

Acorn Aged Care Policy and Procedures Manual

1: MANAGEMENT AND ADMINISTRATION

February 2002

The sections for this manual are:

1. [Document Control](#)
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5. [Financial Management](#)
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A Gevers Goddard Jones Aged Care Management System

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CONTINUOUS IMPROVEMENT

CONTINUOUS IMPROVEMENT

The continuous improvement process for Acorn Aged Care includes the ongoing assessment of information from a range of meetings and ongoing audits, surveys and reports. This is shown below in the figure below: Acorn Aged Care Feedback and Reporting System.

Acorn Aged Care has established a Quality Committee to manage the continuous improvement process. Service information is assessed by the Quality Committee who will decide on action. All **significant** improvements will be recorded on an Improvement Project Log (**Form MA1**) for tracking the improvements and the action. Actions may include:

- changes to policy or procedures and practises;
- staff training;
- purchase of equipment or materials;
- maintenance;
- consultations with key people;
- further review or research of the issue;
- evaluation of the improvement.

This continuous improvement process is illustrated below in the figure Acorn Aged Care Continuous Improvement Process.

The operation of the continuous improvement process is monitored by the Management Committee through a report from the Care Manager at each monthly meeting of the Committee. Continuous improvement is included as a standard agenda item for each meeting of the Management Committee.

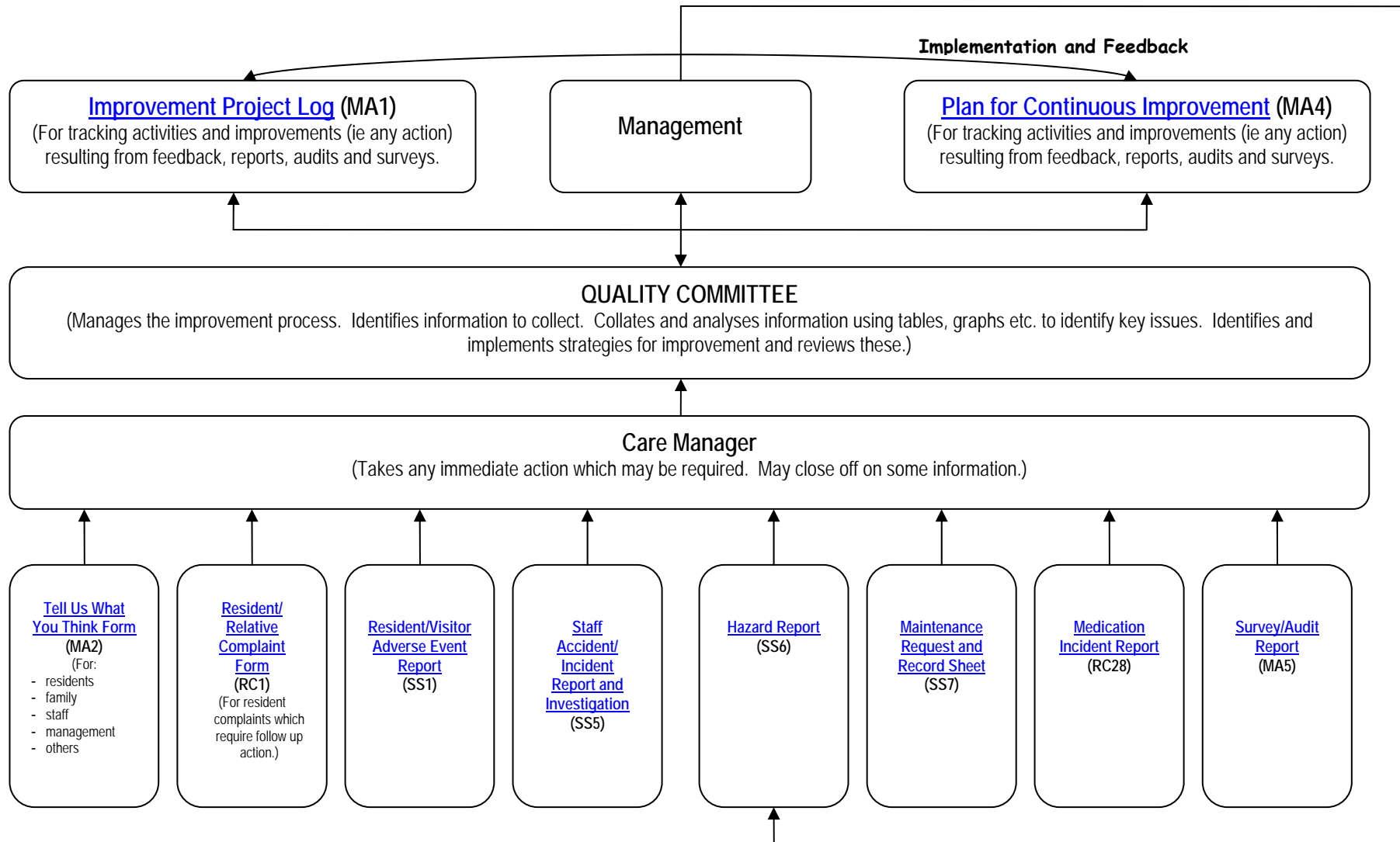
The Management Committee will ensure that the continuous improvement processes are evaluated in June each year.

MEETINGS

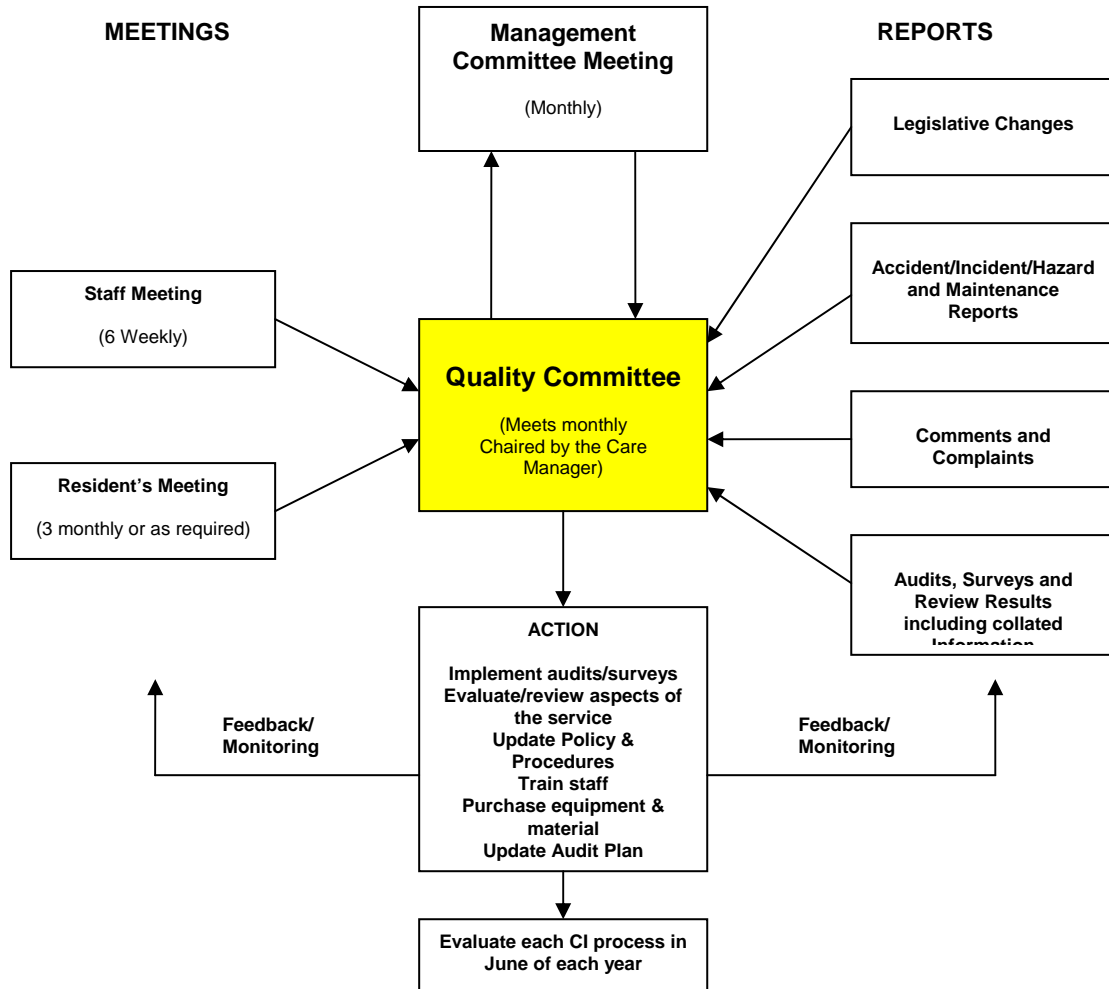
The meetings which contribute to the continuous improvement process are described in detail in Section 3: Service Management. They are also shown in the Continuous Improvement Process diagram below. Current meetings include:

- Management Committee meetings
- Senior management meetings
- Staff meetings
- Resident's meetings
- Quality Committee meetings.

Acorn Aged Care Feedback and Reporting System



Acorn Aged Care Continuous Improvement Process



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THE QUALITY COMMITTEE

THE ROLE OF THE QUALITY COMMITTEE

The role of the Quality Committee is to:

1. Develop and evaluate processes that ensure continuous improvement is achieved and is integrated into the operations of the service. This includes the development of information collection strategies and tools and the allocation of tasks for the processing and presentation of information.
2. Identify areas of service operation where improvements can be made and identify and clarify the outcomes to be achieved by the changes.
3. Develop an ongoing plan for continuous improvement.
4. Monitor the implementation of the continuous improvement plan including identifying any unintended consequences.
5. Ensure that improvements, which have been achieved, are recorded and that evidence of the outcomes is available.
6. Provide monthly reports to the Management Committee on proposed improvements and on the progress of improvements, which have been implemented.
7. Ensure staff, residents/representatives and other key players are involved in and kept informed of continuous improvement activities.
8. Ensure occupational safety and health information and issues are reviewed and examined and that appropriate actions are taken to prevent the occurrence of issues.
9. Evaluate and review the continuous improvement process and make recommendations to the Management Committee on improvements to the processes.

COMPOSITION OF THE QUALITY COMMITTEE

Membership of the Quality Committee comprises of:

- one member of the Management Committee;
- the Care Manager;
- the Occupational Safety and Health representative;
- the infection control officer;
- other staff as appropriate.

QUALITY COMMITTEE MEETINGS

The Quality Committee will meet at least once a month or as often as it needs to deal with quality issues.

FORMS, AUDITS AND REPORTS

The forms, audits and reports that are integral to the continuous improvement strategy include:

- Tell Us What You Think (Feedback form for: residents, family, staff, management and others.) (**Form MA2**)
- Resident/Relative Complaint Form (For recording resident complaints which require follow up action.) (**Form RC1**)
- Resident/Visitor Accident/Incident Report (**Form SS1**) (See also Manual 4: Safety, Security, Cleaning, Laundry and Catering)
- Staff Accident/Incident Report and Investigation (**Form SS5**) (See also Manual 4: Safety, Security, Cleaning, Laundry and Catering)
- Hazard Report (**Form SS6**) (See also Manual 4: Safety, Security, Cleaning, Laundry and Catering)
- Maintenance Request and Record Sheet (**Form SS7**) (See also Manual 4: Safety, Security, Cleaning, Laundry and Catering)
- Medication Incident Report (**Form RC28**) (See also Manual 3: Resident Care)
- Infection/Skin Condition Assessment Report (**Form RC14**) (See also Manual 3: Resident Care)
- Survey/Audit Report (**Form MA5**)
- Improvement Project Log (For tracking activities and improvements resulting from feedback, reports, audits and surveys.) (**Form MA1**)

Audits

Current audits and ongoing data collections include:

- skin tears (using **Form SS1**: Resident/Visitor Accident/Incident Report) and Infection/Skin Condition Assessment Report using **Form RC14**)
- falls (using **Form SS1**: Resident/Visitor Accident/Incident Report)
- rashes and infections (using **Form RC14**: Infection/Skin Condition Assessment Report and **Form SS4** Infection Control Audit)
- cleaning (using **Form SS3**: Safety and Housekeeping Audit)
- medication (using **Form RC28**: Medication Incident Report)
- repairs and maintenance (using **Form SS6**: Hazard Report)
- occupational health and safety (using **Form SS5**: Staff Accident/Incident Report and Investigation)
- client surveys (using **Form MA6**: Resident Survey: Quality of Service, **Form MA7**: Resident Survey: Meals, **Form MA8**: Resident Survey: The Assessment Process)

- relative's surveys (using **Form MA9**: Relative's Survey)
- management committee (using **Form MA10**: Management Committee Assessment Form)

REFERENCE NUMBERS FOR FORMS

Each of the key forms in the Feedback and Reporting System, when completed, needs to be assigned a reference number to easily track it and refer to it.

The reference numbers start with 2 letters to indicate the type of form as follows:

- TU - Tell Us What You Think
- RC - Resident Complaint Form
- RA - Resident/Visitor Adverse Event Report
- SA - Staff Accident/Incident Report and Investigation
- HR - Hazard Report
- MR - Maintenance Request and Record Sheet
- MI - Medication Incident Report
- SC - Infection/Skin Condition Assessment Report
- SU - Survey/Audit Report
- IP - Improvement Project Log

In addition, each form should be assigned a number as follows:

- a form number; and
- the month and year.

For example, HR12/12/01 indicates Hazard Report 12 for December 2001.

The Care Manager will assign the reference number when reviewing each form for any immediate action.

PROCESSING KEY FORMS, AUDITS AND REPORTS

When forms are received the Care Manager checks to see if any immediate action is required and completes all relevant sections of the forms. If immediate action is required the appropriate staff person is instructed and the action is recorded on the form.

At the end of each month the individual key form and an aggregate or summary of the forms and graphs are presented to the Quality Committee to see if any improvements are indicated.

The following process is followed:

1. The forms:
 - Tell Us What You Think
 - Resident/Visitor Adverse Event Report
 - Staff Accident/Incident Report and Investigation

- Medication Incident Report
- Infection/Skin Condition Assessment Report
- Maintenance Requests.

are aggregated using a summary sheet. (Refer to the Management and Administration Forms File for copies of the Summary Sheets (**Forms MA 13 to 17 and MA31**) and trend graphs developed on Excel are updated.

2. The forms:
 - Resident/Relative Complaint Form; and
 - Hazard Report.

are compiled for the month ready for presentation to the Quality Committee.

3. The summary sheets (including comments on the analysis of the information), graphs and all completed forms are presented to the next Quality Committee meeting.
4. The Quality Committee decides if there are any improvements required from the forms. If there are, an Improvement Project Log is set up, and is noted on the relevant form or summary sheet.
5. The Quality Committee also looks at the aggregated information and the graphs to identify any trends and to check if they are meeting targets they previously set. Again, if any improvements are indicated the Quality Committee will commence an Improvement Project Log. Reference is made to the source of the improvement ie the feedback form that the improvement came from (note the number in the right hand corner of the improvement project log).
6. After the Quality Committee meeting any Improvement Project Logs completed from forms are entered in the 'Outcome/Evaluation of Action' section of the summary sheet.
7. The individual completed forms, their summary sheet and graph are filed in the appropriate file. The file includes 'Open' and 'Closed Out' sections. Forms requiring ongoing action are filed in the 'Open' section. Once action is completed they are filed in the 'Closed Out' section, and stapled together in month groupings. The summary sheet and a copy of any graphs are also filed in the appropriate sections of the file. **Only the Quality Committee can close out forms.**

The Care Manager presents forms for closing out to the next Quality Committee meeting. Any forms received but not actioned and closed out in one month are included in the summary sheet and aggregated for that month, but are left in the 'Open' section of the file, and closed out when all action has been completed. ***This means that forms are summarized and aggregated in the month they are received, irrespective of whether they are closed out or not. Once closed out, they are stored with the other forms from the month they were initiated.***

8. Three months of completed data collection forms are stored in the file and then archived off. Summary sheets for the whole year are kept in the file. As each month of data is entered into the Excel spreadsheet, the previous months' graph can be destroyed, as the current graph will have the latest month's data together with all of the previous months' data.
9. The Improvement Project Logs are filed in an Improvement Project Log file. Again the file includes 'Open' and 'Closed Out' sections. **Only the Quality Committee can close out Improvement Project Logs.** The Quality Committee also identifies the tasks to be carried out for an improvement project, who will carry it out and by when. The Care Coordinator is responsible for monitoring this action plan and the progress is checked at each Quality Committee meeting.

An Improvement Project Log is not closed out until the improvement is evaluated and the result of the evaluation recorded on the log. Improvement Logs are not summarized and aggregated until they have been **closed out**.

10. All files containing 'Open' forms are taken to the Quality Committee meeting where action on 'Open' forms is checked.

IMPROVEMENT PROJECT LOG

As noted above an Improvement Project Log is completed for any significant improvements being implemented in the service.

In this way the Improvement Project Logs provide a detailed history of improvements, the strategies to achieve the improvements and the evaluation of the improvements.

All improvements recorded on an Improvement Project Log must be evaluated. The period for evaluating an improvement varies, depending on the improvement, from days to months. If a proposed improvement is causing problems it may be discontinued immediately.

The results of the evaluation are recorded on the Improvement Project Log.

The Improvement Project Log can only be closed out after it has been evaluated.

Improvement Project Logs should be completed for all necessary improvements required by the Aged Care Standards Agency.

AUDIT PLAN

The Care Manager maintains on computer an up-to-date Audit Plan (**Form MA3**) which details the audits, surveys and other data collection and monitoring activities scheduled for the next 12 months. An Audit/Survey Report (**Form MA5**) is completed for each of the Audits/Surveys completed on the Audit Plan and filed in the Audit/Survey Report file. These are numbered as detailed above.

The Management Committee is kept informed of changes and additions to the Audit Plan by the Care Manager.

A current copy of the Audit Plan is kept in the Other Key Documents file.

PLAN FOR CONTINUOUS IMPROVEMENT (PCI)

The Care Manager maintains on Microsoft Word an up-to-date Plan for Continuous Improvement (PCI) (**Form MA4**) as per the format specified by the Aged Care Standards Agency.

Necessary improvements identified by the Aged Care Standards Agency must be listed on a PCI. In addition any improvements for which an Improvement Project Log (**Form MA1**) is completed will also be recorded on the PCI. In this way the PCI will become a tool for scheduling and monitoring improvements.

The Care Manager is responsible for ensuring the PCI is maintained up-to-date.

END OF MONTH REPORTS TO THE MANAGEMENT COMMITTEE

At the end of each month the Care Manager must compile for presentation to the next Management Committee meeting summary information on the following:

- hazards;
- resident incidents;
- staff accidents;
- infection control issues;
- medication incidents;
- Tell Us What You Think forms;
- Resident Complaint forms;
- Maintenance Requests;
- Survey/Audit Reports;
- Continuous Improvement Logs;
- Plans for Continuous Improvement.

The Management Committee will review this information to check the direction of any trends and to check on improvements underway in each service.

EVALUATION OF THE CONTINUOUS IMPROVEMENT PROCESS

In June of each year the Care Manager is to initiate an evaluation of the continuous improvement process in the service. This evaluation will assess whether the process is effective in achieving improved outcomes for residents and staff and whether any changes are necessary to achieve even better outcomes.

Areas reviewed will include all the components and activities of the continuous improvement process including:

- the meeting structure;
- resident involvement;
- staff involvement;
- community involvement;
- the effectiveness of the audits;
- gaps in audits;
- the effectiveness of the incident/accident report processes;
- the effectiveness of the comments and complaints processes;
- the effectiveness of all other forms and processes used for continuous improvement.

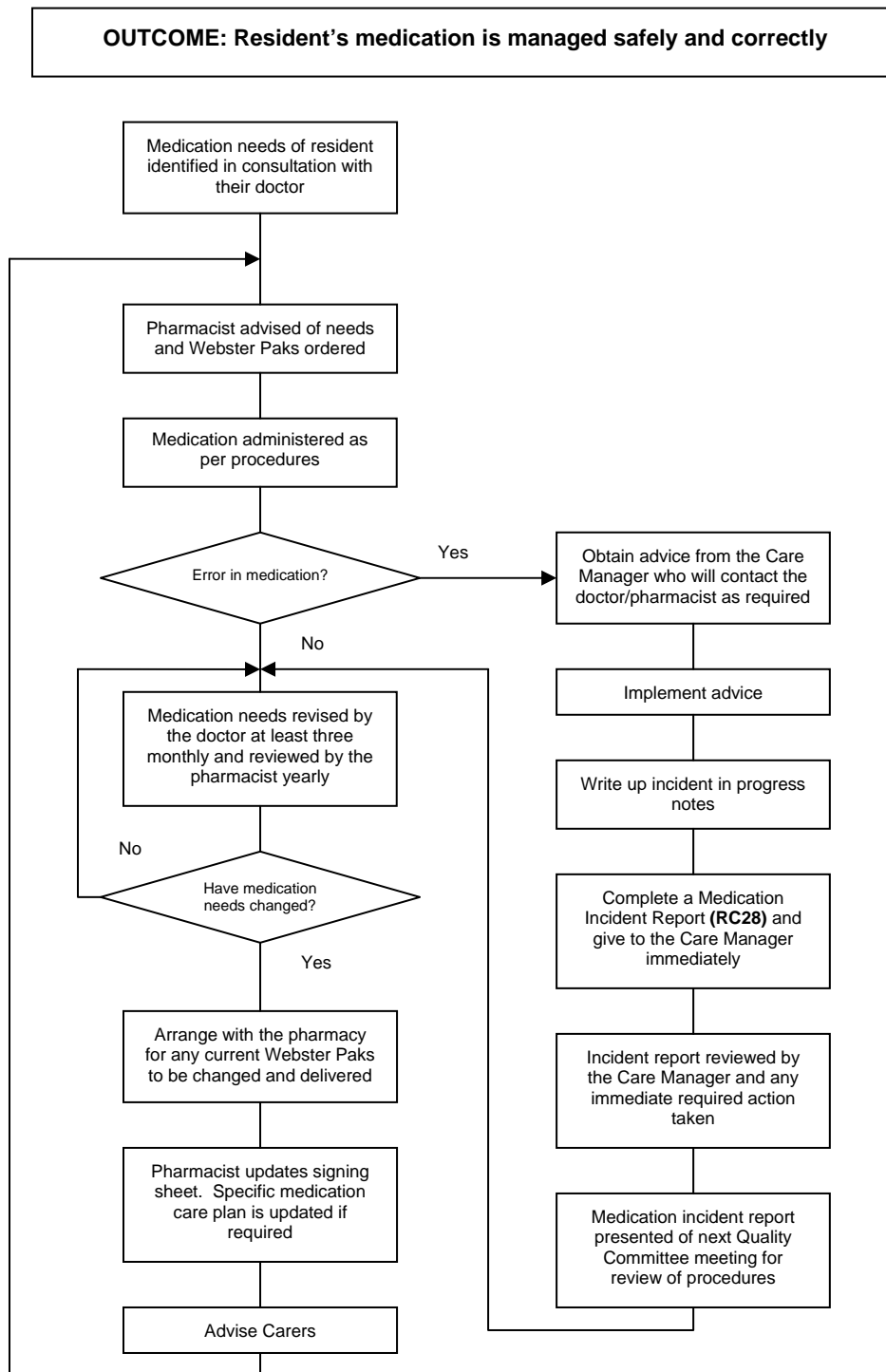
Issues identified and recommendations for improvements will be brought to the Management Committee for discussion.

4

MEDICATION MANAGEMENT

MEDICATION MANAGEMENT

Medication Management Flow Chart



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FLOW CHART

The process for managing medication is shown in the flow chart above and is described below.

ADMINISTRATION OF ORAL MEDICATIONS

1. Only identified staff members are permitted to issue medications to residents. The identified staff include the Care Manager, Registered and Enrolled Nurses and appropriately trained carers.
2. Take the medication trolley from the locked store in the treatment room to the dining area. Keys to the trolley must be held by authorised individuals (as above) at all times.
3. Issue medications to one resident at a time.
4. Staff member confirms that the resident matches their Webster Pak photo ID, and that their name and room number corresponds with the information on the Webster Pak and signing sheet.
 - Check Webster Pak and signing sheet for information indicating changes in medication, allergies or extras not included in the Webster Pak.
 - Staff member will check for added short-term medications in separate Webster Paks.
5. Initial the signing sheet once the resident has ingested the medication.
6. If medications need to be disposed of they are be locked in the treatment room in a cupboard and returned to the pharmacy as soon as possible.
7. The medications trolley must not be left unattended whilst unlocked. (If it is necessary to leave the area take the trolley with you unless another authorised person is able to take over).
8. Sign appropriate forms to indicate what has been taken, when and by whom.
9. Take trolley back to the treatment room and ensure that both the trolley and room are locked.

ADMINISTRATION OF OTHER MEDICATIONS

Other medication, as listed below may also be issued to residents as prescribed. The appropriate area of the signing sheet should be initialed once medication is issued or applied. For PRN medications, the date and time of administration should also be noted.

Medications that may be administered by appropriately trained care staff:

- topical lotions and transdermal patches;
- eye and ear drops and ointments;
- inhalers and nebulisers.

Medication to be administered by Enrolled/Registered Nurses:

- pessaries;
- suppositories;
- enemas;
- injections.

Residents who require insulin injections are encouraged to self administer. If residents require assistance to dial up the correct dose, care staff who have been deemed competent to assist in the preparation of the Novopen are able to dial the required dose as per the medication order sheet. When residents are unable to self administer insulin, the enrolled or registered nurse administers the injection.

Schedule 8 drugs, such as oral sustained release narcotics are provided in Webster Paks, as per other medications. Other Schedule 8 medications, such as IM/SC narcotics, morphine mixture and patches are not routinely held at Acorn Aged Care. In the event of these medications being prescribed, the service will use a Schedule 8 Drug Register and ensure that these medications are administered by the Registered Nurse.

OXYGEN THERAPY

The regular use of oxygen can be administered only if ordered by a doctor (except in an emergency situation).

See Oxygen Therapy Guidelines in Section 16: Care Guidelines in this manual.

INFORMING RESIDENT'S AND RELATIVES ABOUT MEDICATIONS

Staff must endeavour to inform residents and relatives about current medication changes as much as their understanding permits.

Residents who can understand are informed immediately their medication changes and before the medication is administered. If a resident indicates that they do not want a medication this must be referred to the Care Manager who will liaise with the resident, their doctor and their relatives as necessary.

REVIEWING MEDICATIONS

The pharmacist monitors each resident's medication when preparing Webster Paks and advises the service of any issues or concerns via telephone or fax.

Any issues raised are recorded in the progress notes by the Care Manager.

The doctor is advised and asked to consult with the Pharmacist as required.

Advice regarding withholding or issuing medications must be sought from the pharmacist or doctor at the time a concern is raised.

A comprehensive review by the pharmacist of each resident's medication will occur at least yearly and will be organised by the Care Manager. Information received from this process is given to the prescribing doctor.

ORDER, DELIVERY, STORAGE AND ADMINISTRATION OF MEDICATION

ORDERS

1. New residents are assessed by the doctor and medications are reviewed and prescribed.

If a resident is prescribed a medication after consultation with a doctor from the hospital or medical centre, the drug or order is sent to the pharmacy on a Medication Request Fax Form (**Form RC40**) to be packaged in a Webster Pak.

The Webster Pak system is the preferred administration method, and details the residents name, type and strength of medication, dosage, frequency and route of administration.

Webster Paks are ordered in advance. If medications change (on the doctor's orders) scripts are provided to the pharmacy and drugs received and administered from the new Webster Pak with an updated signing sheet.

2. On receipt of drugs staff check that the drugs named on the back of the Webster Pak correspond to the resident's current signing sheet.

The doctor notifies the Pharmacist of any changes to medications and arranges to supply a prescription for the drugs. The Pharmacist then supplies the drug to Acorn Aged Care.

Sometimes the doctor may give a verbal order for a medication. In all cases the responsibility for providing medications to residents rests with the doctor and pharmacist. Drugs are only received from the pharmacy following receipt of a prescription.

DELIVERY

Webster Paks, other prescription and non-prescription items are supplied by the pharmacy.

STORAGE

1. When Webster Paks arrive a delegated staff person checks them to see that the names correspond to the resident's current signing sheet and places them on the rack in the drug trolley.
2. Antibiotics and other drugs that are for short term use are provided in Webster Pak format with a separate signing sheet.
3. The Webster Paks are colour coded to assist in the identification of various drugs and their administration times. There is an explanation of the different colours attached to the drug trolley and also in the Webster Pak folder found in the filing cabinet with the current medications folder. These are also shown below.

WEBSTER PAK FOLDER GUIDELINES

Acorn Aged Care

The following broad guidelines will be used by the pharmacist to decide what colour folder will be used for different medications:

BLUE FOLDER	<i>Most commonly used folder, for regular weekly medication for use up to four times a day. These medications can either be given without regard to food or they need to be given with food. It generally BLUE FOLDER MEDICATION IS GIVEN AT MEAL TIMES, with food and washed down with a drink. The bedtime dose does not generally require food.</i>
PINK FOLDER	<i>For medication best given on an empty stomach. i.e. half an hour before or 2-3 hours after eating.</i>
GREEN FOLDER	<i>For acute medication such as antibiotics, not normally in a residents regimen. May also include items subject to some dose variation, to avoid a whole pack containing multiple medications being affected by any changes.</i>
WHITE FOLDER	<i>For PRN ("when necessary") medications given as needed. Sent with a signing sheet for recording doses as they are given.</i>

PRN Medications

1. PRN medications are prescribed to be given to the resident 'when required'. Usually these drugs are given to aid in symptom control, such as the management of pain, anxiety, constipation or diarrhea.
2. All PRN drugs are reviewed by the prescribing doctor at least six monthly. The Care Manager provides feedback to the doctor regarding frequency of administration of these drugs to ensure that their use is managed effectively.

DISPOSAL OF MEDICATION

Medicines are disposed of if they are out of date or no longer prescribed by returning them to the pharmacy. These drugs are stored in a box in the treatment room for collection by the pharmacy staff.

RIGHT TO REFUSE TREATMENT

The service and staff respects the right of the resident to refuse treatment. This must be documented in the progress notes and the doctor notified.

MEDICATION ERRORS

When a medication error is detected (refer to the flow chart at the beginning of this section):

1. Call the Care Manager to explain the mistake and seek their advice on what action to take. The Care Manager will contact the doctor or pharmacist as required.
2. The doctor will decide if an examination is necessary or may provide verbal advice.
3. Carry out the advice of the doctor.
4. Ensure the incident is fully documented in the resident's progress notes.
5. Complete a Medication Incident Report (**Form RC28**) and place it in the Care Managers office.
6. The incident is investigated by the Care Manager and appropriate action taken and documented on the incident form. If further action is required, an Improvement Project Log (**Form MA1**) is commenced.
7. All medication errors are reported to the next Quality Committee meeting for review of procedures and processes.

SELF MEDICATING RESIDENTS

The service will support the self-administration of medications by a resident under the following conditions:

1. The resident must be assessed by a medical practitioner to be mentally and physically able to self-administer the medication, understanding that it may provide a risk to his/her self and/or other residents/staff if not stored and administered correctly. *(The decision will be made in conjunction with the resident and/or their representative, doctor, Care Manager, carers and other health representatives as appropriate).*
2. The doctor and resident must complete the Ability to Self Medicate form (**Form RC26**). If staff observe the resident having difficulties in self medicating, the doctor should be contacted immediately and the residents ability to self medicate reviewed.
3. The service will provide and have fitted inside the resident's wardrobe, a lockable box or drawer for the storage of medication.
4. The resident will hold one key and the Care Manager will hold a second key (in case of mishap).
5. The resident will be required to remove the medication from the box or drawer only as it is required.
6. Medications **MUST NOT** be left where other residents or staff can access them.

If medicines are left unattended where other parties could access them the issue should be brought to the Care Manager for consideration. Responses may include warning, reassessment, or permission may be retracted.

STAFF

The service employs a Care Manager and carers. A copy of the qualifications of all staff is kept in the staff persons' personnel file. Staff receive training in medication administration and other care procedures and these are documented in their personnel files.

Nursing staff from Silver Chain Nursing Services provide nursing services to residents when a registered nurse is not available.

Nursing staff are supported by doctors from the various general practices in the area.

A management representative is available 24 hours per day. The telephone number of the Care Manager is available in the office. Emergency medical treatment is provided by the local hospital.

Specialised nursing care is undertaken by the registered or enrolled nurse or Silver Chain Nursing Services.

Assessments are carried out by a doctor, registered nurse or care staff, as appropriate.

If an issue arises regarding the specialised care of a resident the Care Manager refers it to the doctor or other health professional as appropriate.

Treatment by the registered nurse, Silver Chain Nursing staff or doctor is recorded by them in the progress notes.

(Reference: Guidelines for medication management in residential aged care facilities. Australian Pharmaceutical Advisory Council 3rd Edition November 2002.)