documenting 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.

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.