Document of Policies

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Complex bowel care

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Introduction

This policy sets the principles for providing bowel care to people we support. Quality bowel care is about ensuring a person's bowels are effectively managed in a safe, consistent and hygienic manner that promotes a person's overall health and wellbeing. All participants we support deserve:

- appropriate advice
- monitoring
- support and intervention
- To feel empowered and supported to understand and manage their bowel care

  with dignity and privacy.

Above all, participants must be treated with dignity at all times regarding a sensitive and important bodily function.

A healthy bowel can be affected by a number of factors including:

- a diet lacking in fibre
- insufficient fluid intake
- disruption to regular diet or routine
- delaying bowel actions due to pain (such as from haemorrhoids)
- certain types of medications—narcotics, opioids, sedatives, Codeine-based medications will slow down bowel movements
- recent illness or hospitalisation
- low activity levels and reduced mobility—particularly those who are in wheelchairs, bed- bound or post-surgery
- reduced physical and emotional wellbeing.

People with disability are more vulnerable to suffer from bowel dysfunction (a bowel that is not functioning correctly) for any of the reasons described above. Bowel function can also be affected by diabetes, obesity, heart problems and other conditions. The main types of bowel dysfunction are:

- constipation and poor bowel emptying
- diarrhoea
- faecal incontinence.

Constipation

Constipation is a condition in which bowel movements occur less often than usual or consist of hard, dry stools that are painful or difficult to pass. While bowel habits vary, an adult who has not had a bowel movement in three days or a child who has not had a bowel movement in four days is considered constipated.

Constipation has many possible causes, including low mobility, chronic health conditions, inadequate diet and fluids, some medications, stress, delaying the urge to use the toilet, inadequate diet, slow movement of faeces through bowels, or abnormality of the muscles involved in emptying the bowel.

Preventing constipation is best practice and involves ensuring a person:

- has sufficient fibre in their diet—see list of high residue foods
- relies less on foods low in fibre (low residue foods)
- has adequate intake of fluids (typically 6-8 glasses of water a day)

- reduces or avoids intake of caffeine drinks (tea, coffee and cola)
- has regular exercise
- maintains a healthy body weight
- goes to the toilet when the urge is felt and has enough time.

Low residue foods (low fibre foods slow down transit times)	High residue foods (high fibre foods speed up transit times)
• white bread, white rice, pasta • raw lettuce, cucumber, avocado • cooked vegetables without skin or seeds • clear broths and strained soups • raw fruit such as apricots, bananas, rock melon, honeydew, watermelon, nectarines, papayas, peaches, plums • tender-cooked meat, seafood, eggs • canned vegetables and fruit • butter, vegetable oils, margarine • yoghurt, cottage cheese, ricotta cheese, milk, soymilk, tofu • fruit juice without pulp.	• wholegrain cereals, oats, brown rice, bread or cakes with bran, nuts or seeds, brown rice, wholemeal pasta • most leafy vegetables, broccoli, cauliflower • raw fruit and vegetables with skins and seeds • nuts, legumes, corn, popcorn • dried fruit, prunes • fruit juice with pulp, prune juice.

Diarrhoea

Diarrhoea is defined as more then 300mls of loose watery stools in a 24-hour period. Diarrhoea can be short lived such as with food poisoning or a bowel infection (which can be spread to other people) or it can be as a result of:

- inflammatory bowel disease
- irritable bowel syndrome
- coeliac disease
- Crohn’s disease.

Diarrhoea may also be caused by food allergies, medications, radiation therapy, overuse of laxatives and diabetes. Consult a doctor if a participant suffers ongoing diarrhoea.

Faecal incontinence

Faecal incontinence is leakage from the bowel due to poor bowel control. Incontinence can often be experienced by people with health conditions such as diabetes, obesity, heart problems, stroke, cancer, prostate and kidney problems, and neurological conditions such as spina bifida, autism, spinal cord injuries and Parkinson’s disease. Incontinence is best managed or prevented with a healthy diet high in fibre, staying active, and regular bowel habits.

Seek medical attention

Call a doctor or seek medical advice if a participant experiences any of the following:

- vomiting blood or faecal matter
- diarrhoea and/or vomiting that is more than a one-off event
- bleeding from the bowel
- fresh (red) or old (black) blood in faeces (note: a person may also have black faeces when taking iron supplements)
- unusual pain before, during or after a bowel action
- constipation not resolved by medication—bowels not open for three days may indicate:
    - faecal impaction
    - bowel obstruction
    - paralytic ileus.

A continence assessment may be required for some participants to help determine the best way to manage ongoing bowel issues. Seek advice from a qualified health practitioner or a Nurse Continence Specialist from the Continence Foundation of Australia.

Applicability

When
• applies when participants require ongoing bowel management.

Who
• applies to all employees, supervisors and key management personnel supporting participants with ongoing bowel management needs.

Governing obligations for this policy

- NDIS Practice Standards SM 1.1.1 Complex Bowel Care
- NDIS Practice Standards SM 1.1.2 Complex Bowel Care
- NDIS Practice Standards SM 1.1.3 Complex Bowel Care

Governing regulations for this policy

- NDIS (Quality Indicators) Guidelines 2018 (Cth)

Applicable processes for this policy

- Assess bowel sounds
- Care for bowel stoma
- Manage bowel

Documents relevant to this policy

- 5 Moments of Hand Hygiene
- Bowel management (easy read)
- Bowel monitoring chart
- Bristol Stool Chart
- Daily fluid balance chart
- Handwashing
- Malnutrition screening tool and monitoring chart
- Phone order for medication form

Promote good bowel management

Guidelines for promoting good bowel management:

- ensure participants have sufficient fluid intake

- ensure participants have sufficient intake of dietary fibre
- ensure participants have adequate physical activity
- provide a relaxed and unhurried setting with which participants can move their bowels
- if necessary, provide planning and daily bowel diary for participants with bowel management needs
- consider the participant's past medical history (including hormonal imbalances), ensure this is addressed as part of their bowel management plan
- ensure the participant understands they are supported and encouraged to take charge of any bowel management regime put in place
    - for example, participants can monitor their own bowel movements using a resource such as a bowel and bladder diary in conjunction with a Bristol Stool Chart
- ensure the participant is well-supported in implementing good bowel management, by supporting their mobility
    - the participant may require mobility aids, appliances and equipment to assist them with toileting needs and reduce the risks of accidents (e.g. walking frames, toilet raise, non-slip mats or handrails).
- aim to establish healthy bowel habits by:
    - supporting the participant to be able to hold on for a short while after feeling the urge to go and giving the participant time to get to the toilet without accidents occurring
    - ensuring that bowel motion occurs within a minute of being positioned on the toilet
    - ensuring that bowel motion passes easily without struggle or pain.
    - ensuring that the bowels empty out completely and that the participant does not have the urge to go again soon after.

Bowel stoma

A bowel stoma is a surgically formed opening; a part or section of the bowel is brought through the abdominal wall and used to pass faeces into a stoma appliance, bag or pouch. The two types of bowel stoma are:

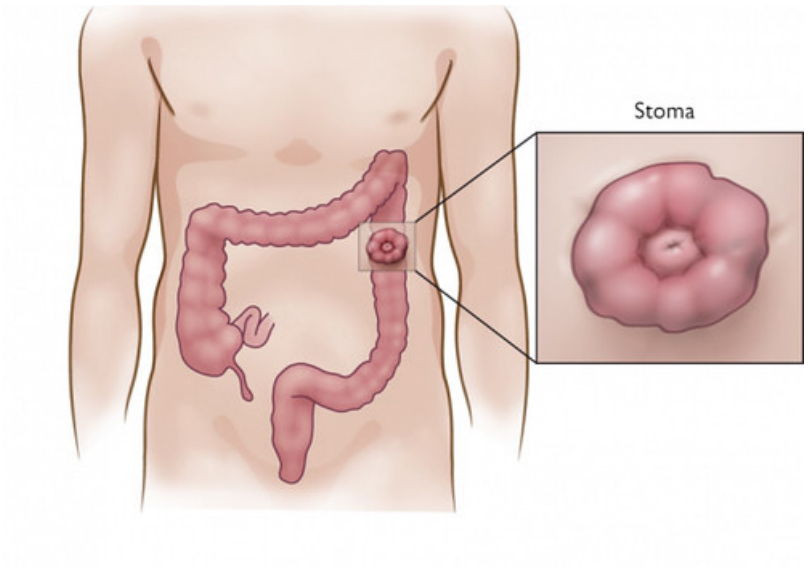
- colostomy – created from a part of your colon in the large intestine
- ileostomy - created from a part of your ileum in the small intestine.

More information about stomas can be found on the Australian Council of Stoma Association website

A healthy stoma should be:

- red or pinkish in colour, moist and shiny
- the border where the stoma meets the abdominal skin should be intact
- surrounding skin should be healthy looking and intact
- stoma should protrude 2-2.5cm.

An illustration of a healthy stoma is shown below.



Bowel care guidelines

Guidelines for providing good bowel care:

- maintain good hand hygiene and infection
- control measures
- use disposable incontinence pads and pants if needed
- suggest participants wear underwear made of natural fibres such as cotton
- clean and wash surrounding peri anal skin/rectal region/moist areas of buttocks and groin with warm water and mild unscented soap
- monitor for skin reaction inflammation, redness, breakdown, bleeding or erythema.

For participants with a stoma, also ensure:

- suitable timing and frequency (i.e emptying and changing the appliance or pouch at an appropriate time)
- all supports are undertaken by a qualified practitioner and in accordance with the participant's plan.

Skills and knowledge for delivering bowel care supports

We will ensure that workers delivering bowel care supports are suitably trained and aware of the specific needs of participants they support. We will also ensure that the training of workers is documented and audited.

Worker competencies will be reviewed annually to confirm their skills and knowledge in delivering complex bowel care supports. Refresher training will be provided where a participant’s support needs or support plan has changed or the worker has not delivered complex bowel care supports within a reasonable timeframe.

Preparing to deliver bowel care supports

When preparing to deliver complex bowel care supports workers will:

- understand the support plan and confirm that it is correct and current for the participant
- check with the participant to understand their specific support requirements, including:

    - timing, frequency and type of support
    - their expectations, capacity and preferences for the delivery of bowel care supports
    - the participant's preferences for communication including the uses of aids, devices and/or methods of communication.
- communicate with the participant using their preferred communication strategies, aids, devices or resources including resources in their own language
- understand the required equipment and consumables and ensure they are available and ready for use
- recognise the intensely personal nature of this type of support and make sure the participant is ready to receive support
- prepare for hygiene and infection control.

Maintain knowledge of:

- the NDIS Code of Conduct and relevant Practice Standards
- the role of bowel care in supporting participants to live the life they choose
- common and participant-specific communication supports e.g. assistive technologies, communication devices and alternative/augmentative communication
- the scope of their responsibilities including supervision and delegation arrangements
- the roles and responsibilities of other members of the participant's support network, including health practitioners, carers and other workers
- features of a safe environment for working and delivering complex bowel care supports
- principles of infection control and personal hygiene (e.g. hand washing, disinfecting, use of appropriate Personal Protective Equipment)
- roles and responsibilities of others involved in providing complex bowel care, including carers, health practitioners and other workers
- features of a safe working environment for delivering complex bowel care support
- common bowel care and stoma equipment and consumables.

Implementing bowel care supports

When implementing complex bowel care support plans workers will:

- check for any specific factors or adjustments at the time of service provision
- follow hygiene and infection control procedures
- deliver supports in ways that:
    - are least intrusive or restrictive and fit best with the participant's daily routines and preferences
    - meet the timing, frequency and type of support required
- support participants to position themselves for bowel care and check they are clean and comfortable with no perianal skin irritation
- use reference guides such as the Bristol Stool Form Scale to observe and record bowel motions and identify any changes that require action
- identify and immediately inform appropriate health practitioners I response to signs of poor bowel function or related problems
- work collaboratively with other stakeholders to ensure continuity and effective delivery of supports
- maintain knowledge of:
    - basic anatomy of the digestive system
    - relationship between nutrition, hydration, dietary fibre, probiotics, and bowel motions and stoma management
    - common causes of bowel care problems such as constipation and faecal incontinence
    - purpose and methods of hygiene and infection control
    - principles for infection control and hygiene. For example, hand washing, gloves available, minimising the risk of infection in the environment
    - symptoms of bowel-related conditions associated with particular types of disability
    - common types of bowel care support such as use of laxatives, enemas, suppositories and abdominal massage.

When supporting participants with a stoma, workers will:

- support participants to clean and maintain healthy condition of the stoma site
- replace and dispose of ileostomy and colotomy bags when necessary
- monitor and record information required by the support plan such as outputs, hydration and appearance of stoma
- identify and respond to problems such as blockage and immediately inform an appropriate health practitioner if participant shows indicators of deteriorating health condition
- involve the participant in their supports to the extent they choose and as outlined in their individual support plan
- maintain knowledge of:
    - the purpose of ileostomy and colostomy stomas and related equipment, and consumables such as stoma bags, skin sealants, barriers or powders
    - common methods to clean and protect skin around the stoma
    - characteristics of a healthy stoma and how these can change over time
    - indicators and actions required to respond to common health problems at the stoma site, such as wetness or signs of infection or inflammation
    - reporting responsibilities including handover, recording observations, and incident reporting.

Reviewing bowel care supports

When reviewing bowel care support plans, workers will:

- check with participants to discuss any changes needed to provided bowel care supports
- identify, document and report information when a support plan is failing to meet participant needs
- support participants to provide feedback and request changes to their support plan
- maintain knowledge of procedures and responsibilities for requesting review of bowel care supports.

Complex wound care support

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Introduction

When supporting participants with complex wounds, it's important to provide consistent individualised support as there are physical, psychological and social impacts of living with a wound. Wounds can cause pain, systemic illness, increased time in hospital, extended absence from normal activities, low self-esteem and altered body image.

A person's wounds can be interfered and/or affected by:

- medication—drugs that suppress the immune system or thin the blood
- age—being elderly means risk of infection is higher, scar tissue is more fragile and other health conditions are more likely
- smoking (including passive smoking)—increased risk of infection, dampened inflammatory response and hypoxia (deficiency in the amount of oxygen reaching the tissues)
- decreased mobility/lack of exercise—particularly a lack of ankle mobility can result in lower limb oedema or venous congestion and ulceration
- obesity—increases risk of wound dehiscence and infection and venous hypertension
- inappropriate dressings—adherent dressings can cause damage while other dressings stay too wet or interfere other ways
- rough handling of the wound—new granulation or epithelium may be damaged
- poor general health—other health conditions can cause hypoxia or impede or delay healing.
- history of tissue damage/injury (from surgery or falls)

Wound healing can be complex and is affected by numerous general and local factors. With this in mind, it is important to support the whole person and not just treat the wound.

Wound management for a participant is a multidisciplinary approach to promote optimal healing. Participant and support worker awareness and monitoring early signs of infection is vital. We will be trained to recognise and assess signs of infection within our scope of practice and will report signs of:

- Redness
- Heat
- Pain
- Flu like symptoms

Our team will support wound healing by following hand hygiene procedures and the wound management plan provided by the Registered Nurse and Doctor.

Photographs of the wound will be taken every week and uploaded to the wound management plan to track healing progress or deterioration.

The objective of complex wound support is to maintain a healthy wound bed to promote healing or manage wound exudate in the case of a palliative wound.

Palliative care

Where palliative care is being provided, healing is not the primary aim. The goal then is to ensure comfort, freedom from pain, itch, malodour and haemorrhage.

Wound assessment

Wounds should be assessed for any local barriers to healing and the results documented at each dressing change.

Wound cleansing

The aim of wound cleansing is to remove gross contamination with minimal pain to the person and minimal trauma to the tissue. Wounds should be cleaned to:

- remove excess exudates
- remove slough
- remove remnants of previous dressings
- facilitate accurate assessment of the wound/wound bed
- promote patient comfort.

Wound infection

It’s important to recognise the distinction between contamination, colonisation and infection when supporting a participant with complex wounds.

Contamination is when small numbers of bacteria are detected in a wound but their presence is short lived and they are not multiplying.

In a colonised wound, bacteria not only increases but have become established. Once an infected wound passes critical colonisation, it may start having an effect on wound healing.

Wound dressing

When selecting dressings, a moist environment at the wound/dressing interface should be selected. The wound dressing product should be appropriate to meet the needs of the wound and/or promote the next stage of the wound-healing matrix, taking into account **TIME**.

In wound care, accurate assessment of pain is essential with regard to choice of the most appropriate dressing. Assessment of pain before, during and after the dressing change can provide vital information for future wound management. The exception is a person with peripheral neuropathy who may have lost sensation and therefore not able to feel pain e.g. diabetic patients may be unable to feel pain in the foot.

In general, pain experienced by a person, although subjective and variable from person to person, falls into the following categories:

- a deep dull constant pain
- a superficial burning type pain
- a neuralgic type pain
- an ischaemic type pain
- pain resulting from cellulites.

Whatever the cause of the pain, the person’s perception should be acknowledged and appropriate action taken to alleviate the pain. The wound dressing should be appropriate to the type, location and size of the wound.

Any wound dressing with leakage or strikethrough causing a break in the barrier that the dressing provides to external contamination should be changed. If it not possible to change the dressing in a timely manner, then establish appropriate physical barriers with application of dressing pad over area of strikethrough. If leakage or strikethrough occurs frequently, it may be appropriate to re-evaluate the dressing product choice.

The effectiveness of the selected dressing product should be evaluated after one week, unless there is an adverse reaction to the dressing product. Any suspected adverse reaction from the wound dressing product should be reported.

A pain scale can assess a person's pain intensity. A simple yet useful tool to detect a person's pain levels throughout the wound management process.

Chronic wounds

A chronic wound is one that fails to follow the normal model of acute wound healing, resulting in delayed or halted closure. Chronic wounds require:

- managing or treating the underlying causes
- assessing and addressing local barriers to wound healing using TIME (see TIME wound management document)
- assessing and addressing wider factors delaying healing
- collaboration with health professionals and specialists
- ongoing education and training for participants and workers.

Examples of chronic wounds include:

- leg ulcers
- pressure ulcers (also called pressure sores, bed sores or decubitis ulcers)
- diabetic foot ulcers.

Chronic wounds can sometimes require hospitalisation (especially diabetic foot ulcers).

Pressure injuries

Pressure injuries are localised damage to the skin and/or underlying soft tissue, where bones are closer to the surface (bony prominences). Pressure injuries, pressure sores or pressure ulcers commonly occur on areas such as, the tailbone, heels, elbows, and feet. These areas are at risks due to friction, shearing and too much pressure applied on them.

Exudate control

Controlling exudate is important for comfort, odour and prevention of maceration and excoriation to the surrounding skin. Controlling exudate may include:

- a stoma pouch (subject to advice by a specialist health professional)
- suitable absorbent dressings
- skin barrier films or creams to protect surrounding skin.

When changing dressings, assess exudate-handling capabilities of dressings and consider with the person if dressing or frequency of dressings needs to be reviewed.

Odour control

Odour is often related to the presence of sloughy or necrotic tissue, which often leads to an increased bacterial burden further contributing to problems with odour. The most effective way to resolve odour is to treat the cause with debridement and/or reduction of bacterial burden. However, this may not be possible or appropriate with every person. Autolytic debridement by maintaining a moist environment is likely the most appropriate method.

Reducing bacteria levels may involve:

- systemic antibiotics
- topical antibacterial
- antiseptic dressings (may increase pain).

Odour may also be masked by charcoal dressings, regular dressing changes, well-sealed/contained dressings and use of deodorisers or essential oils applied to the top layer of dressings.

Bleeding

Preventing bleeding is a key goal when supporting a person with complex wounds. This is generally achieved by:

- careful dressing application and removal
- maintaining a warm moist wound bed
- gentle cleansing techniques.

Psychosocial issues

A person with complex wounds has to deal with not only the pain and discomfort of the wound but also altered body image, reduced mobility and likely deteriorating health. Stress, anxiety and depression can also have a negative effect on wound healing. It is important to involve the person's family, friends and carers according to the person's wishes.

Pain management

Severe pain can contribute to poor wound healing so pain management is essential. Assessing a person's pain requires considering:

- the wound site
- the frequency of occurrence
- the type of pain
- the severity of pain
- any relieving or exacerbating factors
- any present analgesia and frequency of administration.

Knowing this helps identify the likely cause of the pain and how to best manage it. Managing pain may be pharmacological and/or non-pharmacological depending on the situation.

Workers should seek advice from a health professional regarding pain relief for a person with complex wounds. Comprehensive pain management is outside the scope of this policy.

Applicability

When
• applies when participants are supported with complex wounds.

Who
• applies to all workers, supervisors and key management personnel supporting participants with complex wounds.

Governing obligations for this policy

- NDIS Practice Standards SM 1.8.1 Complex Wound Management
- NDIS Practice Standards SM 1.8.2 Complex Wound Management
- NDIS Practice Standards SM 1.8.3 Complex Wound Management

Applicable processes for this policy

- Manage complex wounds

Documents relevant to this policy

- 5 Moments of Hand Hygiene
- Complex wound management (easy read)
- Handwashing
- Mobility diary
- Nutrition chart
- Pressure injury prevention checklist
- Pressure injury risk assessment chart
- TIME wound assessment template
- TIME Wound Management
- Wound assessment form
- Wound treatment management plan template

Holistic wound assessment

A wound assessment will be conducted as part of the participant's support plan. An ongoing assessment and review are required to determine the effectiveness of the wound management plan. We will assess all wounds using relevant assessment guides and tools.

Holistic wound assessment should be:

- person centred
- accurate and precise
- include details of the participant's medical history
- able to detect the presence of complications
- able to detect other risk factors which may delay healing e.g. nutritional status, diabetes, chronic infection and concomitant medication e.g. steroids
- able to provide a framework to monitor the stages of wound healing
- evaluate the effectiveness of any treatment
- inclusive of information on any investigations needed e.g. blood test or scans
- delivered after participants have been informed about their wound care and management
- inclusive of relevant referrals (e.g. GP, wound clinical nurse consultant).

Local wound assessment should be carried out at least monthly and take into account:

- type of wound
- location of wound
- wound ooze (exudate) e.g. volume and consistency
- stage of healing—using a recognised scale e.g. pressure ulcer category 1-4, ungraded
- wound dimensions—length, width, depth, position/extent of sinuses, undermining of surrounding skin
- pain levels.

The participant's nutritional requirements should also be assessed to ensure appropriate nutritional needs. Consultation with a dietitian may be necessary if the participant is at risk of malnutrition.

Inflammation and infection control

It is important to recognise the distinction between contamination, colonisation and infection when supporting a participant with complex wounds.

Contamination is when small numbers of bacteria are detected in a wound but their presence is short lived and they are not multiplying.

In a colonised wound, bacteria not only increases but have become established. Once an infected wound passes critical colonisation, it may start having an effect on wound healing.

For controlling inflammation and infection:

- follow standard clinical infection control procedures
- maintain good hand hygiene practices
- follow Waste management policy
- systemic antibiotic use should only be decided by a medical practitioner
- consider environmental factors that may contribute to infection risks
- educate and support participant about infection control measures
- follow correct techniques for wound dressings (such as aseptic technique to reduce the spread of infection), this should be under the direction of a qualified health practitioner.

General care of participants with complex wounds

As a guide:

- surgical debridement should only be conducted by a qualified and competent health professional
- complex wound assessments should be conducted by a qualified and competent health professional
- wound management and care conducted by trained support workers only
- always choose appropriate and comfortable wound dressings that are trauma free on removal and take into account odour and the person’s culture and beliefs
- always follow manufacturer’s instructions when using wound dressings
- combine primary and secondary dressings from the same manufacturer where possible to avoid possible biochemical reactions of combining interactive dressings
- general use of antiseptics/disinfectants is not recommended as these are shown to kill fibroblasts and thus hamper healing
- if a wound fails to respond to treatment, seek advice from a medical practitioner.

Where palliative care is being provided, healing is not the primary aim. The goal then is to ensure comfort, freedom from pain, itch, malodour and haemorrhage.

if a wound fails to respond to treatment, seek advice from a medical practitioner.

Key management personnel responsibilities when supporting participants with complex wounds

The responsibilities of key management personnel are to:

- ensure workers have current knowledge and a training plan to teach the standards of care for participants with complex wounds
- provide workers education to provide excellent confident care
- ensure workers have access to complex wound management polices and follow the manage complex wound process
- ensure workers follow the Manage complex wound process
- ensure workers comply with the Medication policy
- ensure workers understand the support needs the participant’s support plan

- ensure workers are provided with appropriate equipment and consumables
- ensure workers are able to identify and response to risks, incidents and emergencies.

Worker responsibilities when supporting participants with complex wounds

The responsibilities of workers are to:

- work within their scope of practice and qualifications
- adhere to hand hygiene and infection control policies
- recognise the distinction in a wound between contamination, colonisation and infection
- recognise when a normal inflammatory process, when it becomes abnormal and when it is due to infection
- able to confidently assess, cleanse and dress complex wounds as appropriate
- report incidents via the incident reporting system
- able to recognise the need to escalate care to qualified health practitioner.

Skills and knowledge for delivering complex wound care supports

We will ensure that workers are trained in each participant's specific support needs, according to their wound management regime, delivered by an appropriately qualified health practitioner or person meeting the NDIS High Intensity Skills Descriptors for Complex Wound Care Support.

We will ensure our workers have current skills and knowledge, and that their training is regularly documented and audited. Worker competencies in providing complex wound management will be reviewed annually to ensure that they meet the requirements of the relevant NDIS High Intensity Skills Descriptor. Refresher training will be provided where a participant's support needs or support plan has changed or the worker has not delivered complex wound management within a reasonable timeframe.

Preparing to deliver complex wound management supports

When preparing to deliver complex wound management supports workers will:

- staff will have prior training in complex wound management and have attended our National Disability Council workshops delivered by our Registered Nurse.
- understand the support plan, confirm it is the correct and current plan for the participant, and check the participant's specific support requirements
- check with the participant on their expectations, capacity and preferences for being involved in the delivery of support
- check with the participant on their preferences for communication, including the use of aids, devices and/or methods
- communicate with the participant using participant-specific communication strategies, communication aids, devices, or resources, including resources in their preferred language
- prepare for hygiene and infection control
- check that required equipment and consumables are available and ready for use
- maintain knowledge of:
    - the NDIS Code of Conduct and Practice Standards
    - the role of high intensity supports in supporting participants to lead the life they choose
    - common and participant-specific communication supports, for example, assistive technologies, alternative and augmentative communication, communication devices
    - principles of infection control and personal hygiene, for example, hand washing, disinfecting, and use of appropriate Personal Protective Equipment (PPE) such as sterile gloves

- scope of worker responsibilities, including supervision and delegation arrangements
- roles and responsibilities of others involved in providing wound and pressure complex wound management support to the participant including carers, health practitioners and other workers
- features of a safe environment for working and delivering complex wound management support
- common consumables used in complex wound management and their function, such as different types of dressing
- different types and classifications of wounds and related care requirements
- common equipment used to support wound and pressure injury management and basic troubleshooting procedures.

Implementing complex wound care support plans

When implementing support plans with complex wound supports, workers will:

- check with the participant for any specific factors or adjustments needed at the time support is provided.
- follow hygiene and infection control procedures, for example, hand washing, use of sterile gloves and disinfecting the environment.
- employ methods for positioning and turning where required to prevent a pressure injury.
- deliver supports in ways that are least intrusive or restrictive and fit into the participant's daily routines and preferences.
- check skin integrity to identify indications of initial or worsening infection and takes required action to involve or get advice from the appropriate health practitioner.
- support the use of lymphoedema machines or assistive circulatory devices as required.
- monitor and record any information required by the support plan.
- collaborate with others to ensure continuity and effective delivery of support concerns to the responsible health practitioner.
- actively involve the participant in their support, as outlined in their support plan and to the extent they choose.
- Maintain knowledge of:
    - risks and symptoms of pressure injuries such as, blistering, swelling, dry patches, a change in colouring, shiny or warm areas
    - basic understanding of risk factors for pressure injuries, for example, unable to reposition independently, participants with health conditions including diabetes
    - common strategies to prevent pressure areas and worsening wound status including frequent repositioning (which may include prompting for the participant), appropriate diet to support healing and use of assistive equipment such as lymphoedema machines or assistive circulatory devices
    - the process and stages of wound healing to identify improving or deteriorating conditions when and how to involve or get advice from the appropriate health practitioner
    - reporting responsibilities including, handover, recording observations and incident reporting.

Reviewing complex wound care supports

When reviewing support plans containing complex wound care supports, workers will:

- check with the participant and their supervising health practitioner to discuss any changes needed to the wound and complex wound management support they are receiving
- identify, document and report information where a support plan is not meeting a participant's needs
- support the participant to provide feedback and request changes to their support plan as required
- maintain knowledge of procedures and responsibilities for requesting review of wound and complex wound management support.

Enteral feeding support

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Introduction

Supporting participants to eat naturally by oral means is always preferred. However, some people cannot eat or drink safely or are at risk of malnutrition. These problems are often associated with:

- neuromuscular disorders that affect chewing and swallowing coordination that may result in aspiration (e.g. dysphagia associated with cerebral palsy, motor neurone disease, brain injury, Huntington's disease, stroke)
- medical problems and/or structural abnormalities of the gastrointestinal tract, e.g. inflammatory bowel disease, cancers, hepatic, renal or respiratory failure, anorexia, HIV/AIDS
- cognitive impairments that affect capacity to coordinate chewing and swallowing safely
- fatigue associated with illness
- failure to thrive or severe reflux in infants
- reduced level of consciousness.

Enteral tube feeding can provide nutrition to a person at risk of malnutrition and/or choking. It can be used to:

- administer bolus, intermittent feeds or continuous feeds
- administer medication
- facilitate free drainage and aspiration of the stomach contents
- facilitate venting/decompression of the stomach.

There are many types of enteral feeding tubes, this policy covers the most commonly used as described in the table below. Examples of enteral access can be found from the Nutrition Society.

	Tube type and size	Site	Insertion method	Uses	Key management points
Nasogastric **tube (NGT)**	5-8Fr fine bore tube	Stomach	Usually bedside, by a suitable qualified professional	For short term feeding (up to a month) or when a longer term option is deemed n/a	Position in stomach must be verified before every use with pH paper. Gastric aspirate less than 5.5 before feeding commences. Liable to block —if not managed appropriate. Relatively easy to replace.

Nasojejunal tube (NJT)	6-10Fr fine bore tube	Small intestine	Endoscopic	For short term post pyloric feeding (when n/a to feed into the stomach) (<3 months) or when a longer term option is deemed n/a	Position verified by measurement. Liable to block if not managed appropriately. Replaced in endoscopy.
Percutaneous **endoscopic gastrostomy (PEG)**	Freka PEG 9-20Fr	Stomach	Endoscopic	For long term (>4 weeks) gastric feeding in persons able to undergo endoscopy with sedation	Most common long term feeding tube. Risk of buried bumper leading to surgical intervention. Needs daily advancing and rotating to prevent buried bumper.
Radiologically inserted gastrostomy (RIG)	Balloon gastrostomy tube 14Fr	Stomach	Radiology	For long term (>4 weeks) gastric feeding in persons unable to undergo endoscopy with sedation— because they cannot be ‘scoped or because of poor respiratory function.	Retained by an internal water-filled balloon. If it falls out must be replaced within 2-4 hours. Tube needs changing every 3-6 months.
Jejunostomy tube	Balloon gastrostomy tube or a specific surgical jejunostomy tube	Small intestine	Usually surgery	For long term (>4 weeks post pyloric feeding in persons able to undergo a surgical procedure	For balloon retained tubes, management is as for RIG. Surgical tubes may be retained with a Dacron cuff or sutures.

Participants should always be involved in decisions that affect them including whether to use a feeding tube. This should be decided together with the participant’s family/carer/guardian after assessment by a speech pathologist, dietitian, gastroenterologist and/or paediatrician.

Where nutrition intake is the concern, tube feeding may supplement a person’s oral intake. However, if there are safety concerns for a person with severe dysphagia and chronic aspiration, all nutrition and hydration is administered via tube.

Consumption of food is a sensory, social experience in addition to providing the body with the correct nutritional needs.

Applicability

When
• applies when participants are supported that need enteral tube feeding.

Who
• applies to all employees, supervisors and key management personnel supporting participants with enteral tube feeding needs.

Governing obligations for this policy

- NDIS Practice Standards SM 1.2.1 Enteral Feeding and Management
- NDIS Practice Standards SM 1.2.2 Enteral Feeding and Management
- NDIS Practice Standards SM 1.2.3 Enteral Feeding and Management

Applicable processes for this policy

- Manage enteral tube feeding

Documents relevant to this policy

- 5 Moments of Hand Hygiene

Tube feeding assessment

Assessing participants for tube feeding needs:

- assess all participants during the entry process for nutrition and swallowing as part of a comprehensive health assessment, which is reviewed at least yearly (or more often if there are significant changes to a participant's health)
- decisions on whether to use tube feeding must be person-centred and involve the participant, their family, carer, guardian
- the person-centred assessment should assess the participant's home environment and lifestyle
- participants should be provided additional support when making decisions about tube feeding such as specialised advice from a dietician
- participants that require tube feeding will be involved in making an enteral feeding management plan that suits the individual
- participants being tube fed should be provided opportunities and supported to enjoy oral intake
- only workers trained in tube feeding can support participants with tube feeding.

Interventions and incident reporting

All workers and key management personnel must be aware of potential problems and appropriate corrective measures for participants receiving enteral tube feeding.

Serious complications include:

- tube dislodgement
- breakage/leakage of tube

- infections (eg. aspiration pneumonia)
- gastroenteritis
- septicaemia
- gastrointestinal disturbances (eg. nausea and vomiting)
- unbalanced nutrition (e.g macronutrient)
- fluid and electrolyte imbalance, dehydration.

Common problems include:

- occlusion of feeding tubes (blockages)
- vomiting and or aspiration—caused by improper tube placement, delayed gastric emptying, contamination of formula
- diarrhoea—feeding too fast, lactose intolerance, contamination of formula
- constipation—formula components, poor fluid intake, medication effect.

Managing enteral tube feeding is complex care. Seek advice of healthcare professionals if needed. Close consultation with nutritional support experts can address and resolve issues.

Worker responsibilities when supporting participants with tube feeding

Responsibilities for workers are to:

- provide best practice guidelines for management of participants receiving enteral feeding
- maintain both knowledge and problem-solving skills and a willingness to provide reassurance to participants and seek help when needed
- practice good hand hygiene and wear PPE as required
- accurate documenting including:
    a. fluid/food input and urine/stool output
    b. formula/feed name and composition, labelled with date and time opened, expiration date, formula handling and proper disposal
    c. route and method of feeding delivery
    d. baseline weight and weekly weight of participant
    e. condition of skin around nasal cavity or stoma site and lining for redness or maceration
    f. due date for change of pump tubing (as per manufacture's guidelines)
    g. any complications of intolerances experienced
- ensure feeding tubes are kept clean and are flushed before and after feeding or medication
- confirm feeding tubes are in the correct place before any feed or medication is given
- feed participants according to their tube feeding management plan and the enteral tube feeding process
- promote healthy oral hygiene in participants with no oral intake
- maintain clean work surfaces and proper disposal of equipment and waste
- minimise complications with enteral tube feeding:
    a. use liquid medications rather than pills
    b. ensure crushable pills are diluted with flushes in between each medication
    c. dilute viscous liquid medications
    d. discard outdated formula
    e. follow general principles of tube feeding e.g. elevating head of bed and position participant comfortably
    f. flush feeding tubes regularly to maintain tube patency before and after bolus feeds, administration of medications
    g. assess regularly for complications e.g. aspiration, diarrhoea, constipation.

Key management personnel responsibilities when supporting participants with tube feeding

- ensure workers supporting participants with tube feeding are trained and confident to provide this support
- ensure participants are provided information about tubes, feeding, the purpose and possible complications so that they can make decisions based on correct information
- ensure workers' education and training covers:

    a. positioning of the person
    b. preparation and administration of medication or formula
    c. mealtime assistance techniques
    d. medical administration
    e. infection control
    f. flushing of feeding tubes
    g. care of insertion/stoma site
    h. monitoring feeding equipment e.g alarms and malfunctions
    i. oral health management
    j. correct and accurate documentation e.g. Food chart, fluid balance chart, bowel and weight monitoring charts
    k. information about complications of enteral feeding and escalation in an emergency

- regularly audit enteral tube feeding management practices
- provide template for recording data including specific medical orders
- ensure workers have up-to-date skills and knowledge
- ensure all worker training is documented
- review worker competency annually to ensure skills remain current.

Tube feeding plan

Each participant must have a plan for enteral feeding support in place. The plan will be:

- overseen by a relevant health practitioner
- overseen by Evercare Support's Registered Nurse
- created with the involvement of the participant
- reflective of each participant’s needs and preferences
- communicated to the participant’s support network, with the consent of the participant
- reviewed regularly.

Each participant’s plan will cover all key areas of their supports, including:

- feeding support information
- types of feeds
- feeding delivery mechanisms
- mealtime assistance techniques
- stoma care
- complications/issues
- risk, incident and emergency management information.

Skills and knowledge

We will ensure that workers are suitably trained by an appropriately qualified health practitioner. Workers will have access to all information and support, including:

- policies and procedures
- supervision
- equipment and consumables
- training sessions.

Workers must be trained in:

- the specific needs of each participant
- methods of tube feeding specific to each participant, including feeding regimes
- how to use all relevant equipment
- the participant's related health condition/s
- following specific immediate actions to respond to risks, incidents and emergency situations.

Where a worker has not delivered this support within a reasonable timeframe, or if a participant's support needs have changed and/or they have an updated support plan in place, it is recommended the worker be reassessed before supporting the participant and undertake refresher training if required.

Preparing to support participants with enteral feeding

When preparing support participants with enteral feeding, workers will:

- understand the participant's support plan, ensure specific support requirements are outlined e.g. when support is required from a worker
- ensure the plan is current and reflects the participant's needs and preferences, including preferences regarding communication
- check the participant's expectations, capacity and preferences regarding their involvement in support delivery
- utilise participant-specific communication strategies, including suitable aids and devices
- practice good hygiene and infection control
- ensure that equipment and consumables required are available and ready to use
- ensure required feeds are available and are specific to participant
- support the participant to explore ways to enjoy mealtime and feeding, for example, timing, frequency, choice of environment and social company
- maintain knowledge of:
    - all relevant NDIS legislation
    - the importance of high intensity supports in supporting participant choice
    - common and participant-specific communication supports
    - scope of worker responsibilities, including delegation guidelines
    - features of a safe environment
    - equipment and consumables required
    - infection and hygiene principles
    - safe handling of formulas, including storage and preparation
    - different types of feeding and different equipment associated with these types
    - types and purpose of enteral feeding stomas (gastrostomy, jejunostomy) and related equipment and consumables such as feeding tubes, and skin sealants
    - methods and equipment and consumables used to administer medication through an enteral tube.

Implementing enteral feeding supports

When implementing enteral feeding supports, workers will:

- follow hygiene and infection control procedures for all equipment and supports
- position the participant comfortably and check whether they are ready for their meal

- deliver supports in the least intrusive way possible.
- ensure the participant is comfortable while they are receiving supports
- set up the water flush, assemble the feed, position the tube and introduce the food
- observe and regulate feeding, including rate, flow and volume of formula
- take action if there are equipment alarms or malfunctions
- identify and immediately inform an appropriate health practitioner when required (such as in response to broken or displaced feeding tube, indicators of health-related complications or other high risk indicators)
- support participants to maintain their oral health
- monitor and record relevant information
- work with others where required to provide adequate supports
- if administering a pre-filled injection, ensure the pre-filled pens and pumps are set up properly before administering the injection maintain knowledge of:
    - strategies for improving the participant's mealtime experience
    - basic anatomy of the digestive system
    - correct participant positioning
    - impact of associated health conditions
    - common alarms and actions to deactivating them, including methods of addressing associated issues that triggered the alarms
    - indicators of risk (e.g. coughing, vomiting and changes to bowel habits)
    - indicators of deteriorating health
    - when and how to involve healthcare practitioners
    - risks of poor oral health
    - factors to consider when maintaining tube integrity and cleaning.

Workers supporting participants with a gastronomy will:

- support the participant to clean and maintain their stoma site
- observe and take immediate action in response to a dislodged PEG tubes where the balloon device tube is in position and stable (after the initial tube has been replaced by balloon device)
- maintaining knowledge of:
    - basic procedures to maintain stoma, according to stoma type, such as cleaning and protecting skin around the stoma, checking, and refilling the balloon
    - signs of a healthy stoma and how these can change over time.
    - indicators and action required to respond to common health problems at the stoma site, such as changes in appearance of the skin, wetness or signs of infection or inflammation
    - reporting responsibilities, including handover, recording observations and incident reporting

Workers supporting participants to administer medication through an enteral tube must understand the participant's support plan and participant-specific requirements. Participants must be actively involved in the development of their plan to the extent they choose. They must follow the participant's plan to:

- prepare the medication - check medication type, dosage, delivery method and timing
- administer and flush the feeding tube
- administer the medication into the tube
- flush the feeding tube with water
- identify and immediately inform an appropriate health practitioner of risk indicators such as adverse reactions and/or an overdose.
- safely handle and dispose of sharps and other consumables
- monitor and record relevant information
- maintaining knowledge of:
    - basic understanding of the purpose of the medication and related storage requirements
    - factors that affect medication delivery through a feeding tube
    - common signs and symptoms of medication adverse reactions including reaction to medication and dosage errors.

Reviewing supports

When reviewing practices and associated plans, workers will:

- discuss with the participant to understand whether they require any changes to their supports
- assist participants with providing feedback
- document instances where the participant’s needs are not met by their support plan
- review procedures and responsibilities for reviewing supports
- review troubleshooting plan where PEG becomes blocked or ceases to work.

Epilepsy management

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Introduction

People with a cognitive disability are more likely to experience epilepsy.

Our organisation is committed to managing epilepsy in a holistic way that considers each participant's needs and preferences.

Applicability

When
• applies when supporting participants with epilepsy.

Who
• applies to all key management personnel and workers supporting participants with epilepsy.

Applicable processes for this policy

Manage seizures

Documents relevant to this policy

Seizure Record Chart - Form

Understanding seizures

Seizures can occur when provoked or unprovoked. The three main types of epileptic seizures include:

- focal onset
- generalised onset and;
- unknown onset.

Signs of a seizure can include one or more of the following:

- the person's body stiffening and falling to the ground, followed by strong, symmetrical, rhythmic movements (tonic-clonic)
- loss or disturbance of awareness (‘absence’, blackout spells), blank stare
- feelings of déjà vu or an unpleasant smell or taste
- confusion, disorientation
- a fall, sometimes with no memory of the fall
- involuntary movement—twitching or abnormal sensory disturbance of limb/s or loss of consciousness
- automatisms—repetitive, automatic trance-like movements e.g. fiddling with clothes, repeated use of strange words or repeated swallowing

- sleep disturbances, restlessness, inability to maintain a regular REM sleeping pattern
- loss of bladder or bowel control.

We will ensure that each worker is appropriately trained in recognising and responding to seizures.

Risk management

An important part of supporting a person with epilepsy is understanding the associated risks and putting in place appropriate risk management strategies to ensure the person is fully supported.

We will have a robust risk management system in place that includes records of risk management and mitigation strategies relating to epilepsy.

While the health and safety of participants with epilepsy is paramount, any attempt to reduce risk must avoid, where possible, compromising the participant's safety and dignity or impair their quality of life.

Common risks associated with epilepsy include:

- falls
- burn-related injuries
- aggression or agitation
- risk of drowning
- prolonged seizure
- increased chance of sudden unexpected death.

Additional information can also be found on the following

Epilepsy Smart Disability
Epilepsy Foundation: Recording seizures and seizure diary

Epilepsy management plan

Each participant with epilepsy requires an individually developed epilepsy management plan. Each plan must be developed in consultation with:

- the participant
- their person responsible or guardian
- relevant workers, and;
- the participant's external healthcare providers

A documented epilepsy management plan, must include, at a minimum:

- a description of a person's seizures, including triggers for seizures
- a risk management plan for each participant
- medication and information about existing epilepsy supports
- a seizure record chart
- action plan for responding seizures
- support requirements following a seizure
- a record of the participant's needs and preferences.

Each plan must be reviewed at least annually, and more often if the participant's support needs change or if a review is required for any other reason.

For additional information on epilepsy management plans refer to the following:

Epilepsy Smart Australia (2022)
Epilepsy Foundation (2023)

Water safety for participants with epilepsy

When supporting participants with epilepsy to swim in community pools or at patrolled beaches:

- two workers (that are strong swimmers) must accompany the participant
- one worker must be in the water and remain within arm’s length of the participant
- attendants or lifeguards should be notified of potential risk of seizures.

When participating in water sports, workers must ensure that:

- they are aware of the participant's specific conditions and can undertake first aid if required
- the participant does not swim alone
- the participant is not feeling unusually tired
- the participant wears a buoyant safety swimming vest and a brightly top/ swimming cap.

Dwellings for participants with epilepsy

Dwellings for participants with epilepsy may require additional safety measures. This may include:

- temperature controls on hot water systems
- sliding doors for toilets, or a door that opens outwards or can be unlocked from the outside
- shower recesses with no sharp edges
- showers that have block-proof drains
- wall-mounted fans and heaters or central heating/cooling instead of free-standing fans and heaters
- non-breakable crockery and cordless appliances with automatic switch off functions
- an epilepsy safety poster displayed in the bathroom
- baths with automatic plugs or chain plugs so the plug can be removed quickly in the event of an emergency
- furniture that does not have sharp or pointed edges.

Responsibilities for key management personnel

When supporting participants with epilepsy, key management personnel must:

- ensure all workers are trained to support participants with epilepsy including:
    - understanding and managing epilepsy
    - seizure first aid
    - administration of emergency medication, where prescribed
- ensure each participant has an individually developed epilepsy management plan
- ensure each participant has a regular risk assessment

- ensure participant epilepsy management plans are reviewed annually or more frequently if there are changes to the participant's condition
- periodically audit epilepsy management practices.

Epilepsy management responsibilities for workers

When supporting participants with epilepsy, workers must:

- complete epilepsy education and training as directed by key management personnel
- know and understand duty of care and dignity of risk issues for participants with epilepsy
- ensure consent is appropriately obtained
- be familiar with and follow a participant's epilepsy management plan when providing supports
- involve each participant in decision making about their care and treatment
- be able to recognise and address the risks factors and seizure triggers
- implement strategies to reduce risks and injuries during a seizure
- when required, monitor and supervise participants with epilepsy in a manner which is discreet as possible, minimises disturbances and promotes health and safety
- follow the recommendations of health care providers
- be alert when supporting participants with epilepsy to participate in water activities
- supervise participants with epilepsy when preparing meals, particularly when using knives and sharps
- know how to appropriately respond to a convulsive seizure
- provide a detailed record of seizure activities on a participant's seizure chart or similar documentation
- administer emergency medication where required
- monitor post seizure activity and effects of medication administration
- follow procedures for seizure monitors and devices/equipment
- recognise and follow immediate action plan for early indicators of seizure activity, including seizure monitors and devices
- notify key management personnel and the participant's doctor if a participant experiences atypical (unusual) seizures
- monitor participants with epilepsy at night, if recommended by a medical practitioner.

For additional information refer to the:

NDIS Practice Alert - Epilepsy Management

Severe dysphagia support

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Introduction

Our organisation is committed to providing appropriate supports to each participant that requires dysphagia management, including severe dysphagia management. All supports we provide will be risk-managed and based on each participant's individual needs and preferences.

All supports will be overseen by our registered nurse and monitored regularly.

When
• applies when assisting participants with managing their dysphagia.

Who
• applies to all employees and key management personnel involved in any dysphagia management.

Governing obligations for this policy

- NDIS Practice Standards SM 1.3.1 Severe Dysphagia Management
- NDIS Practice Standards SM 1.3.2 Severe Dysphagia Management
- NDIS Practice Standards SM 1.3.3 Severe Dysphagia Management
- NDIS Practice Standards SM 1.3.4 Severe Dysphagia Management
- NDIS Practice Standards SM 1.3.5 Severe Dysphagia Management

Governing regulations for this policy

- NDIS (Quality Indicators) Guidelines 2018 (Cth)

Documents relevant to this policy

- 5 Moments of Hand Hygiene
- Food Beverage Tacker
- Handwashing
- NDC_Mealtime Management Plan Template
- NDIS Practice Standards skills descriptors (High Intensity Skills Descriptors)

Causes of dysphagia

Dysphagia is a medical term referring to difficulties with swallowing. Dysphagia is associated with a variety of health conditions and disabilities. Some common causes include:

- stroke
- head injuries
- dementia
- reflux
- muscle problems in the face or neck
- cerebral palsy
- structural difficulties, such as damage to the lip.

Certain medications can also increase the risk of dysphagia.

Knowing the cause of the dysphagia is vital for developing and maintaining effective management and treatment strategies for each participant.

Signs and symptoms

Some signs and symptoms of dysphagia include:

- painful chewing and/or swallowing
- avoiding certain foods because they are hard to swallow
- shortness of breath when eating and drinking
- having long mealtimes e.g. taking more than 30 minutes to finish a meal
- regular coughing during or after a meal
- feeling that food gets stuck in the throat or goes down the wrong way
- regurgitating undigested food
- dryness in the mouth
- poor oral hygiene
- drooling
- difficulties with controlling food or liquid when it is in the mouth
- having a hoarse orf gurglingly voice
- frequent heartburn
- frequent respiratory infections
- unexpected weight loss.

If any of the following are present, professional advice and a diagnosis must be obtained.

Choking

Participants with dysphagia, especially severe dysphagia, face a higher risk of choking. Instances of choking should be treated seriously, as choking can result in severe injuries and death.

The signs of choking can vary depending on the severity and cause of the obstruction. Signs of choking include:

- clutching at the throat
- neck or throat pain
- inability to talk, swallow and/or breathe
- coughing, wheezing or gagging
- chest pain

- inability to make any sounds at all
- no air coming out of nose or mouth
- unusual breathing sounds, such as wheezing or whistling
- a change of colour in the body (e.g. blue lips, face, earlobes or fingernails)
- loss of consciousness.

Health professionals involved in severe dysphagia management

Management for dysphagia should always be done with guidance from appropriately qualified health professionals. The types of health professionals involved may depend on the participant's specific needs and the cause of their dysphagia.

In general, advice, assistance and guidance will need to be obtained from the following health professionals:

- speech pathologists
- doctors
- dieticians
- pharmacists
- physiotherapists
- occupational therapists.

Assessing dysphagia management needs

Our organisation will ensure that every participant that requires dysphagia management is identified.

With the participant's consent, we will assist the participant to access the services of an appropriately qualified health professional for:

- assessment
- diagnosis
- treatment options
- development of a suitable mealtime management and dysphagia management plans.

In addition, we will ensure that an appropriately qualified health professional conducts regular and timely reviews of the participant's plans as often as necessary. This may need to be done if:

- the participant's needs change
- additional difficulties are observed.

We will undertake ongoing monitoring and evaluation of each participant's dysphagia to ensure all plans are up-to-date.

Dysphagia management plans

Each participant requiring dysphagia management will be involved in the assessment and development of their dysphagia management plan. Each plan will be developed and overseen by a relevant healthcare practitioner. The dysphagia management plan must cover:

- the participant's individual needs and preferences (relating to food, fluids, preparation techniques, feeding equipment and any other relevant areas of dysphagia management)
- how risks, incidents and emergencies will be managed to ensure participant wellbeing and safety
- actions and plans for escalation (in cases of incidents and emergencies).

We will ensure that dysphagia management plans can be accessed by all relevant workers and participant and can be clearly understood by all relevant parties.

Mealtime management plans

In addition to a dysphagia management plan, participants will require a mealtime management plan. The mealtime management plan must be developed in accordance with our Mealtime management policy.

Worker training

Comprehensive training and knowledge is important for identifying and managing all levels of dysphagia. It helps to minimise risks of serious health complications and improve quality of life.

Our organisation will ensure that each worker that will be undertaking dysphagia management has the ability to do so in a safe and effective manner. This will be done through worker training. Each worker undertaking dysphagia management must have a training plan in place.

An appropriately qualified health practitioner with expertise in severe dysphagia management will deliver training.

All training will cover the requirements of the NDIS Practice Standards High Intensity Skills Descriptor for severe dysphagia management.

Worker training will cover:

- the specific needs and preferences of the participants the worker will be supporting
- the specific skills needed to carry out every aspect of each participant's mealtime and dysphagia management plans
- the signs and symptoms of dysphagia
- how to monitor for symptoms of dysphagia
- the NDIS high intensity support skills descriptor for severe dysphagia management
- risks associated with dysphagia and relevant management strategies
- the use of relevant feeding and swallowing aids (e.g. assistive plates and bowls, adaptive utensils, drinking aids)
- procedures and actions for identifying and responding to early signs of dysphagia
- procedures and actions for responding to dysphagia-related emergencies and incidents, including:
    - immediate first aid emergency response to ensure safety, such as cardiopulmonary resuscitation (CPR) and relevant emergency choking protocols
    - how and when to contact emergency services
    - how and when to escalate incidents to key management personnel
- how to provide safe and enjoyable meals in line with:
    - our Mealtime management policy
    - the advice of qualified health professionals
    - each participant's mealtime management plan
    - all relevant health standards and regulations
- if required, how to prepare texture-modified food and drinks, in line with the participant's dysphagia management plan.

If a worker has not delivered dysphagia management supports for more than 3 months (or if a participant's support needs have changed) we will ensure that the worker has refresher training and their skills are re-assessed.

Risk management

Participants with severe dysphagia are at higher risk of the following complications:

- aspiration pneumonia
- poor nutrition
- reduced quality of life
- choking
- respiratory illnesses.

Our organisation will proactively manage dysphagia-related risks by:

- following expert advice and plans provided by qualified health practitioners
- ensuring all relevant workers have access to and understand expert advice and plans provided by qualified health practitioners
- ensuring our risk management practices in line with our Risk management policy and all relevant legislation
- conducting a dysphagia risk assessment for every participant
- regularly reviewing and updating each participant's risk assessment in response to changing participant needs
- ensuring workers are familiar with all relevant risks and are implementing risk management strategies
- analysing and managing dysphagia-related risks:
    - during staff meetings
    - in participants' documentation
    - during day-to-day procedures
    - when managing participant intake, transition and exit

Incident management

Severe dysphagia can result in very serious and life-threatening incidents. Our organisation will foster a proactive incident management culture by:

- ensuring our workers are properly trained in procedures and actions for responding to dysphagia-related emergencies (e.g. choking) and incidents, including:
    - immediate emergency response to ensure safety (e.g. cardiopulmonary resuscitation)
    - how and when to contact emergency services
    - how and when to escalate incidents to key management personnel
- conducting incident management practices in line with our Incident management policy and all relevant legislation
- recording appropriate procedures and actions for responding to dysphagia-related emergencies and incidents within each participant's dysphagia management plan
- regularly reviewing our approaches to incident management and associated documentation.

Responsibilities of key management personnel

Responsibilities of key management personnel include:

- engaging the services of appropriately qualified health professionals
- arranging training of workers and organise worker training plans
- reviewing the effectiveness of worker training
- ensuring that all dysphagia management approaches are risk-managed
- communicating changes to policies and/or practices to all relevant workers
- ensuring workers can access all relevant policies, procedures and plans
- regularly auditing dysphagia management practices
- responding to escalated incidents.

Responsibilities of workers

Responsibilities of workers include:

- providing supports that are within the scope of their role
- taking part in worker training
- ensuring full understanding of worker training content and materials
- providing supports in accordance with each participant's mealtime management and dysphagia management plans
- monitoring participants for any changes to their needs and preferences
- managing immediate response to emergency situations in accordance with each participant's dysphagia management plan
- escalating emergencies and other incidents to the appropriate people (e.g. emergency services, key management personnel and qualified healthcare practitioners).

Preparing to deliver dysphagia management supports

When preparing to deliver complex bowel care, support workers will:

- understand the support plan and confirm that it is correct and current for the participant
- check with the participant to understand their specific support requirements, including:
    - timing, frequency and type of support
    - food and fluid needs, and preparation techniques
    - safe feeding strategies and feeding equipment
    - their expectations, capacity and preferences for the delivery of dysphagia management supports
    - the participant's preferences for communication including the uses of aids, devices and/or methods of communication
    - the participant's capacity, expectations and preferences for being involved in support delivery
- communicate with each participant using the participant's preferred method and language
- support each participant to make meal time as enjoyable as possible
- maintains impeccable hygiene and infection control
- ensure that the required equipment and consumables are available and ready to use
- maintain knowledge of:
    - NDIS Code of Conduct and Practice Standards
    - the role of high intensity supports in supporting participants to lead the life they choose
    - common communication supports
    - infection control and hygiene
    - the role of food in supporting good health, culture and social connection
    - scope of their responsibilities, including supervision and delegation
    - roles and responsibilities of others involved in supporting the participant
    - features of a safe environment for working and supporting participant with dysphagia.

Implementing dysphagia supports

When implementing dysphagia management plan workers will:

- check with the participant for any adjustments that need to be made on the day supports are being provided
- follow all hygiene and infection control measures
- support the participant with all relevant aspects of their plan in the least intrusive way possible
- support participant to position themselves as safely and comfortably as possible
- prepare food and fluids in accordance with the participant's preferences and the required texture
- support the participant to enjoy their meal
- identify risk indicators such as swallowing or breathing difficulties and inform relevant health practitioners of these risks

- support participants with oral hygiene in line with their plan
- monitor and record support plan information
- collaborate with others to provide effective supports
- involve the participant in their supports, to the extent that the participant chooses
- maintain knowledge of:
    - anatomy of swallowing and respiratory system
    - dysphagia and related factors that present challenges for eating and drinking
    - signs and symptoms of dysphagia
    - infection control and hygiene principles
    - purpose and methods for positioning to assist swallowing
    - aids for supporting participants with dysphagia
    - first aid techniques
    - knowledge of food and fluid preparation requirements set out in the International Dysphagia Diet Standardisation Initiative (IDDSI)
    - risks associated with taking medication and poor oral health
    - Australian Dietary Guidelines for Healthy Eating, and how these apply to menu planning
- get advice from appropriate health practitioners where required
- understand reporting and handover responsibilities.

Reviewing dysphagia support

When reviewing practices and associated plans, workers must:

- discuss with the participant to understand whether changes to their support is needed
- seek feedback from participants to determine if they have enjoyed their meal
- identify and document information where management plan is not meeting the needs of a participant
- encourage participant feedback and request changes as required
- review procedures and responsibilities for reviewing supports.

Subcutaneous injections

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Next review: 3 Nov 2024

Introduction

While injectable medication has many healthcare benefits to participants, there are complexities associated with the prescribing, preparing and administering this form of medication. This means there are greater risks than for other routes of administration. Safe systems of work are required to minimise the risks to ensure participants receive safe effective care.

This policy aims to ensure the safe administration of injectable drugs via the subcutaneous route.

Our support workers are trained and supported by our Registered Nurse.

Hands on opportunities are provided to effectively support and deliver medication by subcutaneous route and continuously evaluated and monitored.

Applicability

When
• applies when participants are supported that require injectable medication via the subcutaneous route.

Who
• applies to all employees, supervisors and key management personnel supporting participants that require subcutaneous injections.

Governing obligations for this policy

- NDIS Practice Standards SM 1.7.1 Subcutaneous Injections
- NDIS Practice Standards SM 1.7.2 Subcutaneous Injections
- NDIS Practice Standards SM 1.7.3 Subcutaneous Injections
- NDIS Practice Standards SM 1.7.4 Subcutaneous Injections

Governing regulations for this policy

- NDIS (Quality Indicators) Guidelines 2018 (Cth)

Applicable processes for this policy

- Administer subcutaneous injection

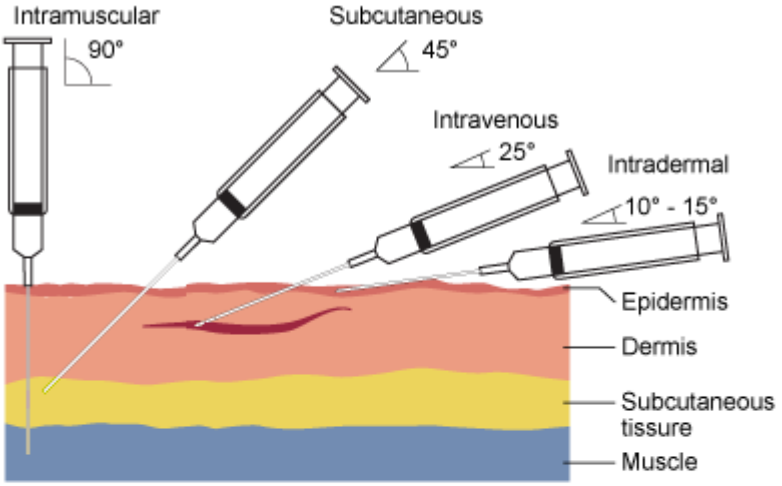
Documents relevant to this policy

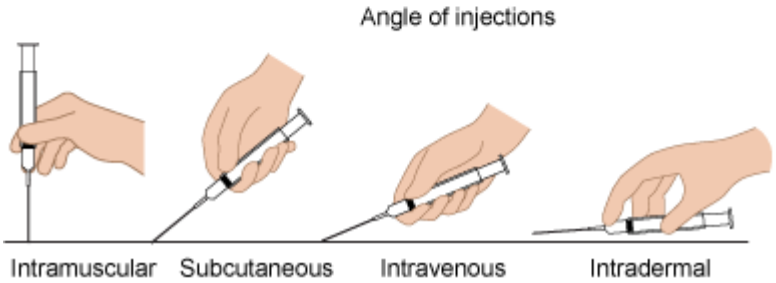
- 5 Moments of Hand Hygiene
- Blood glucose monitoring chart
- Handwashing
- Managing hypoglycaemia flowchart template
- Subcataneous injections (easy read)

Subcutaneous injection general guidelines

The subcutaneous route is used for a slow, sustained absorption of medication. Up to 1-2 ml of drug/fluid is injected, slowly, into the subcutaneous tissue inserting the needle at a 45-90 degree angle into a raised skin fold in order to lift adipose tissue from underlying muscle. Aspiration following needle insertion is not required as risk of puncturing blood vessels is negligible.

The subcutaneous route is suitable for administering small doses of non-irritating water-soluble medication such as insulin or heparin.





"*Needle-insertion-angles-1*" *by British Columbia Institute of Technology (BCIT) is licensed under CC BY 4.0.*

As a guide:

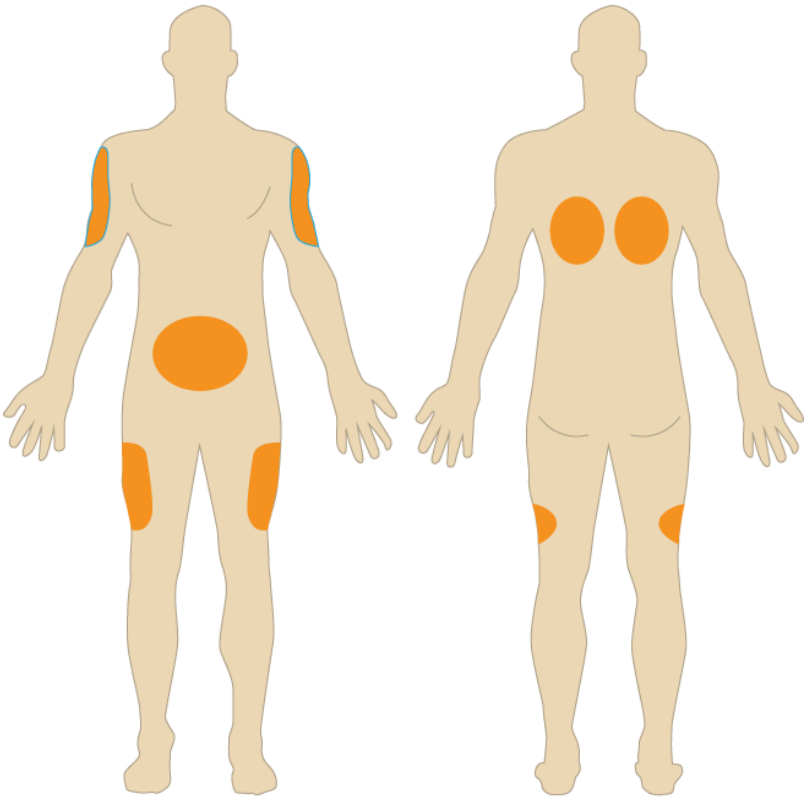
- ensure each participant requiring subcutaneous injection receives relevant support proportionate to their individual needs and specific medication requirements
- recommended needle types can range between 25-27 gauge and up to 16mm long. For more information refer to the Australian Immunisation Handbook
- for diabetic use - shorter length pens, less than 8 mm are recommended for adults and children
- when using a syringe, a needle no longer than 8 mm is recommended

- syringes and pen needles are single use only
- injections should not be administered through clothing
- ensure skin is visibly clean prior to administration. The use of alcohol swabs may not be required. Assess each person's condition and apply best practice. Refer to the Nursing Times Online for further information
- dispose sharps safely and immediately
- shorter length pen needs are recommended for adults and children.

Injection site

The recommended sites to administer medication by subcutaneous are:

- the abdomen in the umbilical region
- the lateral or posterior aspect of the lower part of the upper arm
- the thighs (under the greater trochanter rather than the mid thigh)
- buttocks.



"Subcutaneous-injection-sites-274x300-ar" by British Columbia Institute of Technology (BCIT). Derivative: User:Sarah Ab is licensed under CC BY 4.0.

If medicine is given frequently to the person via the subcutaneous route, rotate injection sites to decrease the likelihood of irritation and ensure improved absorption.

The injection site should be assessed before and after medication administration for signs and symptoms of possible difficulties including: pain/tenderness, inflammation, bruising, oedema, hardness, heat, exudates/leaking, discharge, itching, burning, unresolved blanching and necrosis. Change the injection site immediately if any of these signs and symptoms are present.

A maximum volume of 2 ml is tolerable using this route for injection. Only highly soluble drugs should be administered to prevent irritation.

A 25G needle is usually used to administer medication via subcutaneous.

Recommended subcutaneous needle size and gauge

Adult or child	Needle size	Technique
adult	4-8 mm	• If you can grasp 5 cm of tissue, insert needle at a 90° angle. • If you can grasp 2.5 cm of tissue, insert needle at a 45° angle. • For shorter needles (less than 8mm), 90° is recommended).
child	4-6 mm	• 4 mm needles are recommended for children aged 2-6 years with a lifted skin fold. • The need for lifted skin fold should be reviewed as the child grows.
all people	25-27 gauge and 16 mm long	• Recommended for vaccinations • Insert needle at a 45 degree angle

Needle safety

Never recap a used needle—recapping needles increases risk of needle stick injury.

Always dispose of used needles in a sharps approved container.

Worker responsibilities when supporting participants with subcutaneous injectable medications

Responsibilities of workers are to:

- work within their scope of practice and qualifications
- wear appropriate PPE—gloves are not necessary (they don’t protect from needle stick injury) but an apron is recommended to protect clothes
- correctly identity of the person they are administering medication to using the person’s medication chart
- adhere to hand hygiene and injection control policies
- choose an appropriate needle size and practice good administering techniques
- report incidents via incident management system
- ensure that the health status of participants is reviewed regularly.

Key management personnel responsibilities when supporting participants with subcutaneous injectable medications

Responsibilities of key management personnel are to:

- ensure workers have current knowledge and a training plan to teach the standards of care for participants that require subcutaneous injectable medications
- provide workers education to provide excellent confident care
- regularly audit subcutaneous injection practices
- ensure workers follow the Administer subcutaneous medication process
- ensure workers comply with the Medication policy.
- ensure workers have up-to-date skills and knowledge
- ensure all worker training is documented
- review worker competency annually to ensure skills remain current.

Subcutaneous injection plan

Each participant must have a plan for subcutaneous injections in place. The plan must be:

- overseen by a relevant health practitioner
- created with the involvement of the participant
- reflective of each participant’s needs and preferences
- communicated to the participant’s support network, with the consent of the participant
- reviewed regularly .

Each participant’s plan must cover all key areas of their supports, including:

- medication requirements
- dose calculation
- injecting procedure
- risk, incident and emergency management information.

Skills and knowledge for delivering subcutaneous injections

We will ensure that workers administering subcutaneous injections are suitably trained by an appropriately qualified health practitioner. Workers will have access to all information and support relating to subcutaneous injections, including:

- policies and procedures
- supervision
- equipment and consumables
- training sessions.

Workers must be trained in:

- the specific needs of each participant
- purpose of each medication the participant is taking
- how to use all relevant equipment
- the participant’s related health condition/s.

Where a worker has not delivered this support for a period of more than 3 months, or if a participant’s support needs have changed and/or they have an updated support plan in place, it is recommended the worker be reassessed before supporting the participant and undertake refresher training if required.

Preparing to deliver subcutaneous injections

When preparing to administer subcutaneous injections, workers must:

- understand the participant's support plan
- ensure the plan is current and reflects the participant's needs and preferences, including preferences regarding communication
- check the participant's expectations, capacity and preferences regarding their involvement in support delivery
- utilise participant-specific communication strategies, including suitable aids and devices
- practice good hygiene and infection control
- ensure that required injecting equipment and consumables are available and ready to use
- maintain knowledge of:
    - all relevant NDIS legislation
    - the importance of high intensity supports in supporting participant choice
    - common and participant-specific communication supports
    - scope of worker responsibilities, including delegation guidelines
    - features of a safe environment
    - equipment and consumables required for administering subcutaneous injections (e.g. syringes, needles, swabs, gloves, sharps container)
    - infection and hygiene principles
    - medications that must be administered, including order, storage and disposal
    - strategies for minimising participant anxiety or discomfort
    - others roles and responsibilities involved in subcutaneous injections, such as, carers.

Diabetes management

When administering injectable medications for diabetes there are additional guidelines that must be followed.

- Where a worker supports the participant to calculate the dose of diabetes medication, this should be overseen by a suitable healthcare practitioner.
- The dose of diabetes medication should be double checked before it is injected.
- Workers must ensure that participants have access to glucose monitoring equipment, and associated components as documented in their support plan.
- Workers must be aware of methods and equipment used to administer diabetes medications and monitoring glucose levels.
- Workers should be aware of the methods used to adjust/double check medication doses as well as the people responsible for doing this.
- When implementing the participant's plan, workers must:
    - monitor and document blood glucose in the participant's support plan
    - follow procedures in response to any instances of low or high glucose levels
    - support participant to administer insulin throughout the day in accordance with their plan
    - recognise and respond to signs of illness or any complications relating to diabetes medication
    - involve the participant in the management of their diabetes in accordance with their support plan.
- Workers must maintain knowledge of:
    - type 1 and 2 diabetes
    - different types of diabetes medication
    - the relationship between physical activity, weight, stress, diet and blood glucose levels
    - risks associated with specific diabetes medications
    - risks and complications associated with having diabetes
    - impacts of different diabetes medications
    - risks associated with diabetes medications
    - using sliding scale charts to calculate medication dosages.

Implementing subcutaneous injection supports

When implementing subcutaneous injection supports workers must:

- follow hygiene and infection control procedures
- deliver supports in the least intrusive way possible.
- ensure the participant is comfortable before the injectable as administered
- observe the participant and ensure a qualified healthcare practitioner is informed of any adverse reactions
- handle and dispose of sharps in a safe manner
- monitor and record relevant information
- work with others where required to provide adequate supports
- if administering a pre-filled injection, ensure the pre-filled pens and pumps are set up properly before administering the injection
- maintain knowledge of:
    - basic understanding of the injectable medication
    - the impact of the medication and the variables that may change its affects
    - hygiene and infection control
    - indicators of problems associated with the medication (e.g. infection or side-effects)
    - when healthcare practitioners must get involved
    - procedures for reporting, recording and document management.

Reviewing subcutaneous injection administration

When reviewing their administration practices and associated plans, workers must:

- discuss with the participant to understand whether they require any changes to their supports
- assist participants with providing feedback
- review procedures and responsibilities for reviewing supports
- assess, monitor and report skin integrity of injection site..

Tracheostomy support

Version: 2
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Next review: 12 Nov 2025

Introduction

A tracheostomy is a surgically made opening into the trachea (windpipe) which is held open by a tracheostomy tube. A commonly used tracheostomy tube consists of three parts: outer cannula with flange (neck plate), inner cannula, and an obturator/introducer. The outer cannula is the outer tube that holds the tracheostomy open, this can be cuffed or cuffless, fenestrated (an opening or hole) or non-fenestrated. A neck plate extends from the sides of the outer tube and has holes to attach cloth ties or Velcro strap around the neck. The inner cannula, fenestrated or non-fenestrated, fits inside the outer cannula and has a lock to keep it from being coughed out, and it is removed for cleaning. The obturator fits inside the tracheostomy tube to provide a guide for the tracheostomy tube when it is being inserted.

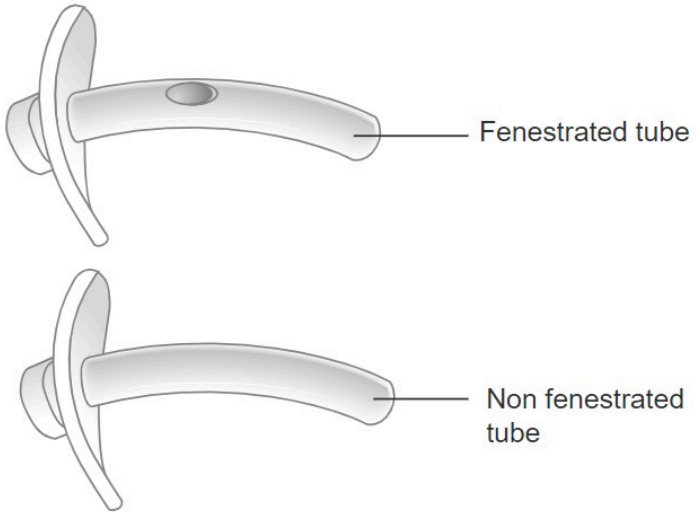

Diagram showing a fenestrated and a non fenestrated tracheostomy tube CRUK 066by Cancer Research UK is licensed under CC BY-SA 4.0.

Having a tracheostomy helps a person to breathe more easily as air now goes in and out through the tracheostomy tube bypassing their nose and mouth. A tracheostomy can be temporary, long term or permanent depending on the participant's medical condition.

More information about tracheostomies can be found here.

There are many different reasons when a tracheostomy may be needed. One of the most common reasons is for prolonged mechanical ventilation. The main reasons are when a person:

- has breathing problems (respiratory failure) such as:
  - being unconscious or in a coma as a result of a severe head injury or stroke
  - when a condition damages the lungs
  - when a condition damages the nervous system
  - paralysis as a result of spinal cord injury
- has blockages:
  - when an injury, infection, burn or severe allergic reaction (anaphylaxis) has swollen or narrowed the throat
  - caused by a cancerous tumour in the throat or thyroid

    - as a result of birth defects
- has fluid in their lungs:
    - during a serious lung infection
    - when chronic pain, muscle weakness or paralysis impedes coughing—the body's way to get rid of foreign particles, irritants, microbes and mucus from the airways.

The correct care of someone with a tracheostomy is important as there is a greater risk of death or harm if inappropriate or inadequate care is provided. Key management personnel must ensure workers follow this policy and that participants have person-centred tracheostomy management plans.

Applicability

When
• applies when participants are supported with a tracheostomy.

Who
• applies to all employees, supervisors and key management personnel supporting participants with a tracheostomy.

Governing obligations for this policy

- NDIS Practice Standards SM 1.4.1 Tracheostomy Management
- NDIS Practice Standards SM 1.4.2 Tracheostomy Management
- NDIS Practice Standards SM 1.4.3 Tracheostomy Management

Governing regulations for this policy

- NDIS (Quality Indicators) Guidelines 2018 (Cth)

Applicable processes for this policy

- Manage tracheostomy

Documents relevant to this policy

- 5 Moments of Hand Hygiene
- Handwashing
- Tracheostomy (easy read)
- Tracheostomy management chart

Tracheostomy assessment

As part of the service entry process, a detailed assessment is required for a participant with tracheostomy. Family presence is recommended for the assessment meeting for additional information and support. This is especially true when verbal

communication is impossible for participants with an inflate tracheostomy cuff (unless a specialised cuff is used i.e. one way speaking valves). It is important to determine the level of care required for care and maintenance of the tracheostomy. Close liaison should also be maintained with the multidisciplinary team including specialised nurses, physiotherapists, speech therapists and doctors. A co-ordinated team approach is best practice for this specialised area of care.

A documented plan for assessment, management and review is required for each individual participant with a tracheostomy. The type of detail to evaluate at initial assessment includes, but not limited to:

- participant history—the level of self-care management the participant is able to perform:
    - reasons for tracheostomy insertion
    - can they change their own tube?
    - how well are they able to clear their own secretions by coughing?
    - are they experiencing swallowing difficulties
    - do they have a speaking valve?
- ways to stabilize the tube
- humidification type
- stoma/skin care
- when was tracheostomy surgery performed? do they have a larynx? or do they have connection between oral airway and lungs?
- record baseline weight and oxygen saturation
- communication strategy e.g. verbal, non-verbal, pen and paper, communication board or voice synthesiser
- oxygen dependence
- type and size of tracheostomy tube—cuffed or non-cuffed tubes, cuff pressure requirements
- when is routine change of tube required—consider manufacturer's recommendations
- how often is suction required? This will depend on whether they are mechanically ventilated or non-ventilated
- nutritional status
- emergency requirements
- routine observations.

Manage tracheostomy risks

The risks and complications for a person with a tracheostomy include:

- respiratory distress (cyanotic, tachypnoea, stridor, gurgling breath sounds, oxygen desaturation)
- dislodged tracheostomy tube
- obstruction
- cuff leak
- faulty oxygen delivery or ventilation device
- ineffective humidification
- bleeding and damage to the throat
- blockage of the tube with secretions, which can be breathed into the lungs causing aspiration pneumonia
- infection
- tube displacement
- scar formation
- dehydration
- cardiac or respiratory arrest (stop breathing)
- aspiration
- breakdown or pressure injury to peristomal skin.

The risks associated with tracheostomies are greater with:

- children
- the elderly
- smokers

- alcoholics
- diabetics
- persons with impaired immune systems
- persons with chronic diseases or respiratory infections
- persons taking steroids or cortisone.

Tracheostomy management planning

Each participant must have a plan for tracheostomy management in place. The plan will be:

- overseen by a relevant health practitioner
- created with the involvement of the participant
- reflective of each participant's needs and preferences
- communicated to the participant's support network, with the consent of the participant
- reviewed regularly.

Each participant's plan will cover all key areas of their supports, including:

- areas detailed under the initial assessment (as shown above)
- hygiene and infection control measures
- accurate monitoring and documentation
- required equipment and resources
- risk, incident and emergency management information.

Tracheostomy care guidelines

It's important that:

- all workers supporting participants with a tracheostomy must adhere to best evidence-based practice in monitoring safety of those participants
- assessing the need for additional support services is ongoing e.g. allied health services such as speech therapy
- a decision to permanently remove or change a tracheostomy tube is made by a qualified health professional.

Further information for tracheostomy care can be found within the resources below:

Agency for Clinical Innovation (NSW Health)

The Global Tracheostomy Collaborative

Critical Care Airway Management (CCAM) Tracheostomy Handbook

Monitoring

People with tracheostomies who rely on ventilators for breathing are often monitored. Devices for monitoring include pulse oximeter (measures oxygen level and heart rate) or apnea monitor (measures heart rate and breathing rate). The person's medical practitioner will determine the need for monitoring.

Ventilator guidelines

Ventilator settings are set by a medical practitioner, they should not be changed by anyone else.

Key management responsibilities when supervising workers supporting participants with a tracheostomy

Responsibilities of key management personnel are to:

- ensure workers have current knowledge and a training plan to learn the standards of care for participants with tracheostomies
- provide workers' education to provide excellent confident care
- ensure workers are following the Manage tracheostomy process
- ensure workers know when and how to activate emergency support
- ensure emergency airway equipment is available at all times including resuscitation bag and airway equipment
- ensure supervisors have accreditation in Basic Life Support
- regularly audit safe tracheostomy management practises
- ensure support workers comply with Manage tracheostomy process
- document all tracheostomy interventions, assessments and care provided in an observation chart and on progress/case notes including any abnormal findings
- ensure skills and knowledge are up-to-date
- document and audit the skills of workers
- re-assess workers that have not delivered tracheostomy support in more than 3 months, or when required (e.g. when a participant’s plan has been updated).

Worker responsibilities when supporting participants with a tracheostomy

Participants that rely on a tracheostomies are at greater risk of pneumonia (chest infection). Providers are responsible to care for and ensure participants are safe. This includes workers to:

- work within their scope of practice and qualifications
- possess competent problem-solving skills and suctioning skills
- support workers need to be able to assess signs and symptoms of upper and lower airway obstruction and the immediate need for suction—this might include:
    - increased respiratory rate
    - persistent coughing
    - nasal secretions
    - anxiety or agitation
    - decreased ability to concentrate
    - fatigue
    - dizziness
    - irritability
    - increased blood pressure
    - pallor
    - hypoxia
    - irregular heartbeat
- adhere to hand hygiene and infection control policies
- physically examine the tracheostomy phlange and the skin condition around stoma site

- if ever in doubt about an intervention, seek assistance from supervisors or key management personnel
- report incidents via the incident reporting system.

Participants with tracheostomy airways no longer have normal humidification of the tracheal mucosa—ensuring humidity is supplied to the airway through nebulisation or with an oxygen delivery system is vital (4 hourly saline nebulisation or as needed).

Risk of respiratory impairment is greater for those with illness or injury that restricts mobility—frequent changes of position reduce the risks of stasis of pulmonary secretions and decreased chest wall expansion.

Preparing to undertake tracheostomy management

When supporting participants with tracheostomy management workers will:

- understand the participant's support plan
- ensure the plan is current and reflects the participant's needs and preferences, including preferences regarding communication
- read the advanced care directive (if a participant has one in place)
- check the participant's expectations, capacity and preferences regarding their involvement in support delivery
- utilise participant-specific communication strategies, including suitable aids and devices
- practice good hygiene and infection control
- ensure that required equipment and consumables are available and ready to use
- maintain knowledge of:
    - all relevant NDIS legislation
    - the importance of high intensity supports in supporting participant choice
    - common and participant-specific communication supports
    - hygiene and infection control principles
    - scope of worker responsibilities, including delegation guidelines
    - features of a safe environment
    - participants' wishes for emergency supports, if these have been documented within an advanced care directive
    - common health conditions associated with tracheostomy support (e.g. spinal injury, paralysis, structural differences or chronic pulmonary disease)
    - common types of tracheostomy and stoma equipment (e.g. speaking valves, tracheostomy cuffs, humidifiers).

Implementing tracheostomy management supports

When implementing tracheostomy support plans, workers will:

- follow hygiene and infection control procedures, including cleaning and maintaining the integrity of the stoma
- deliver supports in the least intrusive way possible
- ensure the participant is comfortable before the injectable as administered
- observe the participant and ensure a qualified healthcare practitioner is informed of any risk indicators, such as abnormal secretion or breathing problems
- monitor and record relevant information, including instances when suctioning is required to maintain clear airways
- work with others where required to provide adequate supports
- clean and maintain suctioning equipment
- clean and maintain stoma site integrity
- monitor skin condition
- support an appropriately qualified health practitioner if required, and as outlined in the participant's support plan, with routine tube tie changes and dressing changes (Tracheostomy ties/straps changes are done by a qualified health practitioner and need a second person to assist)
- actively involve the participant in their supports, as specified by their support plan and to the extent that they choose
- maintain knowledge of:

- basic anatomy of the respiratory system
- basic principles of stoma care, including risks and signs of deteriorating health
- hygiene and infection control
- indicators of common problems, including infections
- when healthcare practitioners must get involved
- procedures for reporting, recording and document management
- warning signs of a blocked tracheostomy tube (e.g. blood or phlegm in the tube, breathing difficulties, inability to pass a catheter through the tube)
- techniques for responding to tube blockages
- first aid techniques.

Reviewing tracheostomy management

When reviewing their practices and associated plans, workers will:

- discuss with the participant to understand whether they require any changes to their supports
- document instances when the plan is not meeting the participant's needs
- assist participants with providing feedback
- review procedures and responsibilities for reviewing supports.

Urinary catheter support

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Last edited: 8 Jan 2025, 1:22 PM
Next review: 3 Nov 2025

Introduction

This policy provides the principles on providing supports and services to participants with urinary catheters. Individuals of any age may require catheterisation for a range of reasons, such as:

- to relieve urinary incontinence when no other means is possible
- to relieve retention of urine
- for investigations
- to accurately measure urine output
- to drain the bladder prior to or after surgery
- long periods of immobilisation e.g, traumatic injuries
- increase comfort measures for end of life care
- to assist with preventing worsening sacral/perineal pressure injuries in incontinent individuals

Urinary catheters may be used by persons with spinal cord injury, stroke, multiple sclerosis, spina bifida or other medical conditions, and before or after surgery of the bladder, prostate or other parts of the urinary tract.

What is a urinary catheter?

A urinary catheter is a flexible or rigid hollow tube introduced into the urinary tract and bladder to drain urine. It is held in place by a small balloon at the catheter tip inside the bladder. The balloon is filled with sterile water to hold catheter in place. The catheter provides a flow of urine for those who are unable to control micturition or those with obstruction or spinal cord injury, paralysis, chronic neurologic disorders. As urine fills the bladder, it drains down the catheter into the drainage bag. The different type of catheters for different individual needs are as follows:

- **Intermittent catheter** (in-out catheter)—a straight single use catheter introduced long enough to empty bladder (5-10 mins). Repeated as necessary. It is possible to self-catheterise using this type of catheter.
- **Indwelling catheter—**for short term or long-term use. An indwelling catheter can be either:

    a. Straight -tipped single-use catheter with small inflatable balloon and a small opening from tip through the lumen to a receptacle. Remains in place for a longer period.
    b. Coude tip or Tiemann catheters—this catheter has a curved tip design, used for male patients with enlarged prostates or complicated insertions.

- Suprapubic catheter—inserted through incision in abdominal wall (whilst patient under general anaesthetic) by use of a **trocar** above the **symphysis pubis**. Used in temporary situations post-surgery OR long term for selected patients i.e quadriplegia. This catheter is sutured in place. Urine drains into a plastic urinary drainage bag, which can be attached to a person’s leg or discretely hidden beneath clothing. Bag is emptied by use of a valve that opens and closes.
- Uridome—a pliable rubber sheath that slips over the penis and is secured by tape. The end of the uridome fits into a plastic drainage bag. Used for incontinent males who have spontaneous bladder emptying. It can be worn continuously or at night only.

Catheterisation is a skill. Knowledge and education are key for provision of appropriate support for catheterised participants.

A recommended guide for catheter size and length:

	Sizes (diameter)	**Lengths**

Adult - Male	14-18Fr	41-45cm
Adult - Female	12-14Fr	20-25cm*
Child	6-10Fr	30cm

*Male lengths can also be used for females.

Further information can be found on the Australia and New Zealand Urological Nurses Society (ANZUNS)

Why are catheter supports important?

Urinary elimination for many of our participants is physiologically difficult. A thorough assessment of a client's continence needs is essential and planning is important.

Correct catheter care is important to ensure its correct function and to prevent catheter-associated urinary tract infection. Workers providing supports to participants with catheters must be trained in the care of a catheter in order to assist participants with correct catheter management. Education and experience are vital to preventing infection, maintaining skin integrity and comfort.

Applicability

When

- applies when are supporting participants with urinary catheters.

Who

- applies to all employees, supervisors and key management personnel supporting participants with catheters.

Governing obligations for this policy

- NDIS Practice Standards SM 1.5.1 Urinary Catheter Management
- NDIS Practice Standards SM 1.5.2 Urinary Catheter Management
- NDIS Practice Standards SM 1.5.3 Urinary Catheter Management

Applicable processes for this policy

- Manage urinary catheter

Documents relevant to this policy

- 5 Moments of Hand Hygiene
- Handwashing
- Support plan template - urinary catheter management
- Urinary catheter (easy read)
- Urinary catheter documentation chart

Catheter changes—indwelling, suprapubic, and in-out catheters

When to change or remove a catheter is decided by a qualified health professional.

Only a clinical nurse or other health professional can change a catheter.

Appropriate training can be provided for workers and participants performing in-out catheters (intermittent). More information on this guide can be found on the ACI urology network.

Catheter assessment

Each individual NDIS participant's needs should be considered when selecting catheter type. These include:

- indication for catheterisation
- type of catheterisation i.e. urethral, suprapubic or in-out
- consistency of urine
- anticipated duration of catheterisation—intermittent/short-term/long-term

Urinary catheter care

As a rule:

- all workers supporting participants with catheters must adhere to best practice in monitoring safety and comfort of individuals who are catheterised
- determine possible allergy to tape, latex or lubricant before any intervention
- obtain permission/consent of participants prior to any physical examination
- always assess participant's knowledge of the purpose of catheterisation and explain your actions
- maintain accurate records and relevant documentations.

Links to recommended guidelines for catheter care can be found on Continence Nurses Society Australia (CONSA).

This should be used in conjunction with Manage urinary catheter process.

Worker responsibilities when supporting participants with urinary catheters

Support workers must be trained

Participants who are catheterised, self-catheterise or use intermittent catheterisation to empty their bladder are at greater risk of catheter associated UTI and renal complications. Providers are responsible to care for and ensure participants are safe through

due diligence.

This includes workers to:

- only insert catheters using aseptic non-touch technique (ANTT)
- appreciate that catheterisation is an invasive procedure that can result in serious complications
- be aware of the signs of autonomic dysreflexia.

Interventions

It is vital that workers are able to determine malfunction of catheters including:

- monitor and watch for potential safety issues i.e. if there is oliguria or no urine in drainage bag, check that catheter has not become misplaced in vagina (females)
- check if catheter has not accidentally been expelled by bladder or urethral contraction (males)
- check drainage tubing for patency
- note any inability to void (urinary retention)
- rapid drainage of urine might result in hypotension
- diuresis might require Intravenous electrolyte replacement
- note participant complaints of pain or fever.

Documentation

- accurate recording and reporting including:
    - document date of catheterisation and due date for changing IDC
    - before emptying drainage bag document time and amount of urinary output and fluid balance—monitor colour, odour and consistency of urine
    - date of removal of catheter
    - note adverse events like pain or bleeding
- ensure notes record type of catheter, size, amount of water in balloon, expiry date of product
- ensure workers know the signs of autonomic dysreflexia
- if stock is low re-order sterile stock and equipment.

Key management responsibilities when supervising workers supporting participants with urinary catheters

Responsibilities of key management personal are to:

- ensure workers have current knowledge and a training plan to teach the standards of care for participants with catheters
- regularly audit safe catheter management practises
- report specific abnormalities to a medical professional
- all personnel will understand how to report specific abnormalities to a medical professional
- ensure support workers comply with the Manage urinary catheter process.

Skills and knowledge for delivering urinary catheter supports

In addition to general training in a range of different types of urinary catheters and their support requirements, workers will be trained in the specific needs of each participant they support, including the appropriate use of equipment.

Training will be delivered by an appropriately qualified health practitioner or a person who meets the expectations outlined in the NDIS High Intensity Skills Descriptors, and the training of workers will be documented and regularly audited to ensure workers have current and up to date skills and training.

We will review each worker's competency to provide urinary catheter supports annually to confirm the worker has current skills and knowledge. Where a worker has not delivered this support for a period of more than three months, or if a participant's support needs have changed and/or they have an updated support plan in place, the worker will be reassessed before supporting the participant and undertake refresher training when required depending on the worker's experience and the type of supports required.

Preparing to deliver urinary catheter supports

When preparing to deliver urinary catheter supports, workers will:

- ensure that they understand the support plan, confirm it is the correct and current plan for the participant, and check the participant's specific support requirements for example, type of catheterisation, timing of catheter drainage
- check with the participant on their expectations, capacity and preferences for being involved in the delivery of support
- prepare required hygiene and infection controls
- checks with the participant on their preferences for communication, including the use of aids, devices and/or methods
- communicate with the participant using participant-specific communication strategies, communication aids, devices, or resources, including resources in the participant's preferred language
- ensure that required equipment and consumables are available and ready for use
- recognise the personal nature of urinary catheter supports and makes sure the participant is ready to receive support
- maintain knowledge of:
    - NDIS Code of Conduct and Practice Standards
    - the role of high intensity supports in supporting participants to lead the life they choose
    - understanding common and participant-specific communication supports, for example, assistive technologies, alternative and augmentative communication, communication devices
    - principles of infection control and personal hygiene, for example, hand washing, disinfecting, and use of appropriate Personal Protective Equipment (PPE) such as gloves
    - scope of support worker responsibilities including supervision and delegation arrangements
    - roles and responsibilities of others involved in supporting a participant who uses a urinary catheter including carers, health practitioners and other workers
    - features of a safe environment for working and delivering complex urinary catheter support
    - types of catheter, their main components, and their function e.g. catheter bags, balloons and tubing.

Implementing urinary catheter supports

When implementing support plans for urinary catheter management, workers will:

- checks with the participant for any specific factors or adjustments needed at the time support is provided
- follows hygiene and infection control procedures
- delivers support in ways that are least intrusive or restrictive and that fit into the participant's daily routines and preferences.
- supports the participant to position themselves for catheter insertion and/or drainage
- supports the participant to clean and maintain healthy condition of the stoma site
- follows procedures for intermittent catheterisation insertion for a male or female participant
- checks catheter functioning and takes action as required including checking bag placement, checking urine levels and draining and/or replacing catheter bags
- identifies and immediately informs an appropriate health practitioner in response to signs and symptoms of complications or infection
- measures and records the amount and consistency of urine output and related information
- actively involves the participant in their support, as outlined in their support plan and to the extent they choose
- maintain knowledge of:
    - basic anatomy of the male and female urinary system

- the risks and health problems associated with using catheters, including urinary tract infections and skin integrity issues
- purpose and methods of hygiene and infection control
- catheter insertion techniques appropriate to males and females to minimise infection risk and participant discomfort
- requirements for catheter functioning including positioning of bag to ensure drainage, tube positioning
- indicators and actions required for common complications or problems such as dislodged catheter tubes, changes in appearance of urine including suspected blood in urine or confusion
- when and how to involve or get advice from the appropriate health practitioner.
- indicators and actions required to respond to common health problems at the stoma site, such as wetness or signs of infection or inflammation
- reporting responsibilities, including handover, recording observations and incident reporting.

Reviewing urinary catheter supports

When reviewing urinary catheter supports, workers will:

- check with the participant and discuss any changes needed to catheter supports they are receiving
- identify, document and report information where a support plan is not meeting a participant's needs
- support the participant to provide feedback and request changes to their support plan as required
- maintain knowledge of procedures and responsibilities for requesting review of urinary catheter supports and related support plans.

Ventilator support

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Introduction

A mechanical ventilator is a machine that helps people breathe when they are not able to breathe enough on their own. Also called a respirator or breathing machine, a ventilator is used to:

- get oxygen into the lungs and body
- help the body get rid of carbon dioxide through the lungs
- ease the work of breathing—some people have difficulty breathing on their own
- breathe for a person who is not breathing because of injury to the nervous system, like the brain or spinal cord or who has very weak muscles.

This policy aims to ensure:

- evidenced-based standards of care are provided for safe and efficient management of mechanically-ventilated participants
- the needs, comfort and goals set for the patient with an acute ventilator or respiratory failure are met
- every patient requiring ventilator management receives appropriate support relevant and proportionate to their individual needs and the specific ventilator used.

When a person breathes normally (spontaneous breathing), the diaphragm contracts on inhalation, moving toward the abdomen, and the chest wall expands. The space inside the thorax enlarges creating a vacuum that draws air into the lungs and helps to distribute the air evenly. In contrast, a ventilator pushes a warm, humidified mixture of oxygen and air into the lungs and creates positive pressure in the thorax during inhalation.

The correct care of a person who relies on mechanical ventilation is critical as they are at a greater risk of death or harm if inadequate or inappropriate care is provided. Key management personnel must ensure workers follow this policy and that participants have person-centred ventilation management plans.

Assessment

As part of the service entry process, a detailed assessment is required for a participant with ventilation needs. Family presence is recommended for the assessment meeting for additional information and support. This is especially important when verbal communication is difficult. It is important to determine the level of care required. Close liaison should be maintained with the multidisciplinary team including specialist nurses, physiotherapists, speech therapists and doctors. A coordinated team approach is best practice for this specialised area of care.

There must be a documented plan for assessment, management and review for each individual participant using a ventilator. The type of detail to evaluate at initial assessment includes, but are not limited to, the following:

- participant history—the level of self-care management the participant is able to:
    - learn the ventilator settings and understand what the alarm might mean
    - can they change their own tube?
    - how well are they able to clear their own secretions by coughing?
    - can they swallow?
- if they have a tracheostomy?
- if they have a larynx?
- do they have a connection between oral airway and lungs?
- communication strategy e.g. verbal, non-verbal, pen and paper, communication board or voice synthesiser

- type and size of tracheostomy tube and when a routine change of tube is required
- oxygen dependence
- how often is suction required
- routine observations.

Risks of mechanical ventilation

There are many problems that can develop from ventilator use including:

- infections such as pneumonia—the ET or trach tube allows bacteria to get into the lungs more easily
- collapsed lung (pneumothorax)—a part of a lung that is weak can become too full of air and start to leak into the chest wall which causes the lung to start to collapse
- lung damage—the pressure of putting air into the lungs with a ventilator can damage the lungs—this is why health professionals should set the ventilator to the lowest amount of pressure needed
- side effects of medications—sedatives and pain medications can cause a person to seem confused or delirious while other medications to prevent muscle movement can cause muscle weakness
- inability to stop using ventilator support—if a person's conditions do not improve, long term reliance on ventilation may be required.

Monitoring

People who rely on mechanical ventilation often require monitoring. Devices for monitoring include pulse oximeter (measures oxygen level and heart rate) or apnea monitor (measures heart rate and breathing rate). The person's medical practitioner will determine the need for monitoring and what ventilation adjustments are required.

Applicability

When
• applies when participants are supported who require mechanical ventilation.

Who
• applies to all employees, supervisors and key management personnel supporting participants with mechanical ventilation needs.

Governing obligations for this policy

- NDIS Practice Standards SM 1.6.1 Ventilator Management
- NDIS Practice Standards SM 1.6.2 Ventilator Management
- NDIS Practice Standards SM 1.6.3 Ventilator Management

Applicable processes for this policy

- Manage ventilator

Documents relevant to this policy

- 5 Moments of Hand Hygiene
- Handwashing
- Ventilator management (easy read)
- Ventilatory support checklist

Ventilator management guidelines

As a guide:

- participants requiring ventilation will only receive support from workers trained and proficient in ventilator management
- ventilator and bedside alarms must be on at all times—never leave a participant unattended with alarms turned off
- suction equipment, oxygen, and manual ventilation device (MVD) and masks must be readily available at the bedside of all participants with artificial airways
- intubation supplies must be readily accessible for all patients with artificial airways
- the decision to wean a participant from ventilation support should only be made by a qualified health professional
- maintain all ventilatory and monitoring equipment according to the manufacturer's instructions at all times in order to reduce the risk of failure.

Non-invasive ventilation (NIV), such as Bilevel Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP) machines can use the following interfaces:

Oronasal masks	Commonly used Covers nose and mouth Facilitates better C02 elimination
Nasal mask/nasal pillows	Most comfortable Covers the nose only Higher likelihood of leakage
Full face masks	Covers the nose and mouth across a area of the face Can be used interchangeably with the oronasal mask

It is important to consider the participant's comfort and tolerance for types of interfaces. Additional information can be found on the ACI: Clinical practice guide for 'Non-ventilation for patients with acute respiratory failure.

Options for NIV

General information about CPAP and BiPAP can be found from The Sleep Foundation For additional information refer to the National Library of Medicine.

CPAP	Constant positive end-expiratory pressure (PEEP) levels on both inhalation and exhalation

BiPAP	Delivers 2 types of air pressures: inspiratory positive airway pressure (IPAP) and expiratory positive airway pressure (EPAP)

Ventilator management plans

A ventilator management plan and/or ventilator support plan is an important customised care plan for a participant requiring ventilation and should be completed by a health professional. Each individual ventilator management plan should include all information relating to:

- nutritional status for a participant who is being tube fed
- cardiovascular and respiratory assessment
- common health problems e.g. signs of infection at stoma site
- signs of infection
- day and night routines
- psychosocial status of participant and family
- ongoing education and support for carers and family members
- advanced care directive (if any)
- medication planning
- risks assessments
- emergency action plan
- multidisciplinary team arrangements.

Ventilator management responsibilities of workers

Participants that rely on ventilation are at greater risk of pneumonia (chest infection). Providers are responsible to care for and ensure participants are safe. This includes workers to:

- read and understand this policy before providing support to ventilated participants
- complete all required competencies and training before providing support to ventilated participants
- work within their scope of practice and qualifications
- wear appropriate PPE at all times
- be competent in setting appropriate alarm settings
- respond immediately to an audible ventilator alarm and assess the participant for respiratory distress or a disconnected ventilator
- suction as required both orally and via the artificial airway
- ensure the securement device goes around the head/neck and is comfortable for the patient
- follow instructions of the responsible clinician which include:
    - set up of the mechanical ventilator, accessories and tubing specific to participant’s needs
    - set up of in-line suction for ventilated participants
    - how to initiate ventilation, set the alarms and provide adjunctive ventilator equipment
    - setting the ventilation parameters based on the participant’s ideal body weight and medical condition
    - adjusting ventilator settings in conjunction with the medical practitioner’s orders
    - monitor the ventilator and patient after setting changes and after re-initiating ventilator i.e. post transport
- be knowledgeable of current and prescribed ventilator settings
- follow the medical practitioner’s orders and ventilator setting change requests
- communicate medical practitioner’s orders promptly with other relevant team members
- assess the participant at regular intervals as directed by a medical practitioner
- collect blood gases if ordered and arterial line is present.

Key management responsibilities when supervising workers supporting participants with ventilators

Responsibilities of supervisors are to:

- ensure workers have current knowledge and a training plan to learn the standards of care for participants that require mechanical ventilation
- provide workers education to provide excellent and confident care
- ensure workers follow and comply with the Manage ventilator process
- ensure workers know how to activate emergency support
- ensure emergency airway equipment is available at all times including resuscitation bag and airway equipment
- ensure supervisors have accreditation in Basic Life Support
- regularly audit safe ventilator management practices
- document all ventilator-related interventions, assessments and care provided in an observation chart including any abnormal findings
- consider whether the participant needs physical restraints to prevent accidental removal of the ETT/tracheostomy tube.

Documentation

Workers must keep clear and legible records on the participants with ventilators. This should include:

- ventilator type, size and location of airway
- if applicable, level of an endotracheal tube (ETT) at the teeth/gum once a shift, after any adjustments and daily in any case
- ventilator and alarm settings at the onset of the shift, q4h and with any change in orders or patient's condition
- SaO_2 and $ETCO_2$ quarter hourly and with any change in orders or participant's condition
- amount, consistency and color of tracheal secretions after each suction session
- duration of time on ventilator
- daily pressure area care and skin integrity check as indicated, such as, where the masks sits on the face and stoma area
- regularly repositioning participant appropriately, such as sitting upright at 30-45 degrees
- accurate fluid balance monitoring
- oxygen therapy and nebuliser management
- vital sign monitoring, such as O2 saturations, heart rate, blood pressure, respiratory rate, level of consciousness and pain levels
- mouth and eye-care attended every 2 hours
- humidification device and related equipment
- for invasive ventilation, cuff deflation/inflation as indicated, and circuit monitoring
- unexpected outcomes and interventions
- required equipment and devices e.g. back-up ventilators, spare batteries and oxygen tanks, reserve masks and cannula.

Skills and knowledge required for delivering ventilator supports

We will ensure that workers are trained in the specific needs of each participant receiving ventilator supports alongside general training in different ventilator types and methods of use. All training will be delivered by an appropriately qualified person who meets the skills and knowledge requirements of the NDIS High Intensity Support Skills Descriptors.

We will ensure that workers have current skills and knowledge which are documented, regularly audited, and reviewed annually to confirm the required competencies to provide ventilator supports. Where a worker has not provided ventilator supports for more than 3 months or a participant's support need or support plan have changed, their competency in delivering ventilator supports will be reassessed and refresher training organised if required.

Preparing to deliver ventilation supports

When preparing to deliver ventilation supports, workers will:

- understand the support plan, confirm it is the correct and current plan for the participant, and checks the participant's specific support requirements for example, their level of dependency
- read the advanced care directive where the participant has one in place
- check with the participant on their expectations, capacity and preferences for being involved in the delivery of support
- check with the participant on their preferences for communication, including the use of aids, devices and/or methods
- communicate with the participant using participant-specific communication strategies, communication aids, devices, or resources, including resources in the participant's preferred language
- prepare for hygiene and infection control
- check the required equipment and consumables are available and ready for use
- records and clearly documents equipment checks on respiratory equipment in a log book, including checking of back-up ventilators, oxygen levels in spare tanks, suction equipment, etc
- maintain knowledge of:
    - NDIS Code of Conduct and Practice Standards
    - the role of high intensity supports in supporting participants to lead the life they choose
    - understanding common communication supports, for example, assistive technologies, alternative and augmentative communication, communication devices
    - principles of infection control and personal hygiene, for example, hand washing, disinfecting, and use of appropriate Personal Protective Equipment (PPE) such as gloves
    - scope of support worker responsibilities, including supervision and delegation arrangements and activities requiring more than one worker
    - roles and responsibilities of others involved in supporting the ventilation needs of the participant this may include, carers, health practitioners, equipment suppliers and other support workers
    - understand the participant's wishes for emergency supports where they have been documented in an advanced care directive
    - features of a safe environment for working and delivering ventilation support
    - types of ventilators, the main components including batteries, and their function.

Implementing ventilation supports

All personnel responsible for implementing ventilation supports will:

- check with the participant for any specific factors or adjustments needed at the time support is provided
- follow hygiene and infection control procedures
- deliver support in ways that are least intrusive or restrictive and fit into the participant's daily routines and preferences
- support the participant to position themselves for ventilation
- support the participant to place and fit the correct mask as documented in the support plan
- follow procedures to start, operate and monitor the ventilator
- respond to ventilator alarms to address issues
- identifies and immediately informs an appropriate health practitioner of risk indicators such as fatigue, anxiety or breathing difficulties
- identify and takes immediate action in response to blocked or occluded airways, signs of choking or difficulty swallowing including suctioning and involving the appropriate health practitioner
- commence and maintains manual ventilation as required
- report any concerns to the appropriate health practitioner
- monitor supply and condition of consumables, non-consumables for routine ventilator use and emergency related consumables, non-consumables and equipment
- follow troubleshooting procedures to conduct maintenance, including replacement of tubes, internal and external batteries

- follow emergency procedures to immediately start, operate and monitor the use of a back-up ventilator, resuscitation bags, oxygen requirements and suctioning equipment
- follow emergency procedures to apply basic first aid or initiating cardiopulmonary resuscitation and basic life support if required
- involve or gets advice from the appropriate health practitioner
- track and record information required by the support plan
- work collaboratively with others including the appropriate health practitioner to ensure continuity and effective delivery of support. This may include written documentation provided to a health practitioner
- actively involve the participant in their support, as outlined in their plan and to the extent they choose
- assist the participant to fit and adjust their breathing mask when supporting participants with non-invasive ventilation.

Workers who support participants with invasive ventilation through a tracheostomy will:

- actively manages invasive ventilation, including monitoring circuits and the need for cuff inflation or deflation
- supports the participant to clean and maintain healthy condition of the stoma.

Reviewing ventilator supports

When reviewing ventilator supports, workers will:

- check with the participant to discuss any changes needed to the ventilation support they are receiving
- identify, documents and reports information where a support plan is not meeting a participant’s needs
- support the participant to provide feedback and request changes to their support plan as required.