

***MODEL ETHICAL
PROTOCOLS
for
PROVIDERS***

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 Providers

These *Ethical Protocols for Providers* express the provider's ethical responsibilities. Often these responsibilities are met by staff acting in roles delegated by the provider. The provider has the overall responsibility to ensure that reasonable steps are taken to adequately staff the homes, to resource staff, and to establish appropriate mechanisms of internal review and audit in relation to the ethical responsibilities.

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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

The provider should ensure that residents and/or (when appropriate) their legally recognised representatives for medical and accommodation decisions are aware of the type and limitations of the accommodation offered and the resident's rights and responsibilities. The provider should be aware of the specific needs of the resident and the expectations that the resident has in relation to the care being offered and its limitations, and the standards of conduct and ethical practice upheld by the home. Providers should not admit residents for whom they cannot provide adequate care. These matters should be individually discussed and documented. The admission process should permit enough time for the resident or his or her legally recognised representative(s) to review and seek advice upon all relevant documentation.

1.1.2 Ethical Issues in Practice

On or prior to admission, the provider should ensure that the resident or the legally recognised representative(s) of a resident assessed as being incompetent by a medical practitioner.*

- a) is presented with the ethical protocols of the home, its *Code of Ethics*, its *Guide to Ethical Conduct*, and its complaints process, which are then explained;
- b) has been asked to give details of specific personal, cultural, language, and religious needs of the resident (including existing care) and to discuss his or her expectations in that respect;
- c) is aware of the resident's rights and responsibilities in relation to other residents for which purpose the home should have a clearly and simply written brochure printed in a size not less than 12 point but preferably 14 point;
- d) is aware of the level of nursing care available within the home and any limitations in the provision of that care;
- e) has discussed who is responsible for medical care of the resident, and provided assistance for the resident or legally recognised representative to choose an alternative medical practitioner as required by the resident or legally recognised representative;
- f) has discussed, within a reasonable time frame shortly after admission, what should happen in the circumstances of a medical emergency affecting the resident, including the possibility of a cardiac or respiratory arrest;
- g) has discussed who is to be notified of the admission including their priest, minister, community elder or spiritual adviser, if any; and

* in relation to accommodation matters and in relation to medical matters

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- h) provides the contact details of the person(s) legally authorised to make decisions on behalf of the resident should the resident become unable to make decisions.

1.1.3 Documentation

The above discussion should be documented in the resident's file and a copy of that report made available to the resident or the legally recognised representative(s) of a resident assessed by a medical practitioner as being incompetent. The names and contact details of the latter should be recorded.

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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. The provider will ensure that the home complies with the Commonwealth legal provisions* concerning equal opportunity in relation to employees and residents.

1.2.2 Ethical Issues in Practice

(a) In engaging, disengaging and in all other dealing with them, all employees are treated on their merits without regard to race, age, gender, marital status, colour, nationality, descent, ethnic or ethno-religious background, sexual orientation, or disease or disability where these differences do not affect the performance of their duties. Employees are valued according to their ability to perform their duties, their ability and their enthusiasm to maintain the philosophy and standards of care of the home.

- (b) The provider will ensure that, within the home:
- i) employees and residents are treated equitably and are not subject to unjust discrimination;
 - ii) people who make complaints, or witnesses, are not victimised in any way;
 - iii) reports of unjust discrimination or harassment will be treated seriously and investigated promptly, confidentially and impartially;
 - iv) disciplinary action will be taken against anyone who unjustly discriminates against a co-worker or a resident – including a warning (verbal or written), transfer, counselling, demotion or dismissal, depending on the circumstances; and
 - v) sexual harassment and unnecessary familiarity are recognised as illegal and subject to disciplinary action.
- c) Complaints about unjust discrimination or harassment should be taken to the person designated to receive complaints (see protocol 1.16 on Complaints).

• including the *Human Rights and Equal Opportunity Commission 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. Residents are to be adequately informed and their consent obtained for 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 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 Ethical Issues in Practice

The provider will take reasonable steps to ensure that:

- a) 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) residents with little or no English language competency be provided with language assistance to facilitate effective communication;
- 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 recognised representative* will 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,

* for accommodation or for medical treatment decisions

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dementia, feelings of fear and vulnerability, sickness, pain, ignorance or confusion), and this assessment is supported by a clinical diagnosis by a healthcare practitioner with appropriate expertise;

- e) except in the case of an emergency, care interventions are not 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, the resident is competent to consent, and is not being coerced or intimidated;
- f) except in the case of an emergency, care interventions should not be administered to an *incompetent* resident until all relevant information has been disclosed and considered by the resident's legally recognised representative, and the consent of that representative has been given;
- g) in the event that the provider 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 provider will seek legal review of the representation of the resident;
- h) in the case of emergency, if consent cannot be obtained, the provider will ensure that employed carers act in the resident's best interests, 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 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 attending healthcare practitioners do not override any refusal of treatment by a competent patient* who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not the provider or the practitioner agrees with the resident's refusal.
- j) when there is significant change in the circumstances of the resident, the family is informed at the earliest possible opportunity unless directed otherwise by the resident.

1.3.3 Documentation

The provider 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) decisions by attending healthcare practitioners concerning treatment administered to residents;
- (c) care decisions by a resident's legally recognised representative(s) for accommodation and medical treatment; and
- (d) emergency measures and any other care interventions that are taken without the consent of a resident or his or her legally recognised representative.

* Note that the word "patient" signifies the particular relationship between a health care practitioner and his or her patient.

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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 will 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 Ethical Issues in Practice

- a) A variety of fresh foods from the five food groups will be offered to all residents who are able to eat and in accordance with their expressed preferences.
- b) Menus are planned to provide a variety of foods, and the menu changes.
- c) A dietician is consulted on matters relating to nutrition and diet therapy when necessary. This is based on assessment of needs.
- d) Residents are to be given a choice of foods at each meal.
- e) Residents' food preferences and cultural requirements are to be identified on admission and reviewed regularly.
- f) Residents' dietary intake is to be maintained by the nursing and personal care staff to ensure that individual food and fluid *actual intake* is nutritionally adequate and to seek advice if there is doubt.
- g) Meals are served at the specified times and at an appetising temperature.
- h) Nourishing snacks should be reasonably available for residents.
- i) Food and fluids are provided in accordance with residents' assessed needs, individual preferences and requests.
- j) For residents with swallowing difficulties see Protocol 1.5 on *Artificial Nutrition and Hydration*.

1.4.3 Documentation

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

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1.5 Artificial Nutrition and Hydration

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1.5.1 Policy

Residents with swallowing difficulties or other pathologies (normally assessed by a speech pathologist) may require artificial delivery of nutrition and hydration (by percutaneous endoscopic gastrostomy (PEG), naso-gastric tube or parenterally). Artificial nutrition and hydration is not to be initiated or continued on the grounds of the convenience of the staff or the providers but is to be initiated by the resident's medical practitioner or dietician.

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 Ethical Issues in Practice

Providers will ensure that:

- a) residents with swallowing difficulties are assessed by a speech pathologist where available or other appropriate health 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 guidance and review of artificial nutrition and hydration by a medical practitioner and/or a dietician for those who require it;
- d) staff are adequately trained to care for those requiring artificial nutrition and hydration; and
- e) the social and psychological needs of those deprived of an ordinary meal event are met.

1.5.3 Documentation

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The resident's care plan should reflect any identified eating problem, the assessments made and by whom, and the outcome or treatment instigated. Monitoring and evaluation of the problem and the treatment is to be recorded. The rationale for artificial nutrition and hydration is to be recorded by the health professional 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, 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 following section on the Care of the Dying).

1.6.2 Ethical Issues in Practice

The provider seeks to develop this area of health care by organising the resources of the home to ensure that

- a) palliative care, knowledge, and skills of the staff are developed;
- b) all residents have access to palliative care expertise as required (by distance communication if necessary); and
- c) when possible, advantage is taken of specific initiatives to support research and develop palliative care for people who are aged;

1.6.3 Documentation

The palliative care needs of residents who are suffering pain or other symptoms 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 individuals to have their religious and cultural identity respected**

1.7.1 Policy

The provider aims to ensure that staff and attending health care practitioners within the home are especially aware of the needs of dying residents (and their families) for respect, love, care, dignity, and compassion. Employed carers should seek to give 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 Ethical Issues in Practice

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, employed carers and healthcare practitioners. The provider aims to ensure that those caring for a dying resident seek to establish a relationship of trust, compassion and confidence with all those in their 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 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. (See Protocol 1.5 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 consequences - anxiety, fear and distress, but also with its spiritual effects such as crises of faith, hope and love. Depression, for example, is often an unrecognised and untreated symptom of illness and providers should strive to ensure that

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there is adequate medical and nursing assistance to relieve it. Providers should ensure that there is adequate professional assessment and assistance available to dying residents.

d) Employed carers' and Residents' Families

Providers should make available grief support to employed carers and residents' families.

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 provider'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 home or its staff to end or to co-operate 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, 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 Ethical Issues in Practice

The provider will ensure that

- a) all staff are aware that the home rejects the practice of euthanasia and that legal and disciplinary action will be taken in the event that euthanasia is attempted or a staff member co-operates in or fails to report an attempt to achieve euthanasia;
- b) visiting medical and other practitioners 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;
- c) adequate care is provided to relieve discomfort and to give emotional and social support. (see protocol 1.6 on *Palliative 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, 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 Ethical Issues in Practice

The provider will ensure that all nursing staff, other employed carers and visiting health practitioners are aware of 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:

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- 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)
- vii) doctor's signature and contact details.

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1.10 Risk-taking

**Based on values from the Code of Ethics,
Especially
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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 the steps the provider will take 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 Ethical Issues in Practice

- a. Counsel 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. Ensure that the residents, relatives and legally recognised representatives are aware of the provider's responsibility and commitment and legal duty to provide for the overall safety of residents.

1.10.3 Documentation

Ensure the discussion of a resident's participation in potentially risky activities is well documented

* for accommodation and medical treatment decisions

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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 provider has a responsibility to ensure that residents living with mental illness or dementia are offered appropriate assistance. The provider seeks to ensure that residents 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 protocol 1.12 on *Restraints*).

Mental illness or dementia in a resident may cause difficulties or burdens for other residents. Providers should ensure that residents are not compelled to become alternative carers. Residents should be helped to understand the issues involved in living with someone who is mentally ill or demented.

1.11.2 Ethical Issues in Practice

The development of mental illness or dementia in a resident is not to be ignored or taken for granted in older persons, by ensuring that:

- a) A diagnosis of mental illness or dementia made prior to admission is supported by proper investigation and assessment;
- b) appropriate medical investigation is obtained to determine whether the condition is reversible or may improve with treatment;
- c) a care plan is developed founded upon medical, nursing, occupational and diversional therapy, other professional and family advice;
- d) a physical and social environment is established which maximises the capacity of the resident to function normally; and
- e) if necessary, appropriate steps are taken to ensure the safety of the resident and others

1.11.3 Documentation

The care plan should specify:

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- a) any medical investigation undertaken or to be undertaken and any treatment decisions made with respect to advice from any attending medical or other health practitioners;
- b) decisions concerning the physical and social environment;
- c) decisions concerning cultural and linguistic needs;
- d) safety measures and any documentation relating to restraint (see protocol 1.12 on *Restraints*).

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

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Especially
The right to privacy and confidentiality**

1.13.1 Policy

Prior to or on admission the resident should be informed of the standard of privacy and confidentiality expected to be observed in the home. 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 employed carers is dependant on them using that information only in the resident's interests and according to the resident's wishes or presumed wishes. That is even more so in relation to those healthcare practitioners who enter into a relationship of care with the resident. Personal privacy and modesty is to be respected and protected.

1.13.2 Ethical Issues in Practice

- 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, employed carers and 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.
- 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, in accordance with privacy principles, 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 healthcare professionals 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 healthcare professionals to divulge confidential information in order to prevent serious harm to their patients.
- d) Provide resources sufficient to protect the resident's privacy and modesty.

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1.13.3 Documentation

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

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1.14 Conscientious objection

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The right of individuals to have their religious and cultural identity respected**

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

1.14.1 Policy

Staff have a right to withdraw their involvement in activities to which they have a grave 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 Ethical Issues in Practice

Where possible staff members 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.

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.

1.15 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. 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 a 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 should 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.

1.15.2 Ethical Issues in Practice

On admission or before commencing a complementary therapy, the resident should be asked about the nature of any complementary therapy and, if necessary, a medical opinion sought concerning its safety. The resident's doctor and pharmacist should be informed about any complementary therapies being used.

1.15.3 Documentation

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

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. The provider seeks to provide residents with a home in which they can function freely within their capacities. In the event that their rights and freedoms of residents and staff, or their enjoyment of the home may be in any way compromised, the provider offers the opportunity for residents, family members or representatives, and staff to complain without fear of reprisal. The complaint should be heard and a decision made in accordance with the law, the philosophy of the home, the good functioning of the home and the rights of the complainant, of other residents and of staff.

1.16.2 Ethical Issues in Practice

The provider will establish a complaints process, designate a member of staff authorised to receive complaints, and make the identity of that person known to the residents and their families. Provision is to be made for those with little or no English language competency. The designated staff member will ensure that all complaints are acted upon. All staff members are able to accept complaints, including verbal complaints, and refer them as soon as practicable to the staff member authorised to receive complaints.

The person designated to receive complaints must:

- a) be reasonably available to receive and investigate complaints;
- b) respect the confidences of the complainant including his or her identity if that is requested or warranted;
- c) seek resolution (including the provision of appropriate feedback) through discussion with the parties, if possible; and
- d) bring to the notice of the provider complaints that have been substantiated and make recommendations concerning any matters that may warrant administrative direction or disciplinary action taken.

1.16.3 Documentation

The person designated to receive complaints documents

- a) all complaints, taking care to protect confidences, including the complainant's identity if that is requested or warranted,

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- b) the process engaged in to resolve a complaint,
- c) his or her report to the provider, and
- d) any action taken as a result of the complaint.

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.

1.17 Security of tenure

**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**

1.17.1 Policy

The provider, consistent with its legal responsibility for providing security of tenure, seeks to assure residents that their place, within the terms of the agreement entered into, is secure for as long as they need the level of accommodation and care that the home can provide and the circumstances remain appropriate for them.

a) Arranging another place out of the home, when the home can no longer provide suitable accommodation and care for the resident, should occur only after consultation with the resident or his or her legally recognised representative(s) and following a legislated notice process. Where providers have established ageing in place, arrangements should be made to assess changes in the resident's needs and of the capacity of the home to care for the resident given changed circumstances.

b) Arranging another place within the home should be negotiated with individual residents and their families or legally recognised representatives. No resident will be displaced from a room unless it is in his or her interests consistent with the provider's legal responsibility on moving a resident within the home.

1.17.2 Ethical Issues in Practice

- a) Residents will not be displaced without due cause, unless it is in their interests, and in accordance with the provider's legal obligations. The provider will inform residents of any organisational changes that may affect their security of tenure as soon as that becomes definite. Rooms are secured for residents who require temporary hospitalisation or vacate their rooms temporarily for other reasons, as required by law.
- b) Room transfers will be negotiated with residents and their families or legally recognised representatives consistent with the provider's legal obligations.

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.

1.18 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**

1.18.1 Policy

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

1.18.2 Ethical Issues in Practice

The provider ensures that

- a) residents are assisted to secure the services of their own choice of health care practitioner if they are unable to make their own arrangements.
- b) when a health care practitioner is required and the resident's choice of practitioner is unwilling or unable to attend, then assistance with arrangements is made for another practitioner to attend;
- c) the relationship between an attending health practitioner is respected as being between the resident (or his or her legally recognised representative) and the health care practitioner;
- d) access for attending health care professionals chosen by the resident is facilitated, but the provider is entitled to require that the conduct of attending health care professionals towards staff, and for the care of the resident, 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 professionals are aware that they have responsibilities for the independent assessment of the health and well-being of their patients and that their advice for improvements in the health care of the resident is welcome;
- f) attending health care professionals 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 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; and
- g) attending health care professionals have the opportunity to give advice indicating the need for consultation with other health care professionals, or for review of the resident's care plan or assessment of the level of care provided to the resident.

1.18.3 Documentation

The provider seeks to ensure that

- a) attending 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;

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- b) attending 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;
- c) nursing and other staff document information required by the health care practitioners attending a resident.

1.19 Religion

**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 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 should have ease of access to priests, ministers, community elders or spiritual advisers.

1.19.2 Ethical Issues in Practice

- a) The provider seeks to ensure that within the limits of the rights of others and in accordance with the philosophy of the home, residents are not obstructed in the exercise of these freedoms and that their religion and beliefs are respected.
- b) The provider ensures that there is opportunity for residents to request a priest, minister, community elder or spiritual adviser of their choice.
- c) The provider makes available a place, not necessarily a dedicated place, for religious observances.

1.19.3 Documentation

- a) For the information of those engaged in the care of the resident and to facilitate access to religious practice and pastoral care of the resident's own choosing, on admission and when otherwise notified by the resident, the provider documents the particular religion and beliefs of the resident and matters relevant to providing accommodation and care.
- b) The resident's choice of priest, minister, community elder or spiritual adviser, if any, and the circumstances in which the latter is to be contacted are to be documented.

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1.20 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**

1.20.1 Policy

Residents have the right to freedom of movement and association consistent with the provider's responsibilities for the safety and security of all residents (refer policies 1.10 on *Risk Taking*, 1.11 on *Care of Persons with Mental Illness or Dementia*, and 1.12 on *Restraint*). Wherever possible, the provider encourages and facilitates the safe enjoyment of independence in residents' living conditions, lifestyle, and cultural and social activities.

1.20.2 Ethical Issues in Practice

On admission, a social history is prepared and the provider ensures that:

- a) contact with family and friends, and participation in community and cultural activities of the resident's own choosing are encouraged and facilitated;
- b) married couples are able to live a married life;
- c) visiting hours and routines are flexible;
- d) residents' visitors are welcomed and residents are able to invite visitors into their home;
- e) private areas other than the resident's own room are provided, where possible, for residents to entertain visitors, attend to business or make telephone calls;
- f) access to communal areas is provided;
- g) communal areas have seating for all residents suited to individual and group needs;
- h) there are joint activities with residents including those with disabilities, and that activities with the wider community are encouraged and facilitated;
- i) activities within the home are culturally appropriate;
- j) residents may choose in which activities they participate;
- k) organised outings into the wider community are arranged in which residents may choose to participate, including those with disabilities;
- l) sound and light are controlled so as to facilitate interaction among residents;
- m) residents have the opportunity to change their personal environment during the day and the choices of environment are conducive to a stimulating life;
- n) communication with non-English speaking residents will be facilitated;
- o) residents have the opportunity to be informed about current affairs and events and be provided with the necessary assistance to attend events of their choice;
- p) restriction of access to and from the facility and within the facility will be justified and kept to a minimum;
- q) if requested, residents will be assisted to organise transport.

1.20.3 Documentation

Refer to admission protocols and to the need to revise documentation as the personal circumstances of resident's change.

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1.21 Younger persons with degenerative disorders or other disabilities

**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**

1.21.1 Policy

The provider may, in special circumstances, opt to admit younger persons who suffer from degenerative disorders or other disabilities. When doing so the provider undertakes to meet the special needs of younger persons where those needs differ from the needs of older persons and can reasonably be met within the circumstances of a home for older persons.

1.21.2 Ethical Issues in Practice

On admission, the provider will seek to identify the particular needs of a younger person and make appropriate arrangements especially in regard to:

- a) timing of daily events such as meal times and hours of rest;
- b) social and cultural activities and entertainment;
- c) contact with wider community and other younger persons;
- d) privacy;
- e) access to further education; and
- f) social relationships.

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.

1.22 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**

1.22.1 Policy

In all financial and legal matters, care is to be taken to avoid conflicts or potential conflicts of interest between the provider 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. Moreover, providers are not only to ensure that they act in the best interests of vulnerable residents in relation to finances and other property, they are also to take all reasonable steps to ensure that they remain removed from the management of residents' long-term financial affairs. Providers are also to ensure that the staff is protected from potentially compromising situations which may arise from their being involved in the day to day finances of residents.

1.22.2 Ethical Issues in Practice

- a. Prospective residents and their families are to be informed, in writing, prior to the admission to the home, of any conflict or potential conflict of interest that may arise if the provider also provides other services to the home or to its residents. These services may include provision of medical, pharmaceutical, nursing or legal services, or supplies.
- b. Where the provider or staff are involved in assisting residents with their day to day finances, a high level of accountability is to be assured to residents or their legally appointed representatives by making available to them documented accounts of any transactions in which the provider or staff may have been involved.
- c. In the event of a resident wishing to make a bequest or a donation to the organisation, the provider ensures that such bequests or donations are freely made. The resident or legally appointed representative(s), are to be advised that such processes are to be carried out independently of the home or its staff. Assistance with access to independent social, legal or other relevant advice is to be provided, where required, and the provider is to remain separate from residents' long-term financial affairs.
- d. The provider will require that staff not act as witnesses to wills or any other documents pertaining to the financial affairs of residents.
- e. Providers will ensure that they understand that engaging a particular supplier of goods or services, such as a hair-dresser, pharmacist or health care practitioner on behalf of a resident, where providers secure some payment, commission or other advantage for themselves, is not only unethical but potentially illegal.

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1.22.3 Documentation

- a. Provide a standardised method of documentation for staff who may be engaged in the day-to-day financial affairs of residents.
- b. Document all requests for assistance in the making of bequests and donations.
- c. Document all action taken to meet requests for assistance in the making of bequests and donations

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.

1.23 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.

1.23.1 Policy

Vigilance in respect of abuse is to be encouraged and providers will ensure that, where there is reasonable suspicion, there is appropriate investigation and management to prevent further abuse. Any investigation and resulting action will respect the rights and needs of the victim, the rights of those suspected, (especially their right to their good name), and the need for a just resolution for all concerned.

1.23.2 Ethical Issues in Practice

- (a) Where a resident has been abused, or there is an accusation or reasonable suspicion of abuse, the provider will ensure that there is an appropriate process for handling such matters.
- (b) That process will adopt the following objectives in order of importance:
 - i. To protect residents from further financial exploitation, theft, violence, threats of violence or other behaviour that causes distress or physical harm;
 - ii. To comply with the law and co-operate with police and other officials in the lawful and reasonable performance of their duties to protect residents and other members of the community from harm caused by illegal acts, to investigate illegal activities and to bring perpetrators to justice;
 - iii. To ensure that good order is maintained in the home and that its functions are not impeded;
 - iv. To ensure that perpetrators or accused perpetrators are justly treated by the home and that within the limits of meeting the above objectives the home's response is charitable and has the interests and welfare of the perpetrator in mind;
 - v. To protect the good name and reputation of an accused person;
 - vi. To ensure that there is adequate counselling and support for each affected resident or staff member including any suspected perpetrators;
 - vii. To protect confidences and personal privacy.
 - viii. To provide support, where practicable, to the immediate affected family.

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.

- c) The legally recognised representative of an incompetent or doubtfully competent resident who is the subject of abuse, and his or her family, shall be notified except in those circumstances in which they have abused the resident or are suspected of the abuse. If a competent resident so wishes his or her family should be notified.

- d) If necessary, alternative representation should be sought which may involve application for a review of the resident's representation by the appropriate legal authority.

1.23.4 Documentation

Suspicious of abuse, investigation and any further action shall be documented. Such reports are to be kept confidential and available only to those who have need of them for the purpose of appropriate investigation and management, including police or other authorities involved.

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.