**P032- SWP Work Practices**

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| Applies to: |
| All staff |

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# **PURPOSE**

The Safe Work Practices (SWP) policy is to ensure the safety of our staff and clients.

# **POLICY**

It is a policy of First Call Nursing that all employees abide by the following safe work practices and procedures.

* Bowel Care (Administering an Enema)
* Caring for Incontinent Clients
* Feeding Dependent Client
* Managing Aggression of Difficult Behaviour
* Meal Preparation
* Performing Home Visit
* Standards Protocol
* Transportation
* Bed making
* Use of Bedpan or Urinal
* Blood Sugar Level (BSL) Monitoring
* Infection Control
* Intervening in Emergency Situations: Performing Cardiopulmonary Resuscitation
* Post Fall Management
* Transfer of Patient Using Mechanical Lifter from Bed
* Working Around Sharps
* Safety Switch - Plug-In Adaptor
* Epilepsy Management

# **FORMS**

F017 Incident Complaint Report Form

# **BOWEL CARE (ADMINISTERING AN ENEMA)**

**Equipment**

* Enema kit
* Toilet
* Bedpan
* Commode
* Pads
* Bath blanket
* Gloves

**Implementation**

1. Determine the last bowel movement and presence of bowel sounds or abdominal pain
2. Assess ability to control sphincter
3. Determine the presence of haemorrhoids
4. Assess abdominal pain
5. Assess patient’s understanding of the procedure
6. Assess patient’s mobility skills

**Enema bag**

1. Fill enema bag with 750-1000ml of warm water. Check temperature of water. Fill tubing with solutions, removing air and clamp
2. Add soap to water if ordered
3. Wash hands and wear gloves
4. Assist patient to side-lying (Sims) position with right knee flexed
5. Place waterproof pad under hips and buttocks
6. Cover patient with bath blanket, exposing only rectal area
7. Explain the procedure to the patient and plan where the patient will defecate. Ensue that toilet, bedpan or commode is available

**Use pre-packaged container**

1. Remove plastic cap from rectal tip, applying more lubricant to cap if needed
2. Gently separate buttocks and locate anus. Instruct patient to take deep breaths through mouth
3. Slowly and gently insert lubricated tip into rectum 4cms. Point tip towards umbilicus
4. Squeeze bottle continuously until all fluids are expelled

**Use an enema bag**

1. Lubricate 7-10cms of tip of tubing
2. Gently separate buttocks and locate anus
3. Slowly and gently insert lubricated tip into rectum 7-10cm. Point tip towards umbilicus
4. Hold tubing until fluid is instilled
5. With container at hip level, open clip and begin instillation
6. Raise height of container above anus and hang on IV pole
7. Lower height of container if client experiences cramping
8. Clamp tubing after solution instilled and inform patient that tubing will be removed
9. Explain to patient that a feeling of distension is expected.
10. Ask patient to retain solution as long as possible between 5-10 mins.
11. Discard enema container and tubing in appropriate receptacle
12. Assist client to use bathroom, bedpan or commode
13. Instruct patient with a history of cardiovascular disease to exhale during defecation
14. Assist patient with perineal care as necessary

**Special precautions**

* Uncooperative client
* Unsupervised or inexperienced staff
* Correct procedure not followed

# **CARING FOR INCONTINENT CLIENTS**

**Equipment**

* Gloves
* Bedpan
* Commode
* Pads or briefs where appropriate
* Sorbolene cream or Sudocrem

**Implementation**

1. Assess frequency and amounts of incontinence
2. Assess amount with each occurrence (occasional dribbling or occasional large amounts)
3. Assess episodes associated with incontinence (coughing, sneezing, exercise)
4. Assess condition of the perineal area
5. Assess fluid intake and characteristics of urine (colour, odour, appearance)
6. Provide client with opportunity to use bathroom, bedpan or commode
7. Maintain record of continent and incontinent periods
8. Provide perineal care
9. Place absorbent under-pad under patient
10. Expose perineal area to air whenever possible
11. Apply skin barrier or Sorbolene cream
12. Provide pads or briefs to ambulatory patients

**Special precautions**

* Uncooperative or aggressive clients

# **CATHETER CARE**

**PROCEDURE FOR CATHETER SITE CARE**

**A. Equipment**

Non-Sterile gloves

Blue pad/linen saver

Organisation-approved cleansing product

Disposable washcloths

Approved securement device (leg band)

Sheet for privacy

**B. Procedure**

Catheter care and perineal cleansing can be delegated to a nursing assistant after proper instruction and observation.

Gather supplies.

Perform hand hygiene

Explain procedure to patient/caregiver as appropriate, emphasizing the need to clean around the catheter and manipulate tubing.

Determine if patient is allergic to antiseptics or soaps.

Provide privacy with sheet.

Don non-sterile gloves.

Raise bed to a comfortable working height and lower side rails.

Place blue pad under patient’s buttocks.

Remove tubing from securement device.

Position patient in supine, dorsal recumbent or side-lying position.

For male patients, cleanse suprapubic and pubic area with approved cleanser and washcloth. Grasp the shaft of the penis firmly. Cleanse urinary meatus and glans with approved cleanser and washcloth beginning at the urethral opening. Retract foreskin on uncircumcised male patients. Cleanse in a circular motion moving from the meatus downward and outward towards the shaft of the penis.

For female patients, open labia and cleanse entrance to urinary meatus with approved cleanser and washcloth wiping from front to back on each side with a downward stroke, using a new washcloth with each stroke, cleaning the innermost surface outward.

Remove gloves, perform hand hygiene and put on a new pair of nonsterile gloves.

Assess catheter insertion site for redness or unusual drainage. Notify office if irritation is noted or patient has discomfort.

Clean the catheter from the insertion site to approximately six (6) inches distally with hospital approved cleanser and washcloths.

Remove any dried secretions on the tube. Be sure not to pull on the catheter.

Discard washcloths.

Re-anchor catheter tubing with approved securement device, (maintain a looseness in tube)

For male patients, on the abdomen or thigh.

For female patients, on the thigh.

Remove all supplies/equipment from bed.

Position the patient for comfort.

Raise side rails and put bed in the lowest position.

Remove and discard gloves.

Perform hand hygiene.

Document in the patient’s progress notes.

**C. Maintenance**

When replacing drainage bag make sure it is closed

Always keep drainage bag below the level of bladder.

Be sure tubing is not kinked, twisted, obstructed or caught on side rails.

Keep drainage bag off the floor.

Tubing should be secured with a securement device.

Empty bag prior to completing service.

# **ENTERAL (PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) FEEDING**

**Equipment**

* Gloves
* During the first 2 weeks after PEG insertion, the peristomal area should be cleaned daily with soft soap and water, from the inside out, drying well and disinfecting with antiseptic and sterile gauze around the stoma-checking that there is no irritation, inflammation, or gastric secretions. A small liquid drainage from granulation tissue of the stoma may be normal during these first weeks.
* It is recommended that the patient wears loose clothing so as not to press the stoma. If the stoma is not red, the patient can shower within a week.

**Care During Feeding**

* An adapted nutritional formula should be used,
* The prescribed formula may be administered by gravity, using a syringe or low-pressure feeding pump, either continuously or intermittently.
* The patient must be positioned at a 30 (degrees)-45 (degrees) angle to facilitate gastric emptying and prevent reflux. This position must be maintained for an hour after completion of the feeding.
* The feeding formula should be administered at room temperature, starting at low volumes, increasing progressively as tolerance rises.
* After food or drugs administration, it is necessary to instil 50 ml of distilled water to flush any residue from the tube.
* In the absence of a fluid restriction, it is recommended to use a large flushing volume when possible. In case of continuous nutrition, flushing should be done every 4-6 hours.
* A syringe sized 30 ml or greater is recommended to avoid too much pressure and consequently the rupture of any component of the PEG tube.
* The patency of the tube can be checked by slowly aspirating gastric contents. It has been recommended that if the aspirate volume is greater than 100 ml, the content should be reintroduced. Wait for one hour before increasing the volume

# **FEEDING DEPENDENT CLIENT**

**Equipment**

* Gloves

**Implementation**

1. Assess patient’s level of consciousness, ability to participate, mobility/activity order and physical limitations. Assess need for toileting, hand washing and oral care before feeding
2. Position patient appropriately. Sitting position is desirable
3. Place protective covering over gown if desired
4. Assist patient in setting up meal tray
5. Place adaptive utensils on tray and instruct patient in their use
6. Identify food location on plate for visually impaired patients
7. Allow client to eat at their own pace – do not rush!
8. Alternate foods. Don’t feed all meat then all vegetables
9. Evaluate patient’s oral intake and ability to eat/feed self

**Special precautions**

* Choking
* Contaminated food

# **MANAGING AGRESSION OR DIFFICULT BEHAVIOUR**

**Equipment**

* Gloves – if required

**Implementation**

1. Assess the patient history via care plan for historical reference of incidents of aggressive behaviour, substance abuse, significant head injury, criminal behaviour, arrest or imprisonment
2. Assess nursing notes or documented history of recent incidents or near misses
3. Assess the workplace upon entering that it is well designed and maintained, well lit, warm and tidy
4. Assess the patient’s access to means of carrying out aggressive behaviour e.g. guns, knives etc.
5. Assess current patient behaviour for signs of impending aggression. Signs can include:
   1. Loud, clipped or angry speech
   2. Pacing
   3. Angry facial expression
   4. Intense staring
   5. Refusal to communicate
   6. Threats or gestures
   7. Physical agitation
   8. Restlessness or fidgeting
   9. Delusions or hallucinations
   10. Intoxication
   11. Aggressive to the environment
   12. Isolative behaviour
   13. Frequent demands
6. Assess risk relating to the behaviour confronted
7. Stay calm and do not confront
8. Make a decision whether to stay or leave
9. The decision to leave should be made when the situation cannot be controlled, you are alone with an aggressive patient or you feel in danger
10. Staying
    1. Seek support from others if possible
    2. Issue a verbal warning to the patient if the risk level is low
    3. If the risk level is medium to high and you are unable to leave, phone the office on (02) **9600 6612**
    4. Let the person who is being spoken to be aware of the situation by using the code “Sunflower Cottage”
    5. Take precautions, keep your distance, ensure you have the patient in complete view and remain vigilant
    6. Leave if the opportunity arises or wait for another staff member to arrive
11. Leaving
    1. Upon leaving the workplace, report the incident immediately to the office on (02) **9600 6612**
    2. Arrange a time to speak in person with one of the professional staff to lodge an incident report

**Special precautions**

* Staff to have thorough knowledge of patient history and current condition
* Staff to be trained or have past experience of managing aggression
* All staff to be inducted in the correct use of the emergency code word.

# **MEAL PREPARATION**

**Equipment**

* General cooking utensils and equipment
* Household cleaning products
* PPE

**Implementation**

1. Wash hands thoroughly, before & after using gloves, before preparing food, as you go and after handling raw meat. Use antibacterial soap.
2. Always ensure that the work area is clean and sterile and be free from pests. Care staff should assess clients’ homes in relation to pests and determine if food can be prepared safely.
3. The kitchen environment should have;
   1. Walls that are clean and there is no evidence of peeling paint.
   2. The ceiling is clean and free from grease and airborne particle build up.
   3. The flooring is in reasonable condition and
   4. Free from rubbish and waste.
4. Before commencing food preparation, consult client’s care plan for dietary requirements / allergies / special requests etc.
5. Clients from diverse cultural backgrounds that have specific dietary needs, particularly during significant religious times.
6. Clients with health changes impacting on swallowing.
7. Staff preparing meals for clients in their homes are not expected to monitor meal temperatures however they should be aware:
   1. Not to leave meals standing which increases the risk of bacterium growing
   2. Cool food quickly and never reheat food more than once.
   3. Make sure it is piping hot when reheated
   4. Make sure frozen food is completely defrosted before cooking unless the manufacturer’s instructions say otherwise
   5. Always encourage client participation in meal preparation to the level of their capability, or simply being in the kitchen for social inclusion.
8. Ask clients before a shopping trip if they would like more food variety in their planned meals.
9. It is important for them to have a choice of food types prepared for them and they should be encouraged to exercise choice in all activities delivered by care staff.
10. A CDC approach puts them in the centre of any service provision, and they should be encouraged to consider all options open to them.
11. Always ensure that food and produce used is free of bacteria and utilised in its entirety prior to its expiry date.
12. Check expiry dates before using foodstuffs.
13. Always ensure that appliances are in good working order and properly maintained.
14. Keep perishable high-risk foods such as meat, fish, eggs and milk products under refrigeration. Use a thermometer to check your fridge is below 8 degrees centigrade.
15. Avoid cross contamination of bacteria between raw and cooked foods by storing raw meat, fish, and poultry in a suitable container in the bottom of the fridge. Cooked and ready-to-eat food should be kept on the top shelves.
16. Food authorities suggest that different coloured boards are used for different purposes. This is not an expectation in a client’s home however, care staff should be aware of the dangers of cutting up raw chicken and then not washing the board immediately after the procedure or reuse.
17. Do not leave cooked meat, fish or dairy foods at room temperature. Keep them piping hot or cold.
18. Make sure food is cooked thoroughly, all the way through – meat juices should run clear.
19. After completing food preparation, keep the kitchen and equipment clean, consider using an anti-bacterial spray on surfaces. Always ensure that utensils and equipment are thoroughly cleaned and have been stored correctly.

**Special precautions**

* Infection control
* Hand Washing control
* Bacteria control
* Hazardous substances
* Feedback regarding food services

# **PERFORMING HOME VISIT**

**Equipment required**

* Gloves
* PPE specific to duties

**Implementation**

1. Verify intervention or duties using the client care plan or booking sheet
2. Establish address and workplace location prior to departing for the workplace
3. Enter the premises only after being invited in or when the client is aware of your presence
4. Do not enter the workplace if no-one is present or answering
5. Contact the office immediately if there is no response
6. If present, identify client
7. Introduce yourself to the client and show identification badge
8. Provide and explain contents of in-home folder to client
9. Explain what duties, job or procedure you are there to carry out
10. Assess the client’s health and condition and whether contradictions to the care plan or booking sheet are evident
11. Assess any cultural practices and beliefs that need to be taken into consideration in the delivery of duties
12. Identify any safety risks or hazards that exist in the workplace, eliminate or reduce these risks or hazards if appropriate
13. Perform duties as per the client care plan or booking sheet
14. Follow documentation procedure upon completion of shift

**Special precautions**

* Aggressive or dangerous patients or carers

If unable to leave the premises, phone the office, use the safety codeword “--------- -------” when contacting the office (reminder given at all staff meetings) and a company representative or police will be sent out to help you.

* Unsafe workplace

If a hazard or risk exists that cannot be controlled immediately contact co-ordinator/office staff

* When advised by care staff member that there is no response at client’s home – coordinator will:
  + Request care staff to remain at residence
  + Phone client’s home to check if there is an answer
  + If no answer coordinator will phone the client’s emergency contact for instructions
  + For Brokerage - If no answer coordinator will phone service provider, inform them there is no response at client’s home and await directions

# **STANDARDS PROTOCOL**

**Equipment**

* Gloves
* PPE specific to duties

**Implementation**

1. Verify intervention or duties using the client care plan or booking sheet
2. Identify client
3. Introduce yourself to the client and show identification badge
4. Explain what duties, job or procedure you are there to carry out
5. Assess the client’s health and condition and whether contradictions to the care plan or booking sheet are evident
6. Gather PPE equipment required to the application of duties
7. Wash your hands
8. Apply clean gloves
9. Ensure the client’s privacy is being maintained
10. Promote client involvement where appropriate or possible
11. Assess the client’s tolerance and reaction to the duties, job or procedure being carried out
12. Ensure the client’s comfort and safety
13. Upon completion, store or dispose of equipment properly
14. Remove gloves and dispose.
15. Wash your hands
16. Report and record your shift in the service record.
17. Report and record client condition and response in your Progress / Nursing notes and monthly feedback.

**Special Precautions**

* Ensure that correct PPE is used and is disposed of correctly
* Ensure that client condition is stable and managed before leaving the workplace
* Ensure that documentation is completed

# **TRANSPORTATION**

**Equipment**

* Vehicle that is registered and insured
* Vehicle that is properly maintained and serviced
* Tyres to be in good condition
* Current drivers licence

**Implementation (Driving Tips)**

1. Mobile phones to be used ONLY while driving with a hands-free kit.
2. Do not engage in complex or emotional conversations on the phone while driving
3. Never take notes, look up phone numbers, read or send SMS while driving
4. Slowdown in wet weather or on rain affected roads
5. Match your speed to the road conditions, which may be slower than the speed limit

**Implementation (Transporting Clients)**

1. Check care plan; sometimes clients must be transported in the back seat.
2. Fluoro vests are to be wore when escorting clients on and/or off the bus or community van
3. Ensure seat beat is properly fastened – adjusted if required
4. Ensure doors are locked at all times
5. Ensure there is suitable ventilation and air in the vehicle for passenger comfort
6. Ensure mobility aides are securely stored
7. Always park as close as possible to the destination
8. Never leave the client alone and unattended in the vehicle

**Implementation (Personal Safety)**

1. Try to carry pen and paper, torch, mobile phone and emergency numbers with you at all times
2. Always park in areas that are well lit and populated
3. Never leave valuables in the vehicle
4. Avoid parking too close to walls and hedges
5. Have your keys ready to open the vehicle rather than looking for them upon arriving at the vehicle
6. Never double park or park in clearways
7. If you break down, endeavour to leave the vehicle in a well-lit, safe spot.
8. Put your bonnet up and turn on your hazard lights before calling for assistance
9. Plan trips in advance

**Ambulance**

1. If an ambulance is called to attend client whilst out of home, care worker is not to put the client into their vehicle to transport home even if the ambulance personal have said it is ok…it is NOT!
2. It is the responsibility of the ambulance personal to make sure the client is transported home safely.

BEDMAKING

**Equipment**

* Linen
* Linen skip or laundry basket
* Gloves

**Implementation**

***To make an unoccupied bed:***

1. Gather linen and linen skip or laundry basket
2. Raise bed to comfortable working height and lower side rail where appropriate
3. Remove personal items
4. Remove linen, holding away from uniform and place in linen skip or basket
5. Clean mattress if necessary
6. Place clean bottom sheet on bed or tie sheet
7. Mitre corners of non-fitted sheets
8. Place drawsheet and plastic on bed (if required) and tuck in
9. Waterproof pads may be placed on top of or underneath drawsheet
10. Complete procedure on other side of bed, pulling sheets taut and flat
11. Place top sheet and blanket on bed, cuffing top sheet over blanket and leaving toe pleats at foot
12. Make modified mitred corners at foot of bed with top sheet and blanket
13. Put clean pillow case on pillow
14. Fanfold top linen down for an open bed or leave top linens up for a closed bed

***To make an occupied bed:***

1. Talk with patient and explain the procedure and how they can be of assistance
2. Gather linen and linen skip or basket
3. Raise bed to a comfortable working height where appropriate
4. Provide privacy for the patient
5. Loosen top linen
6. Ensure side rail (where appropriate) is up on the side that the patient will be rolling to
7. Assist patient to the side-lying position
8. Push dirty linen under or as close as possible to patient
9. Place clean sheet on mattress
10. Cover mattress with bottom sheet
11. Mitre corners of non-fitted sheets
12. Place waterproof pads and/or drawsheet on bed
13. Tuck remaining half of clean linens as close to patient as possible
14. Place additional pads on top of drawsheet if required
15. Assist the patient to roll over linen
16. Raise side rail if appropriate
17. Remove soiled linens and dispose of properly
18. Slide clean linen over to yourself and secure, mitring corners of non-fitted sheets and pulling all linens straight and taut
19. Assist patient to a supine position
20. Place clean top linens over client and remove used top sheet or blanket
21. Make modified mitred corners with top linens at foot of bed
22. Loosen linens at feet to patient’s comfort
23. Remove pillow, supporting patient’s head and change pillowcases.
24. Replace for comfort

**Special precautions**

* Skin irritation
* Uncooperative patient
* Unnecessary reaching or stretching

# **USE OF BEDPAN OR URINAL**

**Equipment**

* Gloves
* Bedpan
* Urinal
* Toilet paper
* Wash basin
* Soap
* Wash cloth

**Implementation**

1. Use common language when explaining the procedure
2. Assess length and extent of immobility in patient
3. Assess patient’s ability to assist, lift hips and turn
4. Assess dietary intake
5. Determine extent and location of discomfort

**Provide bedpan**

1. Wash hands and wear gloves
2. If the bed is adjustable, place it in the high position
3. Lower head of bed and assist patient to roll towards you
4. Raise the side rail if applicable
5. Go to the opposite side of the bed and place bedpan under the patient’s buttocks
6. Press bedpan firmly down onto mattress
7. Assist patient to roll on to bedpan
8. Place bedpan under patient directly if patient is unable to lift self
9. Raise head of bed at least 30-40°, unless contraindicated.
10. Provide toilet paper within reach.
11. Provide privacy
12. Lower head of bed and side rail when patient is finished
13. Assist patient to roll away from you while securing bedpan
14. Assist patient with cleaning where required
15. Provide opportunity for patient to wash hands
16. Rinse bedpan and store appropriately
17. Provide urinal for male patient
18. Wash hands and put on gloves
19. Position patient with head elevated or standing
20. Assist patient as needed to have penis placed in urinal
21. Instruct patient to notify care worker each time urinal is used
22. Place urinal within patient’s reach
23. Rinse and store appropriately

**Special precautions**

* Contact with bodily fluids and waste
* Uncooperative patient
* Lack of competence or supervision

# **BLOOD SUGAR LEVEL (BSL) MONITORING**

**Equipment**

* Gloves
* Glucose meter
* Antiseptic swabs and cotton balls
* Bloodletting device
* Reagent strip
* Sharps receptacle conforming to Australian Standard AS4031

**Implementation**

1. Always follow manufacturer’s instructions for use of glucose meter
2. Instruct patient to wash hands with sop and warm water if able (make sure no food or alcohol has been touched)
3. Position patient comfortably in chair or Semi-Fowlers position if in bed
4. Apply gloves, remove reagent strip from container
5. Insert strip into glucose meter and make necessary adjustments
6. Ask client which finger to be used
7. Hold finger to be punctured in dependant position while gently massaging finger toward the puncture site
8. Place bloodletting device firmly against finger and push release button, causing needle to pierce skin
9. Lightly squeeze puncture site until large droplet of blood has formed
10. Hold reagent strip test pad close to dip of blood, and lightly transfer droplet to test pad
11. Immediately press timer on glucose meter, and place reagent strip on paper towel or on side of timer
12. Apply pressure to the puncture site
13. When timer has completed countdown note and record reading on display
14. Turn meter off. Dispose of test strip, cotton balls and blood-letting device in appropriate and approved receptacles

**Special precautions**

* Infection control

# **INFECTION CONTROL**

**Equipment**

* Gloves
* Eye protection
* Masks
* Aprons
* Gowns
* Overalls
* Sharps containers

**Implementation (reducing the risk of infection)**

1. Avoid touching or being splashed by the client’s bodily fluid where possible
2. Wash hands BEFORE and AFTER client contact
3. Wear gloves at all times
4. Cover any cuts, scrapes or skin conditions you may have by using a waterproof dressing
5. Avoid touching needles and other sharps which may be contaminated
6. Dressings and bandages which have been contaminated with blood or bodily fluids should be placed in leak proof bags or containers

**Implementation (hand washing)**

1. Always wash your hands thoroughly using soap and running water:
   1. At the start and finish of your work shift
   2. before and after physical contact with a patient
   3. after handling contaminated items, such as bedpans, urine bottles and dressings
   4. after removing gloves
   5. before and after eating, drinking and smoking
   6. before and after toileting
   7. After blowing your nose or covering a sneeze
   8. whenever your hands become obviously soiled

**Implementation (contact with patient’s blood or bodily fluid on skin)**

1. Wash the blood or body substance off thoroughly with soap and water
2. Skin acts as an effective barrier and most infections cannot get through the skin
3. All skin cuts, breaks or other lesions should be covered with water resistant occlusive dressing at the start of your shift

**Implementation (contact with patient’s blood or bodily fluid on open cut, non-intact skin, rash or other lesion)**

1. Immediately wash the wound with soap and water
2. Cover all skin breaks with a water-resistant occlusive dressing

**Implementation (accidental prick with a used needle)**

1. Immediately wash the wound with soap and water
2. Do not use any solution other than soap and water
3. Let the wound bleed freely for a few seconds

**Implementation (accidental incidence of blood or body substance in the eye)**

1. Irrigate it gently and thoroughly with water
2. DO NOT USE SOAP
3. Gently pour water over the eye while pulling the eye lids up and down
4. If you wear contact lenses, keep them in while you irrigate the eye
5. Then take the contact lenses out, clean them in the normal manner and put them back in again

**Implementation (accidental incidence of blood or body substance in the mouth)**

1. Spit the blood or body substance out
2. NEVER swallow
3. Rinse the mouth several times with water, spitting out after each and every rinse

**Special precautions**

* Correct incident/accident reporting
* Correct hand washing and use of PPE
* Up to date vaccinations for Hep B and tetanus

# **INTERVENING IN EMERGENCY SITUATIONS**

**Cardiopulmonary Resuscitation**

**Equipment**

* CPR Pocket Mask or another barrier (where available)
* Gloves

**Implementation**

1. Assess the casualty responsiveness by shaking the client and shouting “Are you OK?”. If non-responsive
2. Activate the emergency medical services if in a facility according to the facilities policy and procedure
3. If not in a facility setting, call **000** Emergency services or instruct someone to do so.
4. Check the airway for blockages
5. Check for chest movement, listen and feel for breaths, look for good skin colour
6. If client is breathing, place them in the recovery position on their side
7. If no respirations are detected, call for assistance
8. Start Cardiopulmonary Resuscitation
9. Place on hard surface, such as floor or ground, or use the headboard o the bed if in a facility
10. Correctly position for resuscitative efforts:
    1. One-person rescue: face client while kneeling parallel to the client’s sternum
    2. Two-person rescue: First person faces the client while kneeling parallel to the client’s head. Second person is on the opposite side parallel to the client’s sternum
11. Open the airway
12. Use the head-tilt, chin-lift method to open the casualty’s airway
13. Give casualty two [2] normal rescue breathes
14. Adult and young person
    1. Pinch Casualty’s nose with thumb and forefinger and use a CPR pocket mask or other barrier between rescue’s and casualty’s mouth
    2. The rescuer should take a breath after each breath
    3. Allow the casualty to exhale between breaths
15. **Baby:**
    1. Rescuer to put their mouth over baby’s nose and mouth using CPR pocket mask or another barrier
    2. Rescuer to give small puff into baby’s mouth and nose
    3. Immediately start CPR.
16. **Adult:**
    1. Place heel of hands, one atop the other, on lower third of the sternum. Lock elbows and maintain shoulders in line with the sternum.
17. **Child:**
    1. Place heel of hand on the lower half of the sternum.
    2. Place two or three fingers on the lower half of the sternum just below the level of the infant’s nipples.
    3. Compress chest downward at least 1/3 of the chest depth to be affective and then release. Maintain constant contact with the skin
    4. Maintain the correct ratio of compressions:
18. One or Two rescuer: 30 compressions, breaths
19. Do not delay compressions
20. Continue CPR until
    1. the rescuer is relieved,
    2. Client regains cardiopulmonary function independently
    3. Physician directs that CPR be discontinued.
21. If a defibrillator is available, follow instruction.

**Special precautions**

* Incident/Accident report to be completed
* Adequately trained and qualified staff to undertake CPR
* Current First Aid Certificate must be maintained

# **POST FALL MANAGEMENT**

**Equipment**

* Gloves

**Implementation**

1. Assess the patient immediately post fall or life-threatening disorders
2. Contact the office and call **000** for an ambulance immediately if patient has sustained an injury requiring medical attention
3. Do not move client
4. If no immediate life-threatening condition is found:
   1. Reassure and comfort the patient e.g. if available use pillow and blanket
   2. Check the site for risks and hazards, ensuring the environment is not putting the patient at risk of further injury or discomfort
   3. Check for evidence of obvious bony injury
   4. Check the areas where the patient is complaining of pain or discomfort for evidence of injury
   5. Check for evidence of bruising, abrasion, laceration, swelling particularly in the head or the face
   6. Assess the patient’s level of alertness
   7. Assess whether there is or was any loss any loss of consciousness
5. If the patient appears to have sustained nil or minor injury
   1. Assist them to stand
   2. If patient is unable to stand with minimal assistance call an ambulance immediately
   3. Check for pain and discomfort
   4. Check for evidence of limb shortening, dislocation, external rotation, inability to bear weight or pain on applying any pressure
   5. Enquire whether the patient feels dizzy or faint upon standing
   6. Check for any evidence of injury that was not apparent when the patient was on the floor
6. Advise professional office of the fall
7. Complete incident/accident report
8. Notify carer, next of kin or service provider where appropriate to monitor any deterioration in patient post fall
9. Establish the cause of the fall and institute remedial steps where appropriate
10. After the fall conduct an assessment of the incident and follow the risk management procedure

**Special precautions**

* Every fall must be reported to the professional staff, field staff representative committee or management
* Workplaces to be free of debris and assessed for hazards and risks

# **TRANSFER OF PATIENT USING MECHANICAL LIFTER FROM BED**

**Equipment**

* Mechanical lifter
* Gloves

**Implementation**

1. Compare the weight limit of the lifter with the patient’s weight
   1. Assess the muscle strength and mobility of extremities
   2. Assess vision, hearing and sensation
   3. Assess patient’s motivation
2. Two people are required where possible when using a mechanical lifter
3. Move the lifter beside the bed on the same side that the patient will be transferred from
4. Place a comfortable chair in a convenient location if one is not readily accessible or available
5. Lock brakes on bed (if any)
6. Raise bed to working height (if hydraulics are in place)
7. Turn patient on side and place canvas sling from head to knees
8. Instruct patient to cross arms across their torso.
9. Position lifter with base spread and under bed.
10. Attach lift chains to sling.
11. Adjust sling to evenly distribute patient’s weight
12. Raise lift, elevating sling just above bed
13. Adjust sling as needed. Elevate it enough to clear the bed.
14. Guide patient’s legs over the side of the bed. Protect clients head and extremities from injury
15. Instruct patient to keep arms folded
16. Unlock the wheels on the lifter. Check positioning of chair and guide lift directly over chair or trolley so that client will be positioned appropriately
17. Release lift valve slowly, lower client on to chair and release all lift chains

**Special precautions**

* Confined and restrictive workplace
* Uneven floor
* Faulty lifter not regularly maintained
* Uncooperative patient
* Inappropriately skilled or inexperienced staff operating the lifter
* Operating the lifter and effecting the transfer with only one person

# **WORKING AROUND SHARPS**

**Equipment**

* Gloves
* Masks
* Protective eye wear
* Aprons
* Needles (Hypodermic/IV)
* Lancets
* Razors, scalpels and other blades
* Tongs
* Sharps receptacle conforming to Australian Standard AS403 clients (1992)

**Implementation (Standard precautions)**

**NB.** The person who uses the needle or sharp is responsible for its management and disposal

**NB.** Never re-sheath a used needle

1. Always ensure that a sharps container is nearby every time a needle is used
2. If a needle or sharp must be carried some distance to a sharp’s container, use a puncture resistant tray or dish. Do not carry it in your hand
3. Never pass needles or sharp instruments to another person by hand
4. Never bend needles contaminated with blood or body substance
5. Never force needles into a sharps container or overfill the container
6. Let falling needles or sharp objects fall. Never attempt to catch
7. If the patient is confused or uncooperative, seek assistance
8. Develop a slow, safe handling technique when using sharp objects
9. Store sharp instruments appropriately
10. Dispose of needles correctly
11. NEVER reach into garbage or sharps containers
12. Wear general purpose household gloves when cleaning non-disposable sharps
13. Handle laundry with care
14. Don’t rush or take short cuts when performing procedures
15. Always wear a mask and eye protection or a face shield during procedures that are likely to generate splashes or sprays of blood or other body substances.
16. When removing a needle or syringe that has been incorrectly disposed of
    1. Put on a pair of gloves
    2. Where possible, take a sharps container to the needle or syringe
    3. NEVER re-sheath a needle and syringe even if a cap is available
    4. Use tongs or similar implement, to pick up the needle or syringe. If no implement is available, carefully pick up the needle and syringe with the needle furthest away from fingers and body
    5. Carefully place the needle and syringe in the sharp’s container
    6. Report the incident to the professional staff
17. Immediate response to contaminated needle stick injury
    1. Wash wound with soap and water
    2. If soap and water are not available, use an alcohol-based hand rub or solution
    3. Seek medical advice from local doctor or hospital emergency department
    4. Notify the professional staff and/or management
    5. Complete First Call Incident / Accident / Near Miss Report

**Special precautions**

* Staff to ensure that Hep B and tetanus vaccinations are up to date.

# **SAFETY SWITCH - PLUG-IN ADAPTOR**

Safety switch plug in adaptors are available in the office. Pick up one and sign off the Adaptor Sheet.

Please read the Important Information on package before use.

1. Make sure the power point you are going to use is safe – no burn marks, no cracks, no melting
2. Turn off power point
3. Remove whatever electrical that is attached
4. Plug in safety switch
5. Plug in whatever equipment such as vacuum cleaner
6. Turn on power point and proceed to operate equipment
7. Once work is complete – turn off power point
8. Disconnect device and keep it with you at all times to be used when you are required to provide domestic assistance

The safety switch remains the property of First Call Nursing

# **EPILEPSY MANAGEMENT**

**Stay calm and don’t panic**

1. It might look scary, but an onset of seizures is typically a non-life-threatening event and the best way to handle it is to let it run its course.
2. If a client is having a seizure while standing / sitting, then give support to them, to maintain balance and to prevent a fall. Guide them away from any danger and gently lower to the ground. Care workers are to ensure that they do not place themselves in any danger from manual handling risk.
3. If the client is wearing glasses, remove them.
4. Protect client from harm and move any sharp or hard objects out of the way.
5. Take note of the time and how long the seizure lasted for. If a seizure lasts for 5 minutes or more call an ambulance.

**Basic First Aid**

Remember **DRSABC**- **D**anger, **R**esponse, **S**end for Help, **A**irway, **B**reathing and **C**PR

* 1. **DANGER**. Ensure the area is safe for yourself, others and the client.
  2. **RESPONSE**. Check for response: ask them their name, squeeze shoulders. No response: send for help or call an ambulance. Response: make them comfortable, check for injuries and monitor their response.
  3. **SEND**: as before call **000** triple zero for an ambulance or ask another person to make the call or go and get help.
  4. **AIRWAY**. Open mouth: If foreign material is present: place in recovery position. Only clear airway if safe to do so. An epileptic person could unknowingly bite your finger off. Open airway by tilting head with chin lift.
  5. **BREATHING**. Check for breathing: look, listen, feel. Not normal breathing: start CPR. Normal breathing: place in recovery position. Monitor breathing. Manage injuries and treat for shock.
  6. **CPR**. Start CPR: 30 chest compressions, 2 breaths. Continue CPR until help arrives or patient recovers.

**Call for Ambulance Assistance**

1. If the clients’ seizure lasts for more than 5 minutes or has 2 (two) consecutive seizures call an ambulance by dialling **000**.
2. Please contact the office and inform us what action has been taken, your location and that an ambulance has been contacted on **02 9600 6612** or the mobile **0408 438 902**.

**Continue to Monitor Seizures**

* RULE 1: The less done to a person during a seizure the better.
* RULE 2: Protect the client from harm until full awareness returns or the ambulance arrives.
* Observe the nature of the seizure, taking note of the following:
  + What time did the seizure began?
  + The type of seizure occurring.
  + The duration of a seizure and frequency of seizures.

**Complete Incident Report**

Staff to ensure that an F017 Incident Report Form is completed and forwarded to the office as soon as possible.

# **MANAGING WASTE AND HAZARDOUS MATERIAL**

All incidents involving infectious, hazardous or bodily fluids must be reported, recorded and actioned as part of First Call’s risk management and adverse event reporting policies.

In the event of an incident involving hazardous material, the following procedure is to be implemented.

**In the case of a major spill:**

1. First Call staff should consider the immediate danger to themselves and clients and
2. Contact First Call’s management. Notify Emergency Services if necessary.
3. PPE must be worn; do not touch any hazardous material. Take precautions to protect yourself if necessary
4. Raise the alarm – evacuate persons not involved in contamination from the area. Isolate affected persons and keep on site.
5. Close doors to prevent further contamination. Secure the area to keep non-emergency response personnel away from danger.
6. Assist the emergency response personnel if appropriate.
7. In conjunction with expert assistance, minimise the spread of contamination and commence decontamination/clean up procedures.
8. Ensure emergency procedures are in place and practiced.

**In the case of a minor spill:**

1. Contact First Call’s management
2. Identify the material and hazards involved.
3. PPE must be worn, approach with care - many hazardous materials lack colour or offensive odours. Never assume that they are harmless.
4. Use the information on the physical, biological and chemical properties of the material to judge response and/or evacuation procedures.
5. Containment - spills must be cleaned up promptly and thoroughly.
6. With guidance from management and/or emergency services decontaminate equipment, clothing and personnel, including any victims, on site.
7. Dispose of contaminated equipment and materials only after receiving specialist advice.
8. Ensure emergency procedures are in place and practiced.

**F017 - INCIDENT / COMPLAINT FORM**

**(ACCIDENT/NEAR MISS)**

|  |
| --- |
| **Staff Member:** |
| **Name of person reporting:** |
| **Time & Date of Complaint/Incident:** |
| **Nature of Incident** – please give a detailed report of the complaint/incident |
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| **Staff Member signature:** |
| **Name & Contact number of Witness:** |
| **Incident reported to:** |
| **Signature of person receiving report:** **Date:** |
| **Describe how the issue was resolved and what action was taken:** |
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|  |
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|  |
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|  |
| Is counselling required? |
| **Signed:** (Managing Director, Co-ordinator) **Date:** |

**The person/employee filing this incident/complaint report will be given a copy after it is signed off on behalf of First Call Nursing.**