Australian Government
Department of Veterans' Affairs

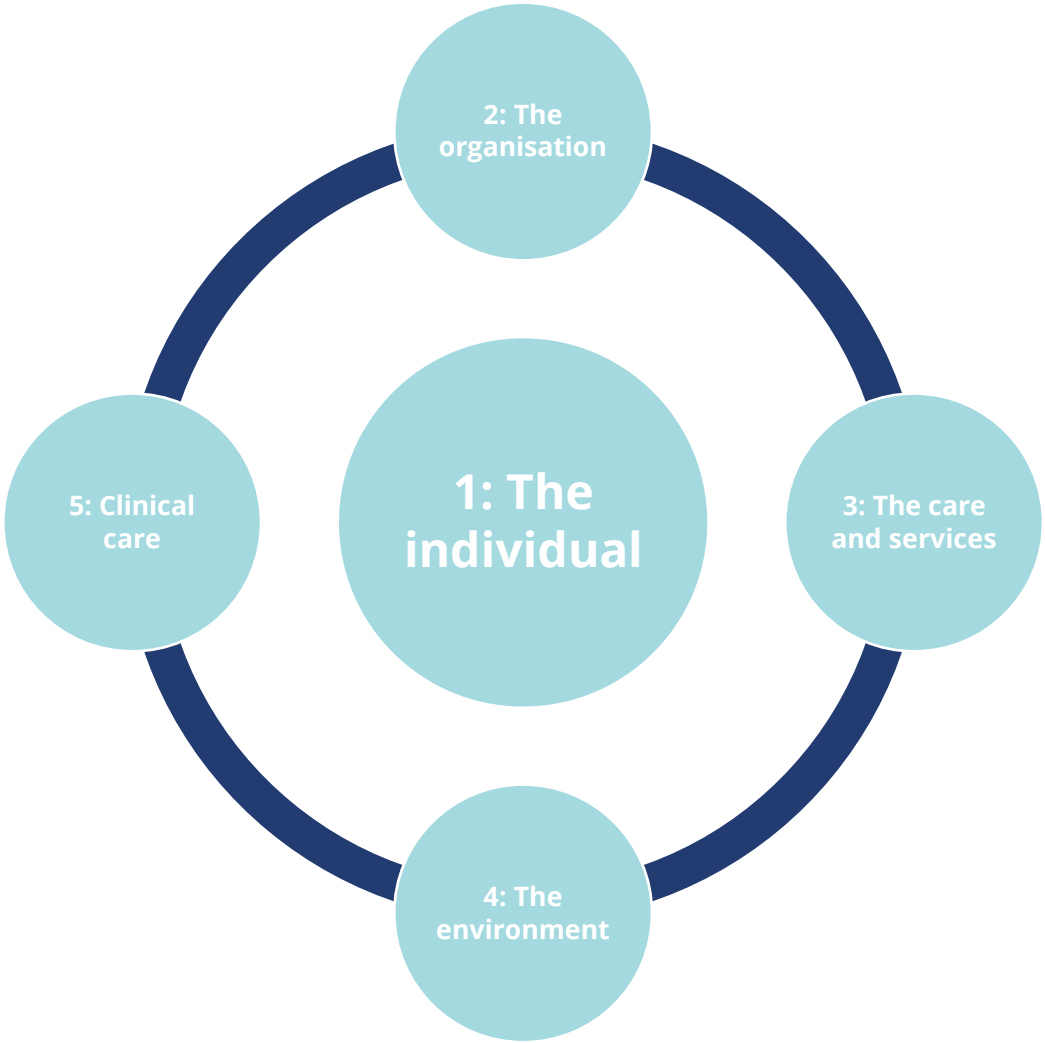
Self-assessment guide for Community Nursing providers

Department of Veterans' Affairs

The Department of Veterans' Affairs (DVA) Community Nursing Program has aligned program requirements with the strengthened Aged Care Quality Standards (**strengthened Standards**), 1 to 5. The strengthened Standards include:

- expectation statements for clients
- the intent of each strengthened standard
- several outcomes, each supported by an outcome statement that providers can self-asses against
- and actions, that list how providers might demonstrate achievement of the outcome.

Please note the strengthened Aged Care Quality and Safety Quality Standards include 7 standards. However, strengthened Standards 6 and 7 are not applicable to in-home care and the Community Nursing Program and are therefore not included in the self-assessment tool.



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Standard 1: The individual

Intent of Standard 1

Standard 1 underpins the way that providers and their staff are expected to treat clients and is relevant to all standards. Standard 1 reflects important concepts about dignity and respect, individuality and diversity, independence, choice and control, culturally safe care and dignity of risk. These are all important in fostering a sense of safety, autonomy, inclusion and quality of life for community nursing clients.

All DVA clients are valuable members of society, with rich and varied histories, characteristics, identities, interests and life experiences.

DVA clients can come from a diverse range of backgrounds and groups, including, but not limited to, Aboriginal or Torres Strait Islander persons, people from culturally and linguistically diverse backgrounds, people living in rural or remote areas, people who are financially or socially disadvantaged, people who are care leavers (i.e. clients who spent time in care as a child), people who are parents separated from their children by forced adoption or removal, people who identify as LGBTQI+, people of various religions, people experiencing mental ill-health, people living with cognitive impairment, including dementia, and people living with disability.

A person's diversity does not define who they are, but providers must recognise and embrace each person's diversity and who they are holistically as a person. This should drive how providers and their staff engage with clients when delivering community nursing services.

Standard 1 expectation statement for clients

I have the right to be treated with dignity and respect and to live free from any form of discrimination. I make decisions about my community nursing services, with support when I want or need it. My identity, culture and diversity are valued and supported, and I have the right to live the life I choose. My provider understands who I am and what is important to me, and this determines the way my community nursing care services are delivered.

Outcome 1.1: Person-centred care

Outcome Statement:

The provider demonstrates an understanding that the safety, health, wellbeing and quality of life of clients is the primary consideration in the delivery of community nursing services.

The provider understands and values clients, including their identity, culture, ability, diversity, beliefs and life experiences.

The provider develops care with, and tailored to, clients, taking into account their needs, goals and preferences.

Actions:

1.1.1 The way the provider and their staff engage with clients supports them to feel safe, welcome, included and understood.

1.1.2 The provider implements strategies to:

a) identify the client's background, culture, diversity, beliefs and life experiences as part of assessment and planning and uses this to direct the way their community nursing services are delivered

b) identify and understand the specific communication needs and preferences of the client

c) ask and record if a client identifies as an Aboriginal or Torres Strait Islander person

d) deliver funded community nursing services that meet the needs of clients with specific needs and diverse backgrounds, including Aboriginal or Torres Strait Islander persons and clients living with dementia

e) deliver community nursing services that are culturally safe, trauma-aware and healing-informed, in accordance with contemporary, evidence-based practice

f) continuously improve its approach to inclusion and diversity.

1.1.3 The provider and their staff recognise and respect the rights autonomy of clients, including their right to intimacy and sexual and gender expression.

1.1.4 Staff have professional and trusting relationships with clients and work in partnership with them to deliver community nursing services.

Outcome 1.2: Dignity, respect and privacy

Outcome Statement:

The provider must deliver community nursing services in a way that is free from all forms of discrimination, abuse and neglect, while treating clients with dignity and respect, and respect for personal privacy.

The provider demonstrates an understanding of the rights of clients as recorded in the DVA Community Nursing Client Charter. The provider must have practices in place to ensure that the provider acts compatibly with the Client Charter.

Actions:

1.2.1 The provider implements a system to recognise, prevent and respond to violence, abuse, racism, neglect, exploitation and discrimination.

1.2.2 Clients are treated with kindness, dignity and respect.

1.2.3 The relationship between clients and their support network, including any authorised representatives, is recognised and respected.

1.2.4 The personal privacy of clients is respected, clients have autonomy over how and when they receive intimate personal care or treatment, and this is carried out sensitively and in private.

Outcome 1.3: Choice, independence and quality of life

Outcome Statement:

The provider must support clients to exercise choice and make decisions about their community nursing services and provide them with support to exercise choice and make decisions.

The provider must provide clients with timely, accurate, tailored and sufficient information about their community nursing services, in a way they understand.

The provider must support clients to exercise dignity of risk to achieve their goals and maintain independence and quality of life.

Actions:

1.3.1 The provider implements a system to ensure information given to clients to enable them to make informed decisions about their community nursing services:

a) is current, accurate and timely

b) is plainly expressed and presented in a way the client understands.

1.3.2 The provider implements a system to ensure that clients give their informed consent where this is required for a treatment, procedure or other intervention.

1.3.3 The provider implements a system:

a) to ensure clients who require support with decision-making are identified and provided access to the support necessary to make, communicate and participate in decisions that affect their lives

b) that involves authorised representatives of clients where possible, for clients who require support with decision-making

c) that uses substitute decision-makers only after all options to support a client to make decisions are exhausted.

1.3.4 The provider supports clients by understanding the client's goals and preferences and enabling positive risk-taking that promotes the client's autonomy and quality of life.

1.3.5 The provider records, monitors and responds to changes to the client's quality of life.

Outcome 1.4: Transparency and agreements

Outcome Statement:

Before commencing the delivery of community nursing services, the provider must provide clients with a copy of the signed nursing care plan and sufficient time and opportunity to review the nursing care plan and seek independent advice, if desired.

The provider must support clients to understand and make informed decisions about their nursing care plan, within the scope of the Community Nursing Program.

Actions:

1.4.1 Prior to implementing the nursing care plan and commencing community nursing services, the provider gives clients information to enable them to make informed decisions about their care.

1.4.2 The provider supports clients to understand information provided to them, including the nursing care plan for the community nursing services to be provided.

1.4.3 The provider allows clients the time they need to consider and review their options and seek external advice before making decisions.

1.4.4 The provider ensures that nursing care plans are reviewed updated to reflect changes in the client's needs, goals and preferences, and obtains informed consent from the client before they changes are made.

1.4.5 The provider ensures nursing care plans are provided in a timely manner, accurate, clear and presented in a way the client understands.

Standard 2: The organisation

Intent of Standard 2

Standard 2 sets out the expectations of the provider to meet the requirements of the strengthened Standards and deliver quality community nursing services.

The provider sets strategic priorities and promotes a culture of safety and quality. The provider is also responsible for driving and monitoring improvements to community nursing services, informed by engagement with clients, their supporters and/or authorised representatives, their staff, and data and information on care quality.

A provider's governance systems and workforce are critical to the delivery of safe, quality, effective and person-centred care for every client, and continuous care and services improvement. Their staff are empowered to do their jobs well.

Standard 2 expectation statement for clients

The organisation is well run. I can contribute to improvements to community nursing services. My provider and their staff listen to and respond to my feedback and concerns. I receive community nursing services from staff who are knowledgeable, competent, capable and caring.

Outcome 2.1: Partnering with clients

Outcome Statement:

The provider must engage in meaningful and active partnerships with clients to inform their strategic priorities and continuous improvement.

Actions:

2.1.1 The provider partners with clients in the design, delivery, evaluation and improvement of quality community nursing services.

Outcome 2.2a: Quality, safety and inclusion culture to support their staff to deliver quality care

Outcome Statement:

The provider must lead a culture of quality, safety and inclusion that supports their staff by focusing on continuous improvement, embracing diversity and prioritising the safety, health and wellbeing of their staff.

Actions:

2.2.1 The provider leads a positive culture of quality community nursing services and continuous improvement and demonstrates that this culture exists within the organisation.

2.2.2 In strategic and business planning, the provider:

a) prioritises the safety, health and wellbeing of their staff

b) proactively engages, listens, consults with their staff to leverage their expertise in delivering quality community nursing services to clients

c) communicates information to their staff that is relevant to staff safety, to support their delivery of quality community nursing services

d) adheres to legislative requirements, and active consideration is given to organisational and operational risks, workforce needs and the wider organisational environment.

Outcome 2.2b: Quality, safety and inclusion culture to support clients

Outcome Statement:

The provider must lead a culture of quality, safety and inclusion that supports clients to access community nursing services by focusing on continuous improvement, embracing diversity and prioritising the safety, health and wellbeing of clients.

Actions:

2.2.1 The provider leads a positive culture of quality community nursing service delivery and continuous improvement and demonstrates that this culture exists within the organisation.

2.2.2 In strategic and business planning, the provider:

a) prioritises the physical and psychological safety, health and wellbeing of clients

b) adheres to legislative requirements, and active consideration is given to organisational and operational risks, and the wider organisational environment.

Outcome 2.3: Accountability, quality system and policies and procedures

Outcome Statement:

The provider is accountable for the delivery of quality community nursing services and must maintain oversight of all aspects of the provider's operations.

The provider must use a quality system to enable and drive continuous improvement of the provider's delivery of community nursing care services.

The provider must maintain current policies and procedures that guide the way their staff to undertake their roles and require their staff to follow the policies and procedures.

Actions:

2.3.1 The provider engages with their staff on the planning and design of systems they are required to engage with, to improve the delivery of quality community nursing services.

2.3.2 The provider implements a quality system that:

a) supports quality community nursing services for all clients

b) sets out accountabilities and responsibilities for supporting quality community nursing services, specific to different roles

c) sets strategic and operational expectations for the delivery of quality community nursing services

d) enables the provider to monitor the organisation's performance in delivering quality community nursing services, informed by:

i) feedback from clients, authorised representatives and their staff delivering the community nursing services

ii) analysis of risks, complaints and incidents (and their underlying causes)

iii) Quality Indicator data

iv) contemporary, evidence-based practice

e) supports the provider to meet strategic and operational expectations and identify opportunities for improvement.

2.3.3 The provider monitors investment in priority areas to deliver quality community nursing services.

2.3.4 The provider regularly reviews and improves the effectiveness of its quality system.

2.3.5 The provider regularly reports on its quality system and performance to clients, authorised representatives their staff.

2.3.6 The provider practices open disclosure and communicates with clients, authorised representatives and their staff when things go wrong.

2.3.7 The provider maintains and implements policies and procedures that are current, regularly reviewed, informed by contemporary, evidence-based practice, and are understood and accessible by their staff.

Outcome 2.4: Risk management

Outcome Statement:

The provider must use a risk management system to identify, manage and continuously review risks to clients, their staff and its operations.

Actions:

2.4.1 The provider implements a risk management system to identify, assess, document, manage and regularly review risks to clients, their staff and the organisation.

2.4.2 The provider puts strategies in place and undertakes actions to prevent, control, minimise or eliminate identified risks.

2.4.3 The provider collects and analyses data and engages with clients and their staff to inform risk assessment and management. This feeds into the provider's quality system to improve community nursing services.

2.4.4 The provider regularly reviews and improves the effectiveness of the risk management system.

Outcome 2.5: Incident management

Outcome Statement:

The provider must use an incident management system to safeguard clients and acknowledge, respond to, effectively manage and learn from incidents.

Actions:

2.5.1 The provider implements an incident management system to record, investigate, respond to and manage incidents and near misses that occur in the delivery of community nursing services and reduces or prevents incidents from recurring.

2.5.2 The provider takes timely action to respond to and manage incidents.

2.5.3 The provider supports clients and authorised representatives to report incidents and encourages their involvement in identifying ways to reduce incidents from occurring.

2.5.4 The provider supports the workforce including through provision of tools, training and clear policies to prevent, recognise, respond to and report incidents.

2.5.5 The provider collects and analyses incident data and reports incidents to the Department of Veterans' Affairs Community Nursing Program, as required. All outcomes are reported to clients and their staff and feed into the provider's quality system to improve the quality of community nursing services.

2.5.6 The provider regularly reviews and improves the effectiveness of the incident management system and communicates changes to their staff and clients.

Outcome 2.6a: Complaints and feedback management for their staff

Outcome Statement:

The provider must encourage and support their staff to make complaints and give feedback about the provider's delivery of community nursing services without reprisal.

The provider must acknowledge and transparently manage all complaints and feedback and use complaints and feedback to contribute to the continuous improvement of community nursing services.

Actions:

2.6.1 The provider implements a complaints and feedback management system to receive, record, respond to and report on complaints and feedback.

2.6.2 The provider encourages and supports their staff to make complaints and give feedback including supporting access to advocates and services to support raising and resolving complaints and feedback.

2.6.3 The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong.

2.6.4 The provider collects and analyses complaints and feedback data. Outcomes are reported to their staff and inform the provider's quality system to improve the quality of community nursing services.

2.6.5 The provider regularly reviews and improves the effectiveness of how complaints and feedback from their staff are managed through the complaints and feedback management system.

Outcome 2.6b: Complaints and feedback management for clients

Outcome Statement:

The provider must encourage and support clients and others to make complaints and give feedback about the provider's delivery of community nursing services without reprisal.

The provider must acknowledge and transparently manage all complaints and feedback and use complaints and feedback to contribute to the continuous improvement of community nursing services.

Actions:

2.6.1 The provider implements a complaints and feedback management system to receive, record, respond to and report on complaints and feedback.

2.6.2 The provider encourages and supports clients, authorised representatives and others to make complaints and give feedback.

2.6.3 Clients are empowered to access advocates, language services and other ways of raising and resolving complaints and feedback.

2.6.4 The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong.

2.6.5 The provider collects and analyses complaints and feedback data. Outcomes are reported to clients, and inform the provider's quality system to improve the quality of community nursing services.

2.6.6 The provider regularly reviews and improves the effectiveness of the complaints management system.

Outcome 2.7: Information management

Outcome Statement:

The provider must ensure that information recorded about clients is accurate and current, is able to be accessed and understood by clients, authorised representatives, their staff, registered health practitioners, allied health professionals, allied health assistants and others involved in the client's care.

The provider must ensure that client information is kept confidential and is managed appropriately, in line with the informed consent of clients.

Actions:

2.7.1 The provider implements an information management system to securely manage records.

2.7.2 The provider's information management system ensures that:

a) their staff and clients, authorised representatives, registered health practitioners, allied health professionals, allied health assistants and others involved in the client's care have access to the right information at the right time to deliver and receive quality community nursing services

b) the accuracy and completeness of information collected and stored is maintained

c) informed consent is sought to collect, use and store the information of clients or to disclose their information (including comprehensive assessments) to other parties

d) clients understand their right to access or correct their information or withdraw their consent to share information

e) information from different sources is integrated.

2.7.3 The provider regularly reviews and improves the effectiveness of the information management system.

Outcome 2.8: Workforce planning

Outcome Statement:

The provider demonstrates that it understands and manages its workforce requirements and plans proactively to meet future workforce needs.

Actions:

2.8.1 The provider implements a workforce strategy to:

a) identify, record and monitor the number and mix of their staff required and engaged to manage and deliver safe, quality community nursing services

b) identify the skills, qualifications and competencies required for each role

c) engage sufficient numbers of suitably qualified and competent staff

d) use direct employment to engage their staff whenever possible, and minimise the use of independent contractors and agencies providing contractors

e) mitigate the risk and impact of workforce shortages and staff absences or vacancies.

2.8.2 The provider implements strategies for supporting and maintaining a satisfied and psychologically safe workforce.

Outcome 2.9: Human resource management

Outcome Statement:

The provider must deliver community nursing services to clients by staff who are skilled and competent in their roles, hold relevant qualifications for their roles and have expertise and experience relevant to delivering quality community nursing services.

The provider must provide their staff with training and supervision to enable them to effectively perform their roles.

Actions:

2.9.1 The provider maintains records of staff pre-employment checks, contact details, qualifications and experience.

2.9.2 The provider engages enough suitably qualified staff to deliver community nursing services. The skills, qualifications and competencies required for each staff role are identified and understood by all staff.

2.9.3 Staff have access to appropriate supervision, escalation, support and resources. This should be accessible for staff with English as a second language and be culturally sensitive.

2.9.4 The provider maintains and implements a training system that:

a) includes training strategies to ensure that staff have the necessary skills, qualifications and competencies to effectively perform their roles

b) draws on the experience of clients to inform training strategies

c) is responsive to feedback, complaints, incidents, identified risks and the outcomes of staff performance reviews.

2.9.5 The provider regularly reviews and improves the effectiveness of the training system.

2.9.6 All staff regularly receive competency-based training in relation to core matters, at a minimum:

a) the delivery of person-centred, rights-based care

b) culturally safe, trauma-aware and healing-informed care

c) caring for clients living with dementia

d) responding to medical emergencies

e) the requirements of the DVA Community Nursing Client Charter, incident reporting, the Notes for Community Nursing providers, the strengthened Aged Care Quality Standards 1 to 5 and other requirements relevant to the staff member's role.

2.9.7 The provider undertakes regular assessment, monitoring and review of the performance of their staff.

Outcome 2.10: Emergency and disaster management

Outcome Statement:

The provider must demonstrate that emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of clients and their staff.

Actions:

2.10.1 The provider develops emergency and disaster management plans that describe how the provider and their staff will respond to an emergency or disaster and to manage risks to the health, safety and wellbeing of clients and staff.

2.10.2 The provider implements strategies to prepare for, and respond to, an emergency or disaster.

2.10.3 The provider engages with clients, supporters of clients and staff about the emergency and disaster management plans.

2.10.4 The provider engages with clients and their authorised representatives, and staff about the emergency and disaster management plans and procedures.

Standard 3: The care and services

Intent of Standard 3

Standard 3 describes the way providers must deliver community nursing services for all types of services being delivered (noting that other strengthened Standards describe requirements relevant to specific service types). Effective assessment, planning, communication and coordination relies on a strong and supported workforce as described in strengthened Standard 2 and is critical to the delivery of quality community nursing services that meet clients' clinical needs, are tailored to their preferences (within scope of the Community Nursing Program) and support them to live their best lives.

In delivering community nursing services, providers and their staff must draw on all relevant strengthened Standards, with particular reference to Standard 1, to ensure care is tailored to the client and what's important to them.

Standard 3 expectation statement for clients

The community nursing services I receive:

- *are safe and effective*
- *optimise my quality of life, including through maximising independence and reablement*
- *meet my current needs, goals and preferences*
- *are well planned and coordinated*
- *respect my right to take risks.*

Outcome 3.1: Assessment and planning

Outcome Statement:

The provider must actively engage with clients to whom the provider delivers community nursing services, authorised representatives (if any) and any other persons involved in the care of clients in developing and reviewing the client's nursing care plan through ongoing communication.

Nursing care plans must describe the current care needs, goals and preferences of clients and include strategies for risk management and preventative care.

The provider must ensure that nursing care plans are regularly reviewed and are used by their staff to guide the delivery of community nursing services.

Actions:

3.1.1 The provider implements a system for assessment and planning that:

a) identifies and records the needs, goals and preferences of the client

b) identifies risks to the client's health, safety and wellbeing and, with the client, identifies strategies for managing these risks

c) supports preventative care and optimises quality of life, reablement and maintenance of function

d) involves relevant registered health practitioners, allied health professionals, allied health assistants and others responsible for the client's care, where required

e) directs the delivery of quality community nursing services.

3.1.2 Assessment and planning are based on ongoing communication and partnership with the client and authorised representatives and others that the client wishes to involve.

3.1.3 The outcomes of assessment and planning are effectively communicated to:

a) the client, in a way they understand

b) authorised representatives and others involved in their care, with the client's informed consent.

3.1.4 Nursing care plans are individualised and:

a) describe the individual's needs, goals and preferences

b) are current and reflect the outcomes of comprehensive assessments

c) include information about the risks associated with the delivery of community nursing services and how their staff can support clients to manage these risks

d) are provided in a format that is accessible to, and can understood by, the client

e) are used and understood by staff to guide the delivery of community nursing care services.

3.1.5 Nursing care plans are reviewed regularly, including when:

a) the client's needs, goals or preferences change, or the nursing care plan is not effective

b) the client's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes

c) the care that can be provided by a client's family or carer changes

d) transition occurs

e) risks emerge or there are changes or an incident that impacts the client

f) care responsibility changes between others involved in the client's care.

3.1.6 The provider has processes that support advance care planning including:

a) support for the client to discuss care, in line with their needs, goals and preferences, including beliefs, cultural and religious practices and traditions

b) referrals to the client's GP to complete and review advance care planning documents, if and when they choose

c) ensuring that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care.

Outcome 3.2: Delivery of community nursing services

Outcome Statement:

The provider must ensure that clients receive quality community nursing services within scope of the Community Nursing Program that meet their clinical needs, goals and preferences and optimise their quality of life, reablement and maintenance of function.

The provider must ensure that community nursing services are delivered in a way that is culturally safe and culturally appropriate for clients with specific needs and diverse backgrounds.

Actions:

3.2.1 Clients receive culturally safe, trauma aware and healing informed community nursing services that:

a) are provided in accordance with contemporary, evidence-based practices

b) meet their current needs, goals and preferences

c) optimise their quality of life.

3.2.2 The provider delivers community nursing services in a way that optimises the client's quality of life, reablement and maintenance of function, where this is consistent with their preferences.

3.2.3 Clients are supported to use equipment, aids, devices and products safely and effectively.

3.2.4 The provider ensures clients receive timely and appropriate referrals to the client's GP to support early identification and intervention, reablement, maintenance of function and quality of life, including for:

a) mental health risks or concerns

b) risks or concerns relating to the client living independently in their home

c) Aged Care assessment or re-assessment as required.

3.2.5 The provider implements strategies for supporting their staff to:

a) recognise risks or concerns related to a client's health, safety and wellbeing

b) identify deterioration or changes to a client's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition

c) respond to, and escalate, risks in a timely manner.

3.2.6 The provider implements a system for caring for clients living with dementia that:

a) incorporates contemporary, evidence-based strategies for the timely recognition of dementia and the delivery of care that best supports clients living with dementia

b) enables the identification and regular review of the strengths and skills of clients living with dementia and encourages use of these

c) enables authorised representatives, registered health practitioners, allied health professionals, allied health assistants and others involved in the client's care to act as partners in planning and delivering the client's community nursing care services (in line with the client's wishes and the scope of the Community Nursing Program).

3.2.7 The provider minimises the use of restrictive practices and, where restrictive practices are used, these are:

a) used as a last resort

b) used in the least restrictive form and for the shortest time needed

c) used with the informed consent of the client

d) monitored and regularly reviewed.

3.2.8 The provider makes reasonable efforts to involve the client in selecting their staff (including the gender of, and language spoken by, their staff providing community nursing services) and maximise staff continuity.

3.2.9 The provider supports their staff to:

a) understand the way different clients communicate, including clients living with dementia or have difficulty communicating

b) communicate effectively with different clients, both verbally and non-verbally.

Outcome 3.3: Communicating for safety and quality

Outcome Statement:

The provider must ensure that critical information relevant to the delivery of community nursing services is communicated effectively to the clients, between staff delivering the services, with authorised representatives, registered health practitioners, allied health professionals, allied health assistants and others involved in the client's care.

The provider must ensure that risks to clients, and changes and deterioration in the condition of clients, are escalated and communicated as appropriate.

Actions:

3.3.1 The provider implements a system for communicating structured information about clients and their community nursing services that ensures critical information is effectively communicated in a timely way to staff, authorised representatives, other persons supporting the client and registered health practitioners, allied health professionals, allied health assistants and others involved in the client's care.

3.3.2 The provider's communication system is used when:

a) the client commences receiving community nursing services

b) the client's needs, goals or preferences change

c) risks emerge, there is a change, deterioration or an incident that impacts the client

d) handover or transitions of care occur between staff or others involved in the client's care.

3.3.3 The provider implements processes for clients, authorised representatives and registered health practitioners, allied health professionals, allied health assistants and others involved in the client's care to escalate concerns about the client's health, safety or wellbeing.

3.3.4 The provider implements processes to:

a) correctly identify and match clients to their required community nursing services

Outcome 3.4: Planning and coordination of community nursing services

Outcome Statement:

The provider must ensure that clients receive community nursing services that are planned and coordinated, including where multiple health providers, and other persons supporting clients are involved.

Actions:

3.4.1 The provider, in partnership with the client, identifies others involved in the client's care and ensures coordination and continuity of care.

3.4.2 Authorised representatives and other persons supporting the client are recognised as partners in the client's care and involved in the coordination of community nursing services (in line with the client's preferences).

3.4.3 The provider facilitates a planned and coordinated transition to or from the provider in collaboration with the client and other health providers (including where there are two DVA Community Nursing providers delivering services to the client), and this is documented, communicated and effectively managed.

Standard 4: The environment

Intent of Standard 4

The intent of Standard 4 is to ensure that clients receive community nursing services in a physical home environment that is safe, supportive and meets their needs. Effective infection prevention and control measures are a core component of service delivery to protect clients, authorised representatives and their staff.

Standard 4 expectation statement for clients

I feel safe when receiving community nursing services. The environment is clean, safe and comfortable and enables me to move around freely. Equipment is safe, appropriate and well-maintained and precautions are taken to prevent the spread of infections.

Outcome 4.1: Environment – services delivered in the client's home

Outcome Statement:

When delivering community nursing services to clients in their homes, the provider must support clients to mitigate environmental risks relevant to the services.

Where the provider uses equipment in the delivery of any community nursing services, the equipment must be safe and must meet the needs of the clients.

Actions:

4.1.1 Where community nursing care services are delivered in the client's home, as relevant to the services being delivered, the provider:

a) identifies any environmental risks to the safety of the client

b) discusses with the client any environmental risks and options to mitigate these.

4.1.2 Equipment and aids provided by the provider are safe, clean, well-maintained and meets the needs of clients.

Outcome 4.2: Infection prevention and control

Outcome Statement:

The provider must have an appropriate infection prevention and control system.

The provider must ensure that their staff use hygienic practices and take appropriate infection prevention and control precautions when delivering community nursing services.

Actions:

4.2.1 The provider implements a system for infection prevention and control that is used where community nursing services are delivered, which:

a) identifies an appropriately qualified and trained infection prevention and control lead

b) prioritises the rights, safety, health and wellbeing of clients

c) complies with contemporary, evidence-based practice

d) describes standard and transmission-based precautions appropriate for the setting, including cleaning practices, hand hygiene practices, respiratory hygiene, cough etiquette and waste management and disposal

e) ensures personal protective equipment is available to staff, clients and others who may need it

f) supports staff, clients and others who need to use personal protective equipment to correctly use personal protective equipment

g) includes additional precautions to respond promptly to novel viruses and outbreaks of infectious diseases (suspected or confirmed)

h) communicates and manages infection risks to clients, authorised representatives and staff

i) is informed by staff and client immunisation and infection rates

j) undertakes risk-based vaccine-preventable diseases screening and immunisation for clients and staff

Standard 5: Clinical care

Intent of Standard 5

Standard 5 describes the responsibilities of providers to deliver safe and quality clinical care services to clients. The provider has overall responsibility to ensure a clinical governance framework is implemented and to monitor its effectiveness in supporting their staff to deliver quality clinical care services. Providers operationalise the clinical governance framework.

Many clients who require community nursing services have multiple chronic co-morbidities and complex care needs. These people may be experiencing sickness, frailty, disability, cognitive impairment or be nearing the end of their life. Communication with the client's GP for referral to a range of registered health practitioners, allied health professionals and allied health assistants is crucial to address these complex needs. Quality clinical nursing care can optimise a client's quality of life, reablement and maintenance of function. Improved health and wellbeing supports continued participation in activities that are enjoyable and give life meaning.

At all times, clinical care services provided should be person-centred, inclusive, safe, effective and coordinated. Services should be planned and delivered in partnership with the client, involving any authorised representatives in line with the client's needs and preferences. Delivering safe, quality clinical care services requires a multidisciplinary approach with a skilled workforce with clear accountabilities that are supported to deliver contemporary, evidence-based care. Allied health professionals have distinct roles in reablement and maintenance of a client's functional capabilities.

Effective implementation of Standard 5 is reliant on the systems and processes from Standards 1–5. Standard 5 does not seek to replicate the base expectation of understanding the person in Standard 1 or the base planning, assessment and delivery expectation of Standard 3. For example, implementation of processes for advance care planning in action 3.1.6 is critical to quality clinical care, including at the end of life (action 5.7.2). These systems and processes establish a baseline expectation which supports the delivery of person-centred and safe clinical care, ensuring that risks of harm to clients from clinical care are minimised and support continuous quality improvement.

Standard 5 expectation statement for clients

I receive person-centred, evidence-based, safe, effective, and coordinated clinical care services by registered nurses, enrolled nurses and/or personal care workers under the delegation of a registered nurse. Competent staff support my changing clinical needs in line with my goals and preferences.

Outcome 5.1: Clinical governance

Outcome Statement:

The provider must ensure continuous improvement of the safety and quality of clinical care services to clients.

The provider must integrate clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care services delivered to clients.

Actions:

5.1.1 The provider:

a) sets priorities and strategic directions for safe and quality clinical nursing services and ensures that these are communicated to their staff and clients

b) endorses the clinical governance framework

c) monitors the safety and quality of clinical systems and performance.

5.1.2 The provider implements the clinical governance framework as part of corporate governance to drive safety and quality improvement.

5.1.3 The provider implements processes to ensure their staff providing clinical care services are qualified, competent and work within their defined scope of practice or role.

5.1.4 The provider and their staff agree on their respective roles, responsibilities and protocols for providing quality clinical care services.

5.1.5 The provider works towards implementing a digital clinical information system that:

a) supports interoperability using established national Healthcare Identifiers, terminology and digital health standards

b) has processes for their staff and others to access information in compliance with legislative requirements.

Outcome 5.2: Preventing and controlling infections in delivering clinical care services

Outcome Statement:

The provider must ensure that clients, their staff, registered health practitioners and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

The provider must ensure that infection risks are minimised and, if they occur, are controlled effectively.

Actions:

5.2.1 The provider implements an antimicrobial stewardship system that complies with contemporary, evidence-based practice and is relevant to the service context.

5.2.2 The provider implements processes to minimise and manage infection when providing clinical care services that include, but are not limited to:

a) performing clean procedures and aseptic techniques

b) using, managing and reviewing invasive devices including urinary catheters

c) minimising the transmission of infections and complications from infections.

Outcome 5.3: Safe and quality use of medicines

Outcome Statement:

The provider must encourage and support clients, their staff and registered health practitioners to use medicines in a way that maximises benefits and minimises the risks of harm.

The provider must ensure that before administering medicine to a client, the medicine has been prescribed for the client and medicines are appropriately and safely stored, administered, monitored and reviewed by registered health practitioners, considering the clinical needs and informed decisions of the client.

The provider must ensure that medicine-related adverse events are monitored and reported and are used to inform safety and quality improvement.

Actions:

5.3.1 The provider implements a system for the safe and quality use of medicines, including processes to ensure:

a) access to medicines-related information for clients, their staff and registered health practitioners

b) registered health practitioners and others caring for a client can access the client's up-to-date medicines list and other supporting information at transitions of care

c) safe administration including assessing the client's swallowing ability, determining suitability of crushing medicines and providing alternative safe formulations when required

d) minimal interruptions to the administration of prescribed medicines when a client is prescribed a new medicine or there is an urgent change to their medicine

e) documentation of a current, accurate and reliable record of all medicines and the clinical reasons for the treatment, including pro re nata (PRN) medicines

f) support for remote access of prescribing.

5.3.2 The provider has processes to ensure medication reviews are conducted, including:

a) at the commencement of care, at transitions of care and annually when care is ongoing

b) when there is a change in diagnosis or deterioration in behaviour, cognition or mental or physical condition or when a person is acutely unwell

c) when there is polypharmacy and the potential to deprescribe

d) when a new medicine is commenced or a change is made to an existing medicine or medication management plan

e) when there is an adverse event potentially related to medicines.

5.3.3 The provider documents existing or known allergies or side effects to medicines, vaccines or other substances at the commencement of care and monitors and updates documentation when new allergies or side effects occur.

5.3.4 The provider implements processes to identify, monitor and mitigate risks to clients associated with the use of high-risk medicines, including communicating with the client's GP regarding reducing the inappropriate use of psychotropic medicines.

5.3.5 The provider has processes to report adverse medicine and vaccine events to the Therapeutic Goods Administration.

5.3.6 The provider regularly reviews and improves the effectiveness of the system for the safe and quality use of medicines.

Outcome 5.4: Comprehensive care

Outcome Statement:

The provider must ensure that clients receive comprehensive, safe and quality clinical care services that are evidence-based, person-centred and delivered by registered health practitioners or personal care workers as delegated and supervised by a registered nurse.

Clinical care delivered by the provider must encompass clinical assessment, prevention, planning, treatment, management and review to minimise harm and optimise quality of life, reablement and maintenance of function.

The provider must have systems and processes that support coordinated, multidisciplinary clinical care services that are delivered to clients, in partnership with clients, any authorised representatives and other persons supporting clients, and that are aligned with the client's needs, goals and preferences.

The provider must support early identification of, and response to, changing clinical needs.

Actions:

5.4.1 The provider implements an assessment and planning system that supports partnering with the client, any authorised representatives and other persons supporting the client to set goals of care and support decision making.

5.4.2 The provider conducts a comprehensive clinical assessment on commencement of community nursing services, at regular intervals and when needs change, that includes:

a) communicating with the client's GP for a comprehensive medical assessment

b) identifying, documenting and planning for clinical risks, acute conditions and exacerbations of chronic conditions

c) identifying a client's level of clinical frailty and communication barriers and planning clinical care services to optimise the client's quality of life, independence, reablement and maintenance of function

d) identifying and referral to other programs and agencies, including other DVA programs for access to the equipment, aids, devices and products required by the client.

5.4.3 The provider refers the client to their GP and facilitates access to other relevant DVA programs or services, to address the client's clinical needs.

5.4.4 The provider implements processes to:

a) deliver coordinated, multidisciplinary and holistic comprehensive care in line with the nursing care plan

b) communicate and collaborate with others involved in the client's clinical nursing care, in line with the client's clinical needs, preferences and the scope of the Community Nursing Program

c) facilitate access to after-hours and urgent clinical nursing care

d) provide timely notification to the client's GP, authorised representatives, other persons supporting the client, registered health practitioners and personal care workers involved in the client's care when clinical incidents or changes occur.

5.4.5 The provider implements processes to monitor clinical conditions and reassess when there is a change in diagnosis or deterioration in behaviour, cognition, mental, physical or oral health, and at transitions of care.

Outcome 5.5: Safety of clinical care services

Outcome Statement:

The provider must identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services to ensure the delivery of safe, quality clinical care services and to reduce the risk of harm to clients.

Actions:

5.5.1 The provider implements a system that supports the identification, monitoring and management of high impact and high prevalence clinical care risks, including but not limited to Actions 5.5.2 to 5.5.10.

Choking and swallowing

5.5.2 The provider implements processes to support safe chewing and swallowing when the client is eating, drinking, taking oral medicines and during oral care.

Continence

5.5.3 The provider implements processes for continence care by:

a) optimising the client's dignity, comfort, function and mobility

b) ensuring safe and responsive assistance with toileting

c) managing incontinence

d) protecting the client's skin integrity and minimising incontinence-associated dermatitis.

Falls and mobility

5.5.4 The provider implements processes to minimise falls and maximise the client's safety and well-being by:

a) reviewing the reasons for and consequences from falls

b) communicating changes in mobility and increase in falls to the client's GP

Nutrition and hydration

5.5.5 The provider implements processes to review a client's nutritional status by:

a) conducting regular malnutrition screening

b) responding to the risk of malnutrition and when a client is malnourished or has unplanned weight loss or gain.

Mental health

5.5.6 The provider implements processes to optimise mental health by:

a) actively promoting a client's mental health and wellbeing

b) responding to signs of deterioration in a client's mental health by communicating with the client's GP

c) responding supportively to distress and symptoms of mental illness including self-harm and suicidal thoughts minimising risks to the psychological and physical safety of each client.

Oral health

5.5.7 The provider implements processes to maintain oral health and prevent decline by:

a) referring to the client's GP for oral health assessments at the commencement of care, regularly and when required

b) responding to deterioration in oral health by communicating with the client's GP

c) assisting with daily oral hygiene needs.

Pain

5.5.8 The provider implements processes to manage pain by:

a) assessing the client's pain including where the client experiences challenges in communicating their pain

b) planning for, monitoring and responding to the client's need for pain relief

c) ensuring pain management is available 24-hours a day.

Pressure injury and wounds

5.5.9 The provider implements processes to prevent and manage pressure injuries and wounds by:

a) conducting routine comprehensive skin inspections

b) monitoring and responding to pressure injuries and wounds when they occur.

Sensory impairment

5.5.10 The provider implements processes to minimise and manage sensory impairment from hearing loss, vision loss and balance disorders by providing access to and supporting the use of assistive devices and aids to maximise the client's independence, function and quality of life.

Outcome 5.6: Cognitive impairment

Outcome Statement:

The provider must ensure that clients who experience cognitive impairment (whether acute, chronic or transitory) receive comprehensive community nursing services that optimise clinical outcomes and are aligned with their clinical needs, goals and preferences.

The provider identifies situations and events that may lead to changes in behaviours.

Actions:

5.6.1 The provider identifies and responds to the complex clinical care needs of people with delirium, dementia and other forms of cognitive impairment by:

a) identifying and mitigating clinical risks

b) delivering increased care requirements

c) being alert to deterioration and underlying contributing clinical factors.

5.6.2 The provider collaborates with clients with cognitive impairment and their GP and authorised representatives to understand the client and to optimise clinical care outcomes.

5.6.3 The provider implements processes to:

a) identify and minimise situations that may precipitate changes in behaviour

b) identify and respond to clinical and other identified causes of changes in behaviour.

Outcome 5.7: Palliative care and end-of-life care

Outcome Statement:

The provider must recognise and address the needs, goals and preferences of clients in palliative care and end-of-life care and must preserve the dignity of clients in those circumstances.

The provider ensures that the pain and symptoms of clients are actively managed, with access to specialist palliative and end-of-life care when required.

The provider must ensure that authorised representatives and other people supporting clients are informed and supported, including during the last days of life.

Actions:

5.7.1 The provider has processes to recognise when the client requires palliative care or is approaching the end of their life, supports them to prepare for the end-of-life and responds to their changing needs and preferences.

5.7.2 The provider supports the client, authorised representatives and other people supporting the clients and substitute decision maker, to:

a) continue end-of-life planning conversations

b) discuss requesting or declining aspects of personal care, life-prolonging treatment and responding to reversible acute conditions

c) review advance care planning documents to align with current clinical needs, goals and preferences.

5.7.3 The provider plans and delivers palliative care that:

a) prioritises the comfort and dignity of the client

b) supports the client's spiritual, cultural and psychosocial needs

c) identifies and manages changes in pain and symptoms

d) provides timely access to specialist equipment and medicines for pain and symptom management

e) communicates information about the client's preferences for palliative care and the place where they wish to receive this care to their staff, authorised representatives and other people supporting clients

f) facilitates access to specialist palliative care and end-of-life registered health practitioners when required

g) provides a suitable environment for palliative care

h) provides information about the process when a client is dying and about loss and bereavement to authorised representatives and other persons supporting clients.

5.7.4 The provider implements processes in the last days of life to:

a) recognise that the client is in the last days of life and respond to rapidly changing needs

b) ensure medicines to manage pain and symptoms, including anticipatory medicines, are prescribed, administered, reviewed and available 24-hours a day

c) provide pressure care, oral care, eye care and bowel and bladder care

d) recognise and respond to delirium

e) minimise unnecessary transfer to hospital, where this is in line with the client's preferences.