E.10 Community Nursing

1.0 INTRODUCTION/BACKGROUND

Mercy Community Nursing Service (MCNS), established in 1976, is the foundation service of Mercy Services. The aim of MCNS is to support the development of optimum health and wellbeing of Mercy Services clients through the provision of high quality nursing care.

2.0 SCOPE

The scope of this policy applies to all nursing care provided by Mercy Services to people who are living in the community (i.e., not in residential aged care).

3.0 POLICY STATEMENT

MCNS enables Mercy Services clients to receive high quality nursing care in their own homes, or when these people are visiting a Mercy Services centre.

Specific nursing care is provided by Registered Nurses and Endorsed Enrolled Nurses (EENs) to eligible clients at times and places agreed to by MCNS and clients.

Specific nursing practices include:

A) Cardiopulmonary resuscitation (CPR);
B) Diabetes monitoring;
C) Foot care;
D) Infection control;
E) Pressure injury prevention and management;
F) Specimen collection;
G) Urinary catheterisation;
H) Wound care;
I) Medication management and administration; and
J) Pain management.

4.0 PROCEDURES

4.1 Hours of operation

The MCNC operates from **0800hrs – 1630hrs** Monday to Friday (excluding public holidays).

The service does not operate on weekends or public holidays. Arrangements may be made to provide a service outside normal operating hours if there is a compelling need and resources are available.

4.2 Services provided

Services provided by MCNS include:

- Initial assessment of client and carer needs;
- Referral to other community services if required;
- Ongoing assessment and nursing management;

- Wound assessment and management;
- Monitoring of blood sugar levels; and
- Organising and education regarding medications / blister packs.

4.3 Eligibility criteria:

- Frail older people or younger people with a disability who, without nursing care, are at risk of premature or inappropriate long-term residential care; or
- Carer of the above; and
- Client living in the Newcastle or Lake Macquarie Local Government Areas (LGAs).

4.4 Entry point to MCNS:

New referrals are received via:

- My Aged Care by phoning 1800 200 422; or
- General Practitioner/Specialist Doctor.

Existing MCNS clients:

- Newcastle: (02) 4961 2686
- Lake Macquarie: (02) 4944 1944

4.5 Prioritisation of referrals

New referrals are contacted within **24hrs** of the referral being received. An appointment is made for an assessment and if the client's needs are appropriate for our nursing service the client is registered for service.

If the client requires care that MCNS cannot provide, after consultation with the client a referral will be made to Hunter New England Health Service or in the case of a Department of Veterans Affairs (DVA) client to a DVA accredited private nursing service.

A letter acknowledging referral and commencement of service will be sent to the GP / Specialist.

4.6 Where nursing care is provided

MCNS provides nursing care within the Newcastle and Lake Macquarie LGAs.

Nursing care is available to eligible Mercy Services clients in their homes or in the clinic rooms at the Mercy Services Tighes Hill and West Wallsend centres. In cases where a client's home may be unsafe or an inappropriate place in which to provide nursing care (due to infection control risks and/or safety concerns for the attending staff), the client may be offered the opportunity to have their care attended to at one of the Mercy Services clinic rooms. This will be offered to the client after a review of the situation under Work Health and Safety (WHS) guidelines, and discussion with the Chief Executive Officer.

4.7 Client Agreement

Clients are required to read a Client Information Booklet that will explain the service and their rights and responsibilities. A Care Plan and other documentation will also be completed. This will include consent for staff to speak with their GP / Specialist and other health professionals. This consent will also

include the taking of photos and graphing of wounds as a way of visualising the wound healing progress.

4.8 Control of Clients' Pets

For the purpose of infection control and WHS reasons if the client has a pet it must be removed from the area in which the nursing care is being done. This may mean closing a door or the pet being taken outside while the nurse is in attendance. **This needs to be conveyed to the client on the first phone contact after receiving the referral.**

4.9 Home Visitation Times

Once a client has been assessed and is accepted onto the MCNS, frequency of service will be discussed. This will include discussion on a mutually acceptable time for service. MCNS will attempt to be flexible on all visit times to allow for the client to attend to Doctors appointments, podiatrist and other health professionals or family reasons.

There may be occasions on which MCNS needs to change the allocated visit (for example, due to staff illness or emergency). If a client is expecting a scheduled home visit and for some reason this needs to change the client will be phoned and informed of the need to change the visit time.

4.10 Refusal by Client of Treatment

If a client refuses appropriate treatment, Mercy Services Community Nurses will contact the referring agency, GP (and contact person if permission given by client) to notify them that treatment has not been accepted by the client.

4.11 Specific Nursing Practices

A. Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary Resuscitation (CPR) comprises rescue breathing and chest compressions. The purpose of CPR is to temporarily maintain sufficient circulation to preserve brain function while waiting for specialised treatment.

Community nurses should start CPR if the victim has no signs of life (unresponsive, unconscious, not breathing normally, and/or not moving). Community nurses should suspect that cardiac arrest has occurred even if the victim takes occasional gasps.

CPR is to be administered under the standard First Aid procedure (DRABCD that being check for Danger, seek a Response, clear Airway, start Breathing, begin Compressions and if available use Defibrillation). The assistance of an Ambulance will be sought at the earliest possible opportunity.

B. Diabetes Monitoring

Community Nurses are to be aware of, and understand their responsibilities regarding, safe and accurate testing of blood glucose levels (BGLs) and correct storage of insulin and administering devices. All MCNS staff are required to follow standard precautions (see G.08 Infection Control Policy).

MCNS staff require knowledge of symptoms and management of hypoglycaemia and hyperglycaemia, and are aware of the importance of detailed and accurate documentation pertaining to the recording of BGLs. Where clients do not have this knowledge MCNS will provide appropriate education.

MCNS clients are supported to manage hypoglycaemia and hyperglycaemia through monitoring of BGLs and, if the client is insulin dependent, supervision of insulin administration.

Procedures

Regular BGLs are recorded and scheduled contact is maintained with the client's GP / Diabetic Educator or Diabetic Specialist. The procedure includes educating the client in the use of their glucometer and the administration of their insulin, if required.

Eligible clients

Diabetes Monitoring is provided to clients who require support to manage hypoglycaemia and/or hyperglycaemia and are;

- cognitively impaired, and/or
- unable to self manage, and /or
- without a carer who can provide assistance.

Limitations of MCNS

Inability of the MCNS to provide diabetes monitoring every day due to hours of work e.g. Monday to Friday service and no service provided on public holidays.

Materials and equipment required for BGL taking

- Glucometer
- Lancet (retractable or recessed safe lancet preferable)
- Tissue
- Sharps container
- Disposable gloves
- Diabetes booklet or BGL chart to accurately record BGL

Safe work procedures for BGL taking

- Wash hands or use hand gel.
- Assemble blood glucose device according to manufacturer's instructions.
- Check clients hands are clean. If not get them to wash hands clean. **Do not use alcohol wipe.**
- Select puncture site off centre of the pad of one of the client's fingers.
- Twist off protective lancet cap, taking care not to contaminate point.
- Operate lancet device, wait a few seconds (with puncture site facing away from your face) until a large drop of blood forms.
- Apply blood to test area of sensor strip and follow instructions for reading blood glucose.
- Wipe puncture site with tissue. Hold pressure over site until bleeding stops.
- Dispose of lancet immediately into sharps container.

- Disinfect blood glucose device with Alco- wipe if visible contamination of surface evident.
- Record blood glucose on appropriate form or booklet, and in care notes (electronically on Carelink+).
- Check whether baseline blood glucose level of client is of acceptable range in order to determine if the current level should be reported to GP.

Safe work practice for hypoglycaemia
Hypoglycaemia is a condition that occurs when the blood glucose level has dropped too low, **usually below 4mmls/L** although this can vary. It is important to treat hypoglycaemia quickly to stop the blood glucose level from falling even lower.

Symptoms of Hypoglycaemia:

- Weakness, trembling or shaking.
- Light headedness.
- Lack of concentration / behaviour change.
- Tearful / crying.
- Numbness around the lips and fingers.
- Sweating.
- Headache.
- Dizziness.
- Irritability.
- Hunger.

Attention:
A 'hypo' may occur without symptoms. In this instance hypoglycaemia can be detected only by measuring the BGL.

Treatment:

- Take glucose tablets equivalent to 15 grams carbohydrate **OR**
- 6-7 jellybeans **OR**
- ½ can regular soft drink (not 'diet')**OR**
- 3 teaspoons of sugar or honey **OR**
- ½ glass fruit juice

If circumstances permit re-test blood glucose levels to ensure they have risen above 4mmols/L. It may take 10 – 15 minutes to see a rise in blood sugar levels. If symptoms persist or blood glucose level remains below 4mmols/L, repeat above step.

If next meal is more than 20 minutes away client will need to eat some longer acting carbohydrate .This could be ONE of the following;

- A slice of bread **OR**
- 1 glass of milk or soy milk **OR**
- 1 piece of fruit **OR**
- 2 – 3 dried apricots, figs or other dried fruit **OR**
- 1 tub natural low fat yoghurt **OR**
- 6 small dry biscuits and cheese.

If not treated quickly, the blood glucose can continue to drop which may progress to;

- Loss of coordination.
- Confusion.
- Slurred speech.
- Loss of consciousness / fitting.

THIS IS AN EMERGENCY!

They must not be given any food or drink by mouth

- Place person on side.
- Give an injection of Glucagon if available and you have a doctors order for its administration.
- Phone for an ambulance (dial 000) stating diabetic emergency.
- Wait with person until ambulance arrives.

Safe work practices for hyperglycaemia

Hyperglycaemia is where blood glucose is elevated. This can develop over many hours or days. It is possible for blood glucose to be high and client to not be aware or show symptoms unless taking a finger prick reading.

Symptoms of hyperglycaemia:

- Feeling excessively thirsty.
- Frequently passing large volumes of urine.
- Feeling tired.
- Blurred vision.
- Infections. (e.g. - thrush, cystitis, wound infections)
- Weight loss.

Treatment for Hyperglycaemia for Type 1 Diabetes:

- Contact GP if BGL outside acceptable level, or follow medication orders.

Documentation

- Ensure there is accurate recording of BGLs in client's home file and care notes (electronically on Carelink+).

- Ensure there are written instructions from the GP or Specialist with the acceptable BGLs for the client and the actions to be taken if the BGLs are not within the acceptable range.

C. Foot Care

Clients requiring foot care will receive appropriate assessment, management and referral. Clients will receive foot care that is delivered in a safe and timely manner. MCNS supports clients to prevent potential adverse events / complications of the foot by facilitating appropriate qualified health professionals undertaking assessments and interventions. Infection control standards are maintained whilst treating clients.

Knowledge of referral processes and knowledge of accredited staff contribute to the facilitation of adequate foot care.

Procedures

Supporting clients with foot care

Clients may require assistance with activities of daily living including foot care. In order to maintain healthy feet, it is important to:

1. Ensure feet are kept clean and dry
2. Apply moisturiser to dry / cracked areas
3. Report any suspected fungal infections, lesions or complaints of pain to the clients GP for investigation.

It is an expected duty of care and role by RN and EN to assist or perform foot care for clients whom are unable to do so.

The provision of foot care by nurses is covered in the NSW Nurses Association Guidelines on Provision of Basic Foot care by Nurses (2008):

- "Health Practitioner Regulation National Law Act 2009 permits the provision of basic foot care by health practitioners regulated under this Act"

- There is a clear boundary between the provision of basic foot care and the practice of podiatry. While podiatrists may offer basic foot care and podiatry services, nurses are generally involved in the provision of basic foot care.

- Registered nurses, enrolled nurses and assistants in nursing may provide basic foot care where they are employed by a hospital, nursing home/aged care facility or community health centre and provide the care as part of their normal duties in that employment.

- In accordance with the Health Practitioner Regulation National Law Act 2009, only registered nurses may, in the course of providing a foot care service, provide treatment to a person who has a medical condition causing inadequate blood circulation to their feet or peripheral neuropathy affecting their feet.

Safe work procedures for foot care

Assessment

Before foot care is undertaken, all clients must be assessed by a RN. This assessment may also be undertaken by an EN who is accredited in Basic Foot care. The Foot Care Assessment form is shown in Appendix 1. The results of client assessment lead to consideration under the following two categories:

1. Clients with Diabetes Mellitus, Peripheral Vascular Disease, deformity, or other condition that may complicate the provision of foot care or healing. Basic foot care for these clients must be undertaken only by nurses accredited in Basic Foot Care. They will then determine if they are competent / qualified to undertake the task or if it requires a referral to a podiatrist.

2. Clients with no complicating factors: all nurses are able to attend to basic foot care for these clients.

Infection control
All instruments and client treatment MUST be in accordance Mercy Services Infection Control Policy.

Staff are to wear personal protective equipment according to the requirements of the individual situation while attending to foot care.

ALL instruments used must be single use items or after use be sent for sterilisation (currently Hunter Valley Private Hospital).

Referral for specialist foot care
In the event that a client is found to have diabetes, deformity, peripheral vascular disease or any other condition that may affect a client's healing / safety whilst foot care is attended, a referral to a podiatrist will be required. If the Podiatrist assesses the client and provides a written referral for Mercy Services to attend to foot care, this service will be initiated.

After consultation with the client a letter will be sent to the client's GP requesting referral to a podiatrist as part of the client's annual health plan.

Education
All staff who complete an accredited Basic Foot Care course must present documented evidence of this to their Manager.

D. Infection control:

Mercy Services aims to create a safe and healthy work environment. There is a two-tier approach to management of cross infection: standard precautions and additional precautions.

State health authority instructions change from time to time, and it is essential that MCNS community nurses refer to current NSW Health instructions and/or consult with an Infection Control Consultant as required in order to prevent and manage infections.

Procedures
Definitions

- *Methicillin-resistant Staphylococcus aureus (MRSA):* Staphylococcus aureus which are resistant to methicillin (and all other beta-lactamase antibiotics).
- *Multiresistant Staphylococcus aureus (MRSA):* MRSA which are resistant to three or more of the following eight antibiotics: erythromycin, tetracycline, trimethoprim, gentamicin, rifampicin, ciprofloxacin, fusidic acid and mupirocin.
- *Non-multiresistant Staphylococcus aureus (NMRSA):* MRSA which are resistant to not more than two of the above antibiotics.

- *Epidemic strains of MRSA (EMRSA):* Certain strains of MRSA are known to spread easily between and within hospitals and are designated epidemic strains of MRSA. These include all MRSA EMRSA - Eastern Australian (resistant to erythromycin, trimethoprim and ciprofloxacin), EMRSA – "Irish 2" (resistant to erythromycin, tetracycline, trimethoprim and usually gentamicin) and UK EMRSA-15 (resistant to ciprofloxacin, often erythromycin and almost always urease negative). All MRSA isolated in WA are considered to be potentially epidemic.
- *MRSA Infection:* Invasion of the host with the production of acute inflammation and/or bacteraemia.
- *MRSA Colonisation:* Detection of MRSA from a site which shows no sign of invasive infection, usually the nose or perineum, and often a chronic ulcer.
- *Active MRSA Carrier:* A person is an active carrier of MRSA when the organism has been isolated on more than one occasion.
- *Transient MRSA Carrier:* A person is a transient carrier of MRSA when the organism has been isolated on only one occasion and when one subsequent full set of screening swabs is negative.
- *Inactive MRSA Carrier:* A previously active carrier becomes inactive when one set of swabs taken from the nostrils, throat, hands (staff only), perineum, wounds/ulcers/skin lesions, umbilicus (neonates only) and urethral meatus and urine (indwelling catheters only) at least one week after cessation of antistaphylococcal treatment, is negative for MRSA.
- *Cleared MRSA Carrier:* A previously active carrier (not currently on antibiotic treatment) who returns two full sets of negative swabs collected on the same or different days at least three months after last returning positive swabs.

Care procedure (MRSA and EMRSA)

- Wash hands with plain soap and water or antibacterial hand gel before attending the client.
- Wash hands or use antibacterial hand gel after attending the client.
- Wear personal protective clothing:
- Gloves – if having direct contact with the client's wound.
- Plastic apron – if doing wound care.
- Gown – if client has an exfoliative skin condition where there is heavy dispersal of MRSA.
- Mask – if client has lower respiratory infection related to MRSA.
- Dispose of personal protective clothing into rubbish bag and dispose in garbage bin.
- Use a non-touch aseptic technique when changing and handling dressings.
- If clinically indicated, cover skin lesions/wounds with an occlusive dressing.
- Where possible do clients with infectious wounds last.
- Clearly record in care notes (electronically on Carelink+) and on Care Plan the client has MRSA.

Note: Staff with any exfoliative skin condition must not attend known clients with MRSA.

Housekeeping procedure

- Use standard cleaning products and procedures.
- Wear plastic apron and gloves and dispose of into rubbish bin.

- Use disposable cleaning cloths and dispose of into rubbish bin. Alternatively, launder after use.

E. Pressure Area Prevention and Management

MCNS aims to minimise the incidence of pressure injuries and to ensure existing pressure injuries are systematically managed and documented according to this policy.

Pressure ulcers are recognised as avoidable adverse events, yet they continue to contribute to the morbidity and mortality of the 'at risk' patients receiving health care. Predicting and preventing pressure ulcers will improve the quality of care. This policy outlines the role and responsibilities health care workers have in prevention, monitoring, documenting and reporting processes.

Procedures

The prevention and management of pressure ulcers requires adherence to the following key points:

- Pressure risk assessment of all clients when commencing services with Mercy Services and after clinical change and reassessment as per guideline.
- Demonstrated use of pressure reduction strategies and equipment.
- Pressure injury classification and management.
- Standardised documentation.
- Transfer of information between all health care workers, referral sites and consumers.
- Education to support implementation of policy to all health care workers within Mercy Services, clients and carers.
- Reporting, investigating and ongoing monitoring of risks.

Pressure Injury Classification: stages of a pressure injury

Stage	***Definition***	***Explanatory Guidelines***
One	Observation of pressure related alteration of intact skin. Indicators are compared to adjacent or opposite areas on the body and may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain/itching).	The injury appears as a defined area of persistent redness in lightly pigmented skin. In dark tone skin the tone may appear with persistent red, blue and purple hues without skin loss.
Two	Partial thickness skin loss involving epidermis and or dermis.	The pressure injury is superficial and presents clinically as an abrasion, blister or shallow crater.
Three	Full thickness skin loss involving damage or necrosis to subcutaneous tissue and extending down but not through the underlying fascia.	The injury presents clinically as a deep crater with or without undermining of the adjacent tissue.

Four	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structure (for example, tendon or joint capsule).	Undermining and sinus tracts may be associated with stage four.

Pressure Risk assessment

Clients will have a risk assessment on the commencement of services with Mercy Services and after any clinical changes using the recommended tool, as shown in Appendix Two. The outcome of the risk assessment will be documented in Carelink+ and communicated to relevant clinical staff.

Reassessment will be done every 6 months if low risk, otherwise each month (clinical assessment attended on each visit in conjunction with wound management).

Pressure Injury Management - Pressure injury prevention

Repositioning

- Clients assessed as being at risk of developing pressure injuries need to be educated with their carers on the importance of repositioning.
- Clients placed on alternate support surfaces still require repositioning
- Clients at risk of developing pressure ulcers should be referred for Occupational Therapist assessment.

Skin care and massage

- Skin cleansing should occur at time of soiling, followed by a moisturiser.
- Hot water and vigorous massages are to be avoided over bony prominences.

Documentation

The presence of a pressure injury will be documented in the client notes along with details of prevention programs' that are either in place or about to be implemented. The minimal requirement to be entered into the client notes include:

- actual or probable cause leading to pressure injury;
- time and date of injury leading to pressure injury;
- location and size of pressure injury;
- stage of injury;
- systemic or local presence of infection;
- photograph and graph of the wound;
- care plan for care of the wound; and
- details of management program in place for those clients with pressure injury or at risk of pressure injury.

Monitoring of incidents and risks

Record on the electronic client record (Carelink+) an alert stating client has pressure ulcer or is at risk of developing a pressure area.

F. Specimen Collection

MCNS community nurses safely collect clients' pathology specimens for the purpose of monitoring infection. Community nurses are expected to:

- be aware of, and understand their responsibilities regarding, safe specimen collection as requested by the GP in the event of suspected infection of a wound / bladder;
- demonstrate an understanding of the importance of accurate history taking and recording;
- have knowledge of universal precautions; and
- provide appropriate treatment and management of suspected infections.

Wounds are observed at each dressing change for signs of infection. All catheters are observed for clinical signs of infection at each change. This includes asking the client key questions in regard to their wound or catheter. Staff and clients require knowledge of signs and symptoms of infection and the management of infection.

Procedures

Indications for specimen collection
Specimens are collected when the client's wound has clinical signs of infection and a wound swab has been requested by the GP. Clinical signs include:

- increased exudate, increased pain from the wound, inflammation and deterioration in the wound bed.

Catheter specimens are collected when there is suspicion of a urinary tract infection (UTI). Signs and symptoms include:

- odourous and / or discoloured urine;
- pain and / or frequency on micturition;
- pain in lower back; and/or
- the presence of blood in the urine.

Equipment and requirements for specimen collection

- Pathology request form from the GP
- Wound swab or in the case of a Catheter specimen of urine a yellow lid collection jar. Sealed plastic bag for transportation of specimen.
- Personal Protective Equipment (PPE) e.g. gloves.
- Bag for disposal of rubbish.
- Bacterial gel for hands.

Safe work procedures

- Always wear PPE when collecting specimens of body fluids. Practice standard precautions.
- Ensure specimens are labelled correctly and pathology form has correct client details including time of collection and what type of specimen it is e.g. wound swab. Ensure specimen is in sealed bag for transport.
- Dispose of PPE into rubbish bag. Wash hands if possible and or apply bacterial gel.

- Deliver specimen to the pathology / doctors rooms as soon as possible.

Documentation

- Document specimen collection date and type in client's care notes (electronically on Carelink+).

G. Urinary Catheterisation

The term catheterisation refers to the passage of a catheter via the urethra into the urinary bladder for the withdrawal of urine.

Catheterisation and catheter care will be undertaken to ensure the safety of both staff and the client.

MCNS staff will ensure urinary catheterisation is performed with minimal risk of injury to staff and client according to infection control and urinary catheterisation policy and procedures**.**

Procedures for urinary catheterisation

Indications for urinary catheterisation

The client requires catheterisation for withdrawal of urine from the bladder.

Equipment and requirements for catheterisation

- Sterile Catheter Pack.
- Appropriate PPE.
- Appropriately sized catheter, a catheter leg strap, if required, and an appropriate catheter bag / catheter valve.
- Disposable sheet.
- Knowledge of infection control and manual handling requirements.
- Knowledge of Work Health & Safety Act and its requirements.

Safe work procedures for urinary catheterisation

- Position client in the bed within easy reach.
- Set up clinical equipment on a table / chair within easy reach of the procedure.
- Position equipment at work height to avoid reaching and twisting.
- Place cushion and disposable sheet onto the floor for nurse to kneel beside the bed to undertake the procedure if necessary.
- Ensure adequate lighting is available
- Ensure correct PPE is worn.

Indwelling catheterisation procedure for males:

NOTE: Always catheterise on a full bladder (contraindicated in clients who experience autonomic dysreflexia). This procedure relies on the "clean hand, dirty hand" technique.

- Explain the procedure to the client to allay fears and to obtain informed consent and co-operation.
- Ensure the client's privacy during the procedure.

- Position a disposable drawsheet under the client's buttocks and assist him to get into the supine position.
- Check the genital area and wash if excessive discharge is present.
- Cover the client to maintain dignity and ensure that a good light is available.
- Wash / gel hands. Put on the apron and the protective eyewear for protection from splashing.
- Place equipment on the suitable surface i.e. table / trolley / chair and move it to the bedside.
- Disturb the bedclothes as little as possible to minimise the change of airborne bacteria contaminating the sterile field.
- Open the outer cover of the catheter pack. Add the extra equipment. The use of a complete catheter pack reduces the risk of accidental contamination of equipment.
- Wash and gel hands. Hands may have become contaminated by handling the outer packs. Put on sterile gloves.
- Check balloon for patency. This is a quality control check of the balloon.
- Ask the client to retract the foreskin if uncircumcised. Wrap a sterile gauze swab around the penis with the non-dominant hand. This hand is now considered to be your 'dirty' hand. Holding the penis in the non-dominant 'dirty' hand ensures that the dominant 'clean' hand is used for catheter insertion.
- Use your 'clean' hand to irrigate the glans penis with the normal saline squeeze pack. Inadequate preparation of the urethral orifice is a major cause of infection.
- Using aseptic technique, drape the area with the fenestrated drape, 'dirty' hand under the drape and 'clean' hand on top. The bladder is a sterile organ. Catheterisation requires the same aseptic precautions as a surgical procedure.
- Hold the penis in the 'dirty' hand.
- Gently introduce the lubricating gel into the urethra via the nozzle while raising and extending the penis. The use of a lubricant, which contains a local anaesthetic, has the effect of minimising the discomfort experienced.
- Wait two (2) minutes prior to proceeding to allow the local anaesthetic to take effect.
- Raise and extend the penis as before. Maintain a firm grasp of the penis until the procedure is finished. This straightens the penal urethra, prevents retraction and reduces the chance of contamination.
- Insert the catheter gently approximately twenty (20) cms. Do not use force.
- The male urethra is approximately eighteen (18) – twenty (20) cms long. If resistance is felt, the following strategies may be used:
    - allow more time for the local anaesthetic to take effect. Resistance might be caused by spasm of the urethra or external sphincter, a stricture or obstruction;
    - increase the traction on the penis and gently push the catheter forward;
    - ask the client to take slow, deep breaths then relax;
    - ask the client to cough; and
    - gently rotate the catheter.
- If these strategies fail, discontinue and notify the GP.

- When the urine begins to flow into the container positioned between the client's thighs advance the catheter two (2) – three (3) cms. Advancing the catheter allows for the balloon to be inflated inside the bladder.
- Inflate the balloon with the correct amount of sterile water. Always ensure that the urine is flowing before inflating the balloon. If the balloon is inflated outside the bladder urethral trauma and pain will result.
- Withdraw the catheter slightly till resistance is felt. This indicates that the base of the balloon is resting on the bladder neck.
- Attach the catheter to the chosen drainage system / sterile catheter valve. Fix the catheter to the thigh with an approved catheter strap. This prevents yawing of the catheter which could result in:
    - introduction of infection; and/or
    - ulceration at pressure points (meatus, peno-scrotal junction, and bladder neck.)
- Make sure that the catheter is not taut on the skin to allow for spontaneous erection of the penis and to minimise the risk of meatal erosion or ulceration.
- Reposition the foreskin, if applicable, to avoid constriction behind the glans penis which could result in paraphimosis.
- Ensure that the client is dry and comfortable to avoid skin irritation and secondary infection.
- Take urine specimen for examination if required. Urine for culture and sensitivity must be collected from the newly inserted catheter as bacterial colonisation of the catheter occurs within twenty-four (24) to forty-eight (48) hours of insertion.
- Remove gloves and place in bag, this is to prevent environmental contamination.
- Dispose of equipment in a disposable plastic bag and seal the bag before moving the table / trolley. Place bag in the garbage.
- Record the following documentation in clients care notes (electronically on Carelink+):
    - difficulty / ease of insertion;
    - reasons for catheterisation;
    - catheter size and brand;
    - balloon size and amount of sterile water to fill;
    - amount / colour of the urine; and
    - date for the next catheter change.

Indwelling catheterisation procedure for females:

NOTE: Always catheterise on a full bladder (contraindicated in patients who experience autonomic dysreflexia). This procedure relies on the 'clean hand, dirty hand' technique.

- Explain the procedure to the client to allay any fears and to obtain informed consent and co-operation.
- Ensure client's privacy.
- Position a disposable drawsheet under the client's buttocks. Assist her to get into the supine position.
- Check the genital area and wash if excessive discharge is present.
- Cover the client to maintain dignity and ensure that a good light source is available.

- Wash / gel hands. Put on the disposable plastic apron and the protective eyewear for protection from splashing.
- Place equipment on the suitable surface i.e. table / trolley / chair, and move it to the bedside.
- Open the outer cover of the catheterisation pack and add the contents of the supplementary packs. The use of a complete catheter pack reduces the risk of accidental contamination of equipment.
- Wash and gel hands. Hands may have become contaminated by handling the outer packs. Put on sterile gloves.
- Check balloon for patency. Quality control check before catheter insertion.
- Using the non-dominant "dirty" hand separate the labia minora to expose the urethral meatus. Separating the labia with the non-dominant 'dirty' hand allows the dominant 'clean' hand to be used for catheter insertion.
- Use your 'clean' hand to irrigate the urethral orifice and labia with the normal saline squeeze pack. Inadequate preparation of the urethral orifice is a major cause of infection.
- Using an aseptic technique, drape the area using the fenestrated drape, 'dirty' hand under the drape and 'clean' hand on top. The bladder is a sterile organ. Catheterisation requires the same aseptic precautions as a surgical procedure.
- Lubricate the catheter with the lubricant.
- Separate the labia with the non-dominant hand. To locate the urethral orifice ask the client to cough or bear down.
- Introduce the catheter. Insert the catheter gently approximately five (5) cms. Do not use force. The female urethra is approximately four (4) cms long.
- Resistance might be caused by spasm of the urethra, a stricture or obstruction. If resistance is felt the following strategies may be used:
    - ask the client to take a deep breath, then relax;
    - ask the client to cough; and
    - gently rotate the catheter.
- If these strategies fail, discontinue procedure and notify the GP.
- When the urine begins to flow into the container positioned between the clients thighs advance the catheter two (2) - three (3) cms. Advancing the catheter allows for the balloon to be inflated inside the bladder.
- Inflate the balloon with the correct amount of sterile water. Always ensure that the urine is flowing before inflating the balloon. If the balloon is inflated outside the bladder, urethral trauma and pain will result.
- Withdraw the catheter slightly until resistance is felt. This indicates that the base of the balloon is resting on bladder neck. Attach the catheter to the chosen drainage system / sterile catheter valve.
- Fix the catheter to the thigh with a catheter strap. This prevents yawing of the catheter which could result in:
    - introduction of infection; or
    - ulceration at pressure points (meatus, bladder neck).
- Ensure that the client is dry and comfortable. This is to avoid skin irritation and secondary infection.
- Take a urine specimen for examination if required. Urine for culture and sensitivity should be collected from the newly inserted catheter as bacterial colonisation of the catheter occurs within twenty-four (24) to forty-eight (48) hours of insertion.

- Remove gloves. Place in a bag. Use of Standard precautions to prevent environmental contamination.
- Dispose of equipment in a disposable plastic bag and seal the bag. Place bag in the garbage bin.
- Record the following documentation in clients care notes (electronically on Carelink+):
    - difficulty / ease of insertion;
    - reason for catheterisation;
    - catheter size and brand;
    - balloon size and amount of water to fill it;
    - date for the next catheter change; and
    - date for change of bag / valve.

Supra Pubic Catheterisation Procedure

NOTE: Always catheterise on a full bladder (contraindicated in clients who experience autonomic dysreflexia). This procedure relies on the 'clean hand, dirty hand' technique.

- Explain the procedure to the client to allay any fears and to obtain informed consent and cooperation.
- Ensure client's privacy.
- Position a disposable drawsheet under the client's buttocks and assist him / her to get into the supine position.
- Check the abdominal area and wash if excessive discharge is present.
- Wash / gel hands. Attach the syringe to the catheter and withdraw the water from the catheter balloon.
- Cover the client to maintain dignity and ensure that a good light source is available.
- Wash / gel hands. Put on plastic apron and protective eyewear. These are standard precautions for protection from splashing.
- Place all the equipment on the table / trolley / chair and move it to the bedside.
- Open the outer cover of the catheterisation pack and add the contents of the supplementary packs. The use of a complete pack, as listed reduces the risk of accidental contamination of equipment.
- Wash and gel hands. Hands may have become contaminated by handling the outer packs. Put on sterile gloves.
- Check balloon for patency. This is a quality control check.
- Lubricate the catheter.
- Ask the client / carer to fold back the bedclothes, if necessary.
- Use your 'clean' hand to irrigate the area around the catheter with the normal saline squeeze pack. Inadequate preparation of the orifice is a major cause of infection.
- Using an aseptic technique, drape the area with the fenestrated drape, 'dirty' hand under the drape and 'clean' hand on top. The bladder is a sterile organ. Catheterisation requires the same aseptic precautions as a surgical procedure.
- Hold the old catheter with the 'dirty' hand under the sterile drape. Remove the catheter and drop into the waste bag.
- Removal and immediate replacement of the catheter minimises the risk of the orifice spontaneously closing over.

- Insert the catheter, gently until urine flows. Advance the catheter two (2) cms. Do not use force. Advancing the catheter allows the balloon to be inflated in the bladder.
- Always ensure that the urine is flowing before inflating the balloon with the sterile water. If the balloon is inflated outside the bladder, trauma and pain will result.
- Withdraw the catheter slightly until resistance is felt.
- Attach the catheter to the chosen drainage system / sterile catheter valve. Fix the catheter to the thigh with an approved catheter strap, if applicable. This prevents yawing of the catheter which could result in:
    - introduction of infection; or
    - ulceration or granulation at the entry point.
- Ensure that the client is dry and comfortable to avoid skin irritation and secondary infection.
- Test a portion of the urine, if necessary. Take urine specimen for examination if required. Urine for culture and sensitivity must be collected from the newly inserted catheter as bacterial colonisation of the catheter occurs within twenty-four (24) to forty-eight (48) hours of insertion.
- Remove gloves and place in the bag. Use of standard precautions to prevent environmental contamination.
- Record the following documentation in clients home based health record or Carelink+ Care Note:
    - difficulty / ease of insertion;
    - reasons for catheterisation;
    - amount / colour of the urine;
    - date for change of bag / valve;
    - catheter size and brand;
    - balloon size and amount of water to fill it; and
    - date for the next catheter change.

Removal of a urinary catheter

- Take a bucket to the bedside.
- Wash / gel hands.
- Place a disposable sheet under the client's buttocks.
- Don non sterile gloves apron and goggles.
- Leg bag – remove straps and catheter strap.
- If client has a two (2) litre bag - place it in the bucket. If there is a catheter valve – leave it in situ.
- Insert the syringe in the valve of the filling line and allow the water to drain unassisted. Do not disconnect the syringe.
- Remove the catheter when the balloon is deflated.
- If it is a difficult removal - reinflate the balloon with the water in the syringe and allow the water to drain unassisted.
- Repeat the above until the catheter is able to be withdrawn.
- If the problem persists insert 0.2 mls of water into the balloon and try to remove in a twisting motion. The 0.2mls of water will straighten out any hysteresis the catheter has developed.
- If the problem still persists irrigate the shaft of the catheter and the urethral meatus using a sterile squirt pack of normal saline and a non-touch technique.

- Insert the nozzle of sterile anaesthetic lubricant at the meatus alongside the catheter and lubricate the meatus and area of the shaft that has been irrigated.
- Wait two (2) minutes and remove the catheter. If unable, contact the urology department for further advice.
- Drop the catheter bag or valve into the bucket.
- Ensure the client is clean and dry.
- Document all details relating to the intervention including the time of removal.
- Dispose of catheter and drainage system appropriately (rinse the valve if for reuse).

What to do if the urinary catheter bypasses

Check the following, any of these can cause bypassing of urine:

- Kinks in the tubing – The "Y" junction of the catheter and the tubing / bag junction are the most likely kink points.
- Loops in the tubing – urine stagnating in loops encourages colonisation of bacteria, which can lead to cystitis.
- Lack of catheter strap – allows movement of the catheter, resulting in friction, inflammation and infection.
- Balloon size – Balloons greater than five (5) – ten (10) mls result in detrusor contraction.
- Gauge size – Continued use of large gauge catheters causes patulous (open, distended) urethras.
- Bag suspension – Excessive pull on the catheter damages the urethra. Use catheter strap, harness, holster or bag stand.
- Drainage – Urine doesn't drain uphill! Keep catheter, tubing and bag BELOW the level of the bladder.
- Clots / debris in the bag – CHANGE the catheter if blocked, NEVER IRRIGATE, increase intake to 3000mls/day, unless contraindicated.
- Low fluid intake – Concentrated urine can irritate the bladder and cause blockage – fluid intake should be close to two thousand (2000) mls / twenty-four (24) hrs and urine faintly straw coloured.
- Genital inflammation – Genital infections (fungal and bacterial) can lead to urethritis and result in bypassing.
- Fistulas – Vesico / vaginal and urethro / vaginal fistulas can cause urine to bypass the catheter.
- Medication – Any medication that decreases urethral closure pressure or increases detrusor pressure can cause urine to bypass the catheter.
- Constipation – A full bowel and straining at stool can cause bypassing and dislodgment of the catheter.

NOTE: If all these strategies fail to identify the cause of the bypassing, consider detrusor instability or urinary tract infection. Refer to the client's GP as anti cholinergic medication or antibiotics might be needed.

Drainage system for urinary catheter

Choice of drainage system:

The drainage system should be chosen to suit the individual needs of the wearer and be in readiness on completion of catheterisation. An assessment of the

person's lifestyle, mobility, manual dexterity and cognitive abilities will help decide on the most comfortable and appropriate closed-system.

Procedure for changing catheter drainage bags

Equipment and requirements for changing catheter bag

- A plastic bag for disposing of rubbish including leg bag.
- Disposable sheet.
- Alcohol wipes (staff) or moist towelettes (self care)

Procedure and points to remember for changing catheter bag

- Wash / gel hands.
- Place disposable sheet (staff) or paper towelling (self care) under the connecting point of the catheter and the bag tubing to absorb any urine that spills.
- Put on protective eyewear and apron for work health and safety guidelines.
- Wash hands, put on non-sterile gloves. This is to protect the wearer and the client.
- Place the used urine bag in the plastic bag. This is to lessen the risk of bacterial contamination.
- Squeeze the opening of the catheter to keep it closed. Hold it in the non-dominant hand until reconnection is complete. This is to prevent spillage of urine.
- Disconnect the used bag; straighten the tubing to allow urine to drain into the bag. Place the tubing and bag in the plastic bag. Swab the end of the catheter with an alcohol wipe or moist towelette to reduce bacterial contamination.
- Remove the cover protecting the inlet connector of the new bag and immediately insert the connector into the catheter to regain the closed system of drainage.
- Ensure the catheter is draining correctly as loops and kinks in the tubing cause pooling of urine.
- The client should empty the urine into the toilet.
- Remove gloves and place in waste bag. Wash / gel hands. Document all details relating to the intervention in the clients care notes (electronically on Carelink+).

Instilling maintenance solution

- Explain the procedure to client
- Assist client into a supine position, ensuring privacy and modesty
- Put on disposable apron
- Wash hands with soap and water
- The Uro-tainer is supplied sterile. If desired bring solution to body temperature by immersing the wrapped sachet into luke-warm water.
- Open outer packaging to expose inner sterile solution container
- Apply alcohol gel and put on sterile examination gloves
- Remove inner sterile solution container
- Close the clip to prevent solution loss
- Remove the security ring on the solution container
- Disconnect urine bag from catheter

- Twist and withdraw cap without touching connector
- Open the clip and allow a few drops of the solution to flow into the catheter to remove any air locks
- Insert connector into the catheter and allow solution to flow into the bladder by gravity and ensure that the solution is higher than the bladder (DO NOT APPLY FORCE TO INSTIL SOLUTION)
- If the solution is to be retained in the bladder close the clip for the specified period, cover the exposed area of the client and dispose of the old urine drainage bag
- If you leave the client, discard gloves and wash hands. Before resuming the procedure wash hands and put on sterile gloves
- When the solution is to be removed, lower the bag below the level of the bladder, open the clip and allow the solution to drain back into the bag
- Close the clip and disconnect the solution bag and connect the appropriate sterile drainage bag
- Empty solution from bag into toilet and appropriate dispose of bag
- Document solution administered and any complications encountered

Using a Uro-tainer twin

- Explain the procedure to client
- Assist client into a supine position, ensuring privacy and modesty
- Put on disposable apron
- Wash hands with soap and water
- The Uro-tainer is supplied sterile. If desired bring solution to body temperature by immersing the wrapped sachet into luke-warm water.
- Open outer packaging to expose inner sterile solution container
- Apply alcohol gel and put on sterile examination gloves (polythene gloves are not appropriate)
- Remove inner sterile solution container
- Close the both tubes with green and white clamps
- Remove the security ring on the solution container
- Disconnect urine bag from catheter
- Twist and withdraw cap without touching connector
- Open the white clamp and allow a few drops of the solution to flow into the catheter to remove any air locks
- Insert connector into the catheter and allow solution to flow into the bladder by gravity and ensure that the solution is higher than the bladder. You may find that you will not be able to instil the full 30mls therefore (DO NOT APPLY FORCE TO INSTIL SOLUTION)

H. <u>Wound Care</u>

Clients will receive a wound assessment each time wound care is undertaken. Documentation of wound care assessment will occur using the Wound Care Assessment form shown in Appendix 3.

All community nurses within MCNS:

- recognise the importance of consistent individualised care and the need to include clinically effective techniques and wound dressing;

- provide a standardised approach to wound care within the framework of holistic care, with community nurses encountering a wide range of wounds;
- ensure the most appropriate product is utilised for optimum wound healing, client comfort and cost effectiveness;
- ensure no act or omission on the nurses' part leads to inappropriate management of a wound;
- attend wound dressings according to infection control and manual handling policy requirements; and
- ensure wound dressing procedures are attended to according to best practice guidelines and evidence-based Mercy Services– Wound Care Algorithms.

Procedures

Indications for wound management

Wound management will be provided to Mercy Services clients who require attendance of wound management by Mercy Services Nurses.

Equipment and requirements for wound management:

- knowledge and understanding of relevant wound care algorithm/s;
- appropriate wound products;
- disposable sheet / pillow, if required;
- appropriate personal protective equipment (PPE) i.e. gloves, goggles, and apron if risk of splash or spill;
- plastic bag for waste disposal;
- knowledge of infection control and manual handling requirements; and
- knowledge of WHS procedures.

Safe work procedures for wound management

Preparation of client:

- Explain the procedure to the client and obtain informed consent and co-operation.
- Explain the WHS and Manual Handling requirements.
- For lower leg wounds, client should be sitting with leg elevated or lying on a bed of suitable height with lower limb elevated.
- For sacral, lower back or abdominal wounds, client should be lying on a bed of suitable height.
- If the client's bed is not of suitable height, the Nurse should place disposable sheet / pillow on the floor and kneel to attend the dressing. If this is not possible the height of the bed may be elevated by the use of bed blocks. Referral for an Occupational Therapist assessment may be required.
- For all other wounds, position the client in a manner that ensures that the clinician avoids bending, twisting or stretching.

Preparation of clinical supplies

- Place clinical supplies on a flat, clean and clutter free surface.
- Have plastic bag for disposal of waste products nearby.
- Wash / gel hands.

Removal of soiled / current dressings

- Wear appropriate PPE, including gloves.
- Remove any adhesive tapes or dressing products with care to reduce risk of skin tears. The use of adhesive remover swabs is recommended.
- Dispose of all soiled dressing products into waste bag.

Wound care:

- Wash / gel hands and put on clean gloves.
- Attend dressing in accordance with clean techniques.
- Apply and secure the selected dressing product/s.

Waste management:

- Place all disposal items in the plastic bag.
- Remove PPE and place gloves and apron (if used) in plastic bag. Remove and clean safety goggles before returning to case or dressing box.
- Client disposes of the waste in their household garbage.

Completion of activity:

- Wash / gel hands.
- Any wound care aids or products that are to remain in the client's home must be placed into a resealable plastic bag.

Documentation - Record the following documentation in client's care notes (electronically on Carelink+):

- description of type and amount of exudate;
- description of wound appearance and condition including the surrounding area;
- pain – type, level and frequency;
- type of dressing product / process utilised;
- any management plan changes and rationale for same;
- any information provided by client / carer in relation to the wound since previous home visit;
- details of next scheduled visit / review date;
- any referrals or discussions with other health care providers while attending home visit; and
- changes to dressing products or dressing frequency are to be documented in the clients care plan in the home file and office file.

I. Medication Management & Administration

Mercy Services supports Registered Nurses (RNs) and Endorsed Enrolled Nurses (EENs) to clarify their roles, responsibilities and functions in relation to the administration and management of medications to clients in the community.

This document ensures that RNs and EENs are aware of, and understand, their responsibilities regarding the safe and accurate administration of medications;

reinforces the importance of detailed and accurate documentation pertaining to the administration of medications; and highlights legislative requirements for the administration and management of medications by RNs and EENs in the community.

RN/s and EEN/s will administer medication in accordance with current legislation, and are responsible for ensuring they have requisite knowledge and understanding of client and staff safety pertaining to the administration of medication/s.

Throughout this document, blister pack (e.g. "Webster Pak™") is defined as *a heat sealed tamper evident individual dose system of medication issue prepared by or under the direct personal supervision of a registered Pharmacist*.

Procedures

Eligible clients

Medication administration services are provided to Mercy Services clients who:
- cannot self-manage their own medication, and/or
- are without a carer who can provide assistance.

Prohibited activity

Community Nurses are **not** to fill or administer medications from a dosette type medication compliance aid.

Clients with mental illness

Clients with a history of mental illness should be referred to the Community Mental Health Team if they require:
- supervision / administration of their medications either following discharge from a mental health facility or following review or modification of medication type and dosage; or
- long-term supervision / administration of medications required to assist in the management of their mental health condition.

Medication requirements

MCNS administers and manages medication when it has been established that it is necessary for the Mercy Services client to have medication administered or managed in a community setting by a community nurse.

The Medication Assistance Checklist (Appendix 4) is used to ascertain how much assistance is required for the client to take each medication.

Medications must be labelled correctly (i.e. client's name, the name and strength of the medication, dosage frequency and route of administration).

If necessary a locked box is available for storage of client medications. Access is to be with a key or a combination lock (*see "Containment Devices")*

A current legible medication authority must be available.

Safe work procedures for medication management and administration

1. Medication authorisation

A medication authorisation is required for any medication that is ordered by a Medical Officer (MO) and requires the provision of a prescription to enable the client to obtain these medications from a pharmacy. This includes topical creams and applications.

If a medication authorisation is unclear, ambiguous or incomplete, the RN responsible for the client's case management must clarify the instructions with the requesting MO and return the document for modification.

Written authorisation

Administration of medications or supervision of clients self-administering medications, by a Community Nurse is not to be attended without a written legible authorisation from a MO. This authorisation should be on a Mercy Services medication chart (see appendix 4) when possible. If this is not possible, appropriately completed medication authorisations from the referring hospital or doctor are acceptable. If a prescribing MO does not have access to the Mercy Services document, a hand written authorisation is acceptable, but must include the following:

1. Client name – Surname and other names
2. Date of birth
3. Allergies or adverse drug reactions, if none, must note *Nil Known Allergies / Adverse Drug Reactions*
4. Date administration of medications is to commence
5. Name of medication, dose, route and frequency
6. Date medications are to cease or be reviewed
7. Signature of MO / Nurse Practitioner (NP), including a printed version of that signature.

The Medication Chart provides authorisation for administration by a Community Nurse of MO prescribed medications.

As a minimum requirement, written medication authorisations for **ALL** clients must be reviewed and updated by the client's General Practitioner (GP) or relevant NP/MO every twelve (12) months. The authorisation must also be updated when a MO has reviewed the client's medications and altered them in any way.

Outdated Medication charts must be removed from the client home progress file and placed in office client medical record.

Verbal authorisation

A MO may give a medication order by telephone or facsimile and forward the original to the MCNS. The community nurse must ensure that an original written authorisation is placed in the clients home based medical record upon receipt and the facsimile copy is removed and added to client office medical record.

The community nurse may give the medication that was authorised verbally / via facsimile, and must note in the client's care notes (electronically on Carelink+) that it was a verbal / facsimile order and sign and date the entry.

A facsimile is merely an alternative to, or additional clarification of a telephone order. It cannot be used as either the nurse's record of administration or the medical practitioner's confirmation of the order. (NSW Health, pd2005_105)

2. Containment Devices:

Locked Boxes

A locked box will be required when secure storage of medications is necessary for client safety. The locked box may be used to store labelled bottles / vials / blister packs of medication dispensed by a pharmacist. The client / carer will be requested to supply the locked box. Access to the locked box will be limited to the community nurse, relevant pharmacy staff and carer. The community nurse is to be supplied with access to a key or the combination code to the locked box.

The combination code and/or location of keys are to be recorded on the client information form and are not to be noted in clients' home progress file.

Pharmacies are to be provided with information of location of locked boxes, keys or combination codes so as they can place medication into the locked box. Either the carer or the community nurse can provide this information.

Administration of Medications

Responsibilities of all nursing staff

- Check that medication is being administered to the correct client and exclude known drug allergies;
- Check medication/s expiry dates, if required, and presence of package tampering;
- Ensure medication/s and pharmacy labelling are consistent with current MO's medication authorisation;
- If there are any discrepancies, the community nurse is to contact the MO / GP for clarification and obtain a verbal order if documentation / labelling is incorrect. When this occurs, the community nurse must then follow the instructions as outlined in authorisations – verbal. Document clearly and accurately the outcome of MO / GP contact and any instructions given. Administer only medication/s as prescribed on medication authority.
- When community nurses are administering medication to a client from the client's individually dispensed labelled containers, it is considered best practice for the medical practitioner to provide written confirmation of the client's medication.
- Clearly and accurately document the administration of the medication/s.
- RNs and EENs must not administer, or prompt clients to take, medications from anything other than labelled pharmacy containers.

Nurse initiated medication

Nurses may administer some medication that is referred to as 'nurse initiated medication'. Nurse initiated medication is the administration of **non-prescription**

(over the counter) medication/s by a nurse qualified to administer medications when the need arises and with the prior agreement of the client's GP / MO.

Registered Nurses

The RN has an accountability and responsibility to have a working knowledge of the medication being administered and its effects.
The RN will use clinical judgement to assess if medications should be administered or withheld in view of clients' clinical status e.g. withhold insulin dose from a client with a low blood glucose level. In this instance, the MO must be contacted and informed of the client's health status and the RN should follow direction/s provided regarding medication administration.

If a dose is not taken for other than predetermined or prescribed reasons, such as refusal, the registered nurse must consult the prescribing MO.

The RN must provide supervision and direction for medication administration by an EEN.
First Dose Medications:
The RN administering prescribed substances must know the intended, and potential for non-intended, effects of the substance in order to assess response and initiate appropriate action.
First dose medication is not to be delegated to the EEN.

Endorsed Enrolled Nurses:

An "endorsed" enrolled nurse is a person:

- who has successfully completed a Nurses and Midwives Board (NMB) of NSW accredited course that includes a medication component, **OR**
- to whom the NMB of NSW has issued with an enrolled nurse endorsement of the administration of medications either by a notation on the EENs *Authority to Practice* certificate, or, an original letter from the Board stating that the nurse has successfully completed an accredited medication course and is endorsed for this practice. In this case, the Board will endorse the nurse's *Authority to Practice*, when next issued.

All enrolled nurses will continue to practice under the direction and supervision of the registered nurse and will administer medications in accordance with conditions outlined in the NSW Health Policy (pd2005_343).

The conditions under which an EEN must practice include:

- **Category 1 –** EENs who hold a Certificate IV or equivalent and are undertaking a post enrolment clinical assessment in medication administration approved by the NMB of NSW leading to medication endorsement.
- **Category 2 –** EENs who have completed the NSW College of Nursing Medication Administration for Enrolled Nurses Certificate of Attainment. EENs in this category will administer Schedule Two (2) and Three (3) medications (other than by injection) in accordance with their level of education, expertise and authorisation under the supervision of an RN.

- **Category 3 –** ENs who have successfully completed a NMB accredited medication course and have been issued with an endorsement by the NMB for the administration of medications.

Administration of medication by categorised enrolled nurses:
Category 1: The EEN may administer medications by all routes **(other than S8)** as required to complete the assessment requirements of the course under the **DIRECT** supervision of an RN. The RN assessing the EEN must be orientated to the clinical practice and assessment requirements of the NMB of NSW approved course. EENs in Category One (1) who administer medications under Category Two (2) of this guideline will continue to function in this role.

Category 2: The EEN may administer unscheduled, Schedule Two (2) and Schedule Three (3) medications, when and only when ALL of the following criteria apply.
The medication:

- has been prescribed in writing by a MO / NP, except in the case of unscheduled, Schedule Two (2) and Three (3) medications;
- is administered under the direction and supervision of the RN responsible for the care of the client and is informed of the administration of the medication;
- is given by route other than injection;
- Is included on a list of substances approved to be administered by EENs in specified circumstances;
- following completion of six (6) months full time equivalent post enrolment experience; and
- the EEN has completed the drug assessment according to their level of practice (if applicable).

Category 3: The EEN may administer unscheduled, Schedule Two (2), Schedule Three (3) and Schedule Four (4) medications via all routes, when and only when ALL of the following criteria apply. The summary and conditions in NSW Health Circular 2005_343 are met. These include:

- accreditation for administration of medications;
- ongoing annual competency assessment and accreditation for administration of intravenous medications;
- a MO have prescribed the medication in writing, except in the case of unscheduled, Schedule Two (2) and Schedule Three (3) medications. (Refer to Appendix 2);
- RNs are informed of the EENs who are endorsed by the NMB of NSW to administer medications; and
- NMB endorsed EENs must administer medications according to the Endorsed Enrolled Nurse guidelines which follow in *Endorsed Enrolled Nurse Guidelines.*

Endorsed Enrolled Nurse Guidelines:
"Supervision" means the direction and guidance given by a RN to an EEN. This supervision may be direct or indirect according to the nature of the work delegated to the EEN. (PD 2005_047, page 3)

- The EEN will, at all times, work under the direction and supervision of the RN.
- At all times, the EEN retains sole responsibility for their actions and remains accountable to the RN.
- The EEN has a responsibility to have a working knowledge of all medication being administered and their effects.
- The EEN may administer some nurse-initiated medications, (refer to Appendix 1), provided they have checked with the supervising RN, prior to administration, that the medication is appropriate and safe for the client.
- The EEN may *not* withhold or administer any PRN medication without consulting the RN.
- The first dose of any medication **is not** to be attended by the EEN.
- *Intravenous medication* – an RN, preferably the RN who is supervising the EEN, checks all medications prior to administration. This check **is not** to be attended by a second EEN. The check must include the drug, dose, dilution, calculations, intravenous fluid, infusion device setting and the client identity, according to the MOs / NPs medication order.

Medication error
If a medication error occurs the client's GP will be contacted and informed of the error.

The error will be noted in the client's care notes (electronically on Carelink+).

An incident form will be completed for management.

J. Pain Management

Clients will be asked about their experience of pain as it relates to the condition being treated and the interventions provided by Mercy Services nurses.

Nurses will recommend clients take paracetamol where the pain is mild or a temporary consequence of the nursing intervention.

Nurses will recommend clients discuss other pain with their GP. If appropriate, and with the client's permission, the nurse may discuss pain management with the client's GP.

4.12 Compliance

Compliance with this policy is being measured by:

a) all nurses have current registration; and
b) at least 90% compliance scores in audit of MCNS client files.

4.13 Evaluation

The performance indicators for the evaluation of this policy are:

a) 0% of Incidents highlighting breaches of infection control procedures; and

b) at least 75% satisfaction rating from MCNS clients in Mercy Services biennial Client Satisfaction Survey.

5.0 REFERENCES

1. Current issues	a) None identified
2. Australian Standards	a) nil
3. Legislation	a) Nurses and Midwives Act and Regulations esp. clause 33 b) Health Practitioner Regulation National Law Act 2009 (Cth) c) Health Records and Information Privacy Act, 2002 (NSW) d) Work Health Safety Act, 2011 (NSW) e) Work Health Safety Regulations, 2011 (NSW)
4. Professional guidelines	a) nil
5. Codes of Practice	a) National competency standards for the registered nurse http://www.anmc.org.au/userfiles/file/RN%20Competency%20Standards%20August%202008%20(new%20format).pdf
6. Codes of Ethics	a) Australian Association of Social Workers Code of Ethics http://www.aasw.asn.au/document/item/1201 b) Australian Psychological Association Code of Ethics http://www.psychology.org.au/Assets/Files/Code_Ethics_2007.pdf c) The Nursing and Midwifery Board of Australia. Registration Requirements http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx d) Integrity in the Service of the Church https://www.catholic.org.au/media-centre/media-releases/cat_view/10-organisations/38-national-committee-for-professional-standards e) Mercy Services Code of Conduct
7. Evidence	a) **Foot care** • Podiatry Association NSW Australia. "Podiatry and Your Feet". • NSW Nurses' Association 2001 Guidelines on Provision of Basic Foot Care by Nurses http://www.nswnma.asn.au/wp-content/uploads/2013/07/Guidelines-on-Provision-of-Basic-Foot-Care-by-Nurses.pdf b) **Infection control** • Communicable Diseases Network of Australia (2001). Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting. Canberra: Australian Government Publishing Services. [Draft]. • National Health and Medical Research Council and Australian National Council on AIDS. (1996). Infection control in the health care setting. Guidelines for the prevention of transmission of infectious diseases. Canberra: AGPS. • Health Department of Western Australia. (1998). Guidelines for infection control in non-teaching health care establishments. Perth: Disease Control. c) **Urinary catheterisation** • Catheterisation – Male. Hunter New England Area Health Service. Manning Rural Referral Hospital – Clinical Competency. http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0019/44641/Catherisation-Male_1207.pdf • A Practical Guide to Urinary Catheterisation. Hunter Area Health Service. Lloyd, G. & Watts, W. 2003. http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0017/34316/Nurse_UrinaryCatheterisationManual.pdf

	• A Practical Guide to Continence Promotion. Hunter Area Health Service. Lloyd, G. & Watts, W. 2003. http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0019/33337/Nurse_ContinenceGuide.pdf • Infection Control Manual - 2004. Hunter Area Health Service, Chapter 12 – Specimen Collection, page 6-7. http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0008/40859/Standard_12_Specimen_Collection.pdf d) **Wound management** • CIAP. Wound Care Association of NSW Inc. http://www.ciap.health.nsw.gov.au/wcansw/download.html • Correct Patient, Correct Procedure and Correct Site. NSW Department of Health. http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_079.pdf • Wounds West. http://www.health.wa.gov.au/WoundsWest/home/ • Infection Control Policy. NSW Department of Health. http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_036.pdf • Manual Handling Incidents – NSW Public Health Services – Policy / Best Practice Guidelines Prevention. NSW Department of Health. http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_224.pdf e) **Medication management** • Australian Pharmaceutical Advisory Council (2006) Guiding principles to achieve continuity in medication management http://www.health.gov.au/internet/main/publishing.nsf/Content/4182D79CFCB23CA2CA25738E001B94C2/$File/guiding.pdf
8. Mercy Services Values	a) Justice, Respect, Care, Unity, Service

6.0 OTHER RELATED POLICIES

- A.01 Mission and Philosophy
- A.03 Code of Conduct (staff and volunteers)
- C.04 Program performance and monitoring
- C.05 Quality Improvement
- E.01 Service Guarantee
- E.02 Service Access and Equity
- E.03 Meeting Individual Needs
- E.04 Client Fees
- E.05 Client Participation, Decision Making & Advocacy
- E.06 Involvement of Families and Friends
- E.07 Behaviour Support
- E.08 Complaints
- E.09 Client Records
- E.11 Coordination with other services
- E.13 Cultural Awareness
- E.14 Duty of Care
- E.15 Privacy
- E.16 Protection of vulnerable adults from abuse and neglect
- F.03 Recruitment
- F.04 Learning and Development
- G.06 Safe Home Visiting Policy & Procedure
- G.08 Infection Control
- G.15 First Aid

7.0 RELATIONSHIP WITH STANDARDS

Aged Care Accreditation Standards	*Home Care Standards*	*Disability Standards*	*EQuIP Standards*

Not applicable	*1.4, 1.5, 2.1, 2.2, 2.3, 2.5, 3.1, 3.2, 3.3, 3.4, 3.5*	*1.1, 1.3, 1.4, 1.9, 2.4, 2.5, 3.1, 3.2, 3.4, 3.5, 4.1, 4.2, 5.2, 6.1, 6.2, 6.3*	*1.1.2, 1.1.3, 1.6.1, 1.6.2, 1.6.3,*

8.0 DOCUMENT CHANGES RECORD

Dates of change	***Section altered***	***Natures of changes made***
June 2005	All previous Mercy Services Community Nursing Policy and Procedures	Document created
16/08/2010	All sections	Major re-write
25/03/2011	7.0 Relationship to Standards	Replace HACC Standards and CACP Standards with Community Care Common Standards and update to EQuIP 5 Standards
11/05/2011	a) 4.3 b) 4.11.H c) 4.11.J d) Appendix Two	a) Removal of DVA clients from eligibility list b) Specify that gloves are worn when removing soiled/current dressing and that wound care requires clean NOT aseptic technique c) New Pain Management section added d) Referral to OT added where pressure area risk exists
19/03/2012	a) 4.12 Compliance and 4.13 Evaluation b) 5.0 references	a) New sections b) Updated legislation, added medication management evidence, added current issues section
26/11/2012	All Sections	Organisation name updated
19/04/2016	a) All sections b) 2.0 Scope c) 3.0 Policy d) 4.04 Entry point for MCNS e) 4.07 Client Agreement f) 4.10 Refusal by client of treatment g) 4.11 Specific nursing practices (c)Foot Care h) 4.11 Specific nursing practices (f) Specimen collection i) 4.11 Specific nursing practices (i) Medication Management and Administration j) 5.0 References k) 6.0 Other Policy l) 7.0 Relationship with Standards m) Appendices	a) Replace GM with CEO, replace OH&S with WHS, replace TCM with Carelink+, replace BSL with BGL, replace pressure ulcer with pressure injury b) Rewritten c) Delete section on HACC d) Replace Access Point with My Aged Care and delete section on internal referrals (as these now go via MyAgedCare) e) Change types of documentation given to and completed with client f) Change “next of kin” to contact person g) Update details from NSWNMA Guidelines on Foot Care and update agency that sterilises instruments h) Change infection of catheter to infection of bladder i) Remove people with cognitive impairment and people who cannot access pharmacy from list of eligible clients. Under medication requirements delete paragraph on Blister Packs. Under Containment devices delete section on Blister packs. Under Administration of medications delete 2nd and 3rd last points j) Update legislation, Codes of Ethics and Evidence (Foot Care) k) Update list l) Update Disability Standards

		m) Update with Mercy Services logo and 3 points of client ID
21/06/2017	G. Urinary Catheterisation	Add a section on instilling maintenance solution and a section on Using a Uro-tainer twin
Review due 21/06/2020		

Appendix 1.

Community Nursing Service
Basic Footcare and Assessment Form

Client name: _____ **DOB:** _____/_____/_____

Client address: _____

This form is to be used for the initial assessment and for annual review.

REFERRING AGENCY:	ASSESSMENT DATE:
GP:	ALLERGIES:

CHIEF FOOT REQUEST:

1. HISTORY			
a.	Numbness & or burning in feet	Yes No	1 0
b.	Past history of undetected Foot / leg injuries	Yes No	1 0
c.	Past history of ulceration or amputation	Yes No	3 0
d.	Smoker	Yes No	2 0

2. EXAMINATION			
a.	Pulses present	Yes No	0 1
b.	Feet / toes cyanosed	Yes No	1 0
c.	Light touch present on dorsum of toes (use cotton wool)	Yes No	0 1
d.	Is there any foot deformity? Hammer toes, bunions, arthritic joints	Yes No	1 0
e.	Are there any lesions present? Current leg ulcers, blisters, calluses, corns, rubbed areas	Yes No	2 0

4. NAILS	**Right foot**	**Left foot**
Thickened	Yes / No	Yes / No
Infected	Yes / No	Yes / No
Ingrown	Yes / No	Yes / No
Pain on dorsal pressure	Yes / No	Yes / No
Pain on lateral pressure	Yes / No	Yes / No
Detached from nail bed	Yes / No	Yes / No
Discoloured	Yes / No	Yes / No

3. FOOTWEAR	
Type of shoe worn	
Adequate fit	Yes / No
Type of socks worn	
Adequate fit	Yes / No

4. VISION		
Can the client see effectively or do they require glasses? e.g. for cutting own nails.	Yes No	0 1

5. MOBILITY		
Can the client reach their feet?	Yes No	0 1

RATING	
Preventative foot education – initial assessment and education advised	Less than 5
Annual monitoring of feet by GP, Podiatrist and diabetes educator	5- 9
AT RISK patient must be reviewed by diabetes CNC, Podiatrist and GP at least every 6/12 months. - **No foot care will be attended by the RN.**	10+
If the client responded YES to question 2e* they must see a GP and Podiatrist ASAP. - **No foot care will be attended by the RN.**	*

TREATMENT PLAN			
Basic foot care provided			Yes / No
Follow up provided			Yes / No
Requires Referral to**:**	**GP** ☐	**PODIATRSIT** ☐	**DIABETES EDUCATOR** ☐

COMMENTS

Appendix 2.

Community Nursing Service
Nursing Pressure Area Assessment

Client name: _____ **DOB: _____/_____/_____**

Client address: _____

Allergies:

Assessment Type:	New referral ☐ · Re-assessment ☐	**Assessor**_____ **Date**_____/_____/_____

- **Refer to Mercy Services Policy on Pressure Ulcers**
- **Document skin integrity on admission to the service**
- **Document pressure relieving interventions on care plan**
- **Document any abnormality in skin integrity during clients stay with service**
- **Document client's skin integrity on discharge/transfer to another service or hospital**

Skin Integrity

Time and date of injury or fall (if applicable)_____

Is there evidence of any reddened area(s) or a break in skin integrity? Yes ☐ No ☐
(If **Yes**, complete **Wound Management Chart** and attend **scale**)

Has there been a history of previous pressure injury? Yes ☐ No ☐
(if **Yes**, this client is **deemed at high risk** and an **alert should be raised)**

Please complete assessment scale on reverse side

SCALE: (Score more than **10** indicates serious risk of pressure sores)

Build/Weight for Height		**Appetite**		**Continence**	
Average	0	Average	0	Complete/catheterized	0
Above Average	1	Poor	1	Occasional incontinence	1
Obese	2	Fluids only	2	Incontinent of faeces	2
Below Average	3	Anorexic	3	Double incontinence	3
Skin Type and Visual Risk Areas		**Tissue Malnutrition**		**Sex**	
Healthy	0	Terminal cachexia	8	Male	1
Tissue paper	1	Cardiac failure	5	Female	2
Dry	1	Peripheral vascular∆	2		
Oedematous	1	Anaemia	2	**Age**	
Clammy (temp)	1	Smoking	1	14 - 49	1
Discoloured	2			50 – 64	2
Broken/spot	3			65 – 74	3
				75 – 80	4
				81+	5
Mobility		**Neurological Deficit**		**Medication**	
Fully	0	*eg* Diabetes	4 – 6	Cytotoxic	4
Restless/Fidgity	1	MS	4 – 6	High dose steroids	4
Apathetic	2	CVA	4 – 6	Anti-inflammatory	4
Restricted	3	Paraplegia	4 - 6		
Chair bound	5				
Bed Bound	6				

TOTAL SCORE:

(10 + at risk 15 + high risk 20 + Very high risk)

Mercy Services

Appendix 3

Community Nursing Service
Wound Assessment Part 1

Mercy Services

Client name: _____ **DOB:** _____/_____/____

Client address: _____

GP:_____ GP contact no:_____

General Healing Assessment

Factors that inhibit healing
❑ Diabetes† ❑ Poor vascularity † ❑ Rheumatoid arthritis ❑ Smoking †
❑ Anaemia† ❑ Inflammatory bowel† ❑ Foreign bodies † ❑ Malignancy†
❑ Other †
Comments:……...

Medications
❑ Steroids † ❑ Cytotoxics† ❑ Immunosuppressant's† ❑ NSAID's†
❑ Antibiotics† ❑ Other …….

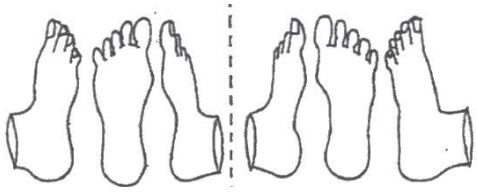
Nutritional status
❑ Good† ❑ Average† ❑ Poor†

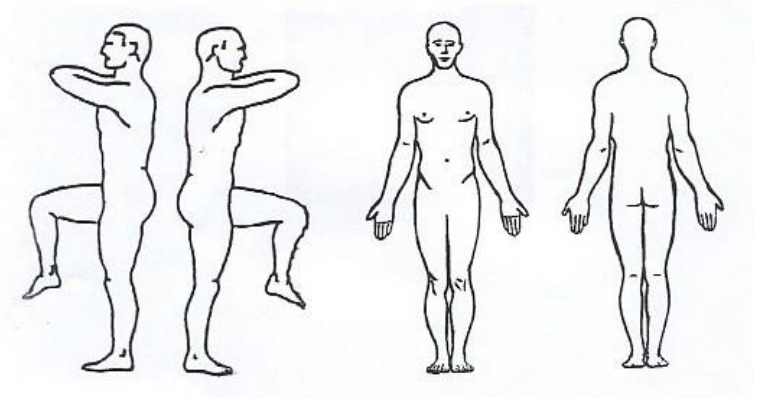
Recent weight loss……kgs. Recent weight gain……kgs.

Mobility
❑ No limitations† ❑ Slightly limited† ❑ Very limited† ❑ Immobile†
Comments:……

Diagnostic Investigations (list and date procedure and results)
❑ Wound swab† ❑ Result† ❑ Action† ❑ Antibiotics†
❑ Other †
Comments:……

Sites





Wound type

❑ Pressure † ❑ Abrasion † ❑ Laceration † ❑ †Other ……

❑ Burn † ❑ Ulcer † ❑ Post operation

Wound site: _____

Aetiology : _____

Duration: _____

Allergies: _____

Attach wound tracing to assessment sheet - note any sinus tracks

	Date:	Date:	Date:	Date:
Location				
Dimensions:				
Width	_____cms	_____cms	_____cms	_____cms
Length	_____cms	_____cms	_____cms	_____cms
Depth	_____cms	_____cms	_____cms	_____cms
Appearance				
Necrotic	❑ _____	❑ _____	❑ _____	❑ _____
Sloughy	❑ _____	❑ _____	❑ _____	❑ _____
Infected	❑ _____	❑ _____	❑ _____	❑ _____
Epithelisation	❑ _____	❑ _____	❑ _____	❑ _____
Granulation	❑ _____	❑ _____	❑ _____	❑ _____
Exudate - Amount	❑ nil † ❑ low ❑ mod † ❑ heavy	❑ nil † ❑ low ❑ mod † ❑ heavy	❑ nil † ❑ low ❑ mod † ❑ heavy	❑ nil † ❑ low ❑ mod ❑ heavy
Type:				
Serous	❑ _____	❑ _____	❑ _____	❑ _____
Haemoserous	❑ _____	❑ _____	❑ _____	❑ _____
Purulent	❑ _____	❑ _____	❑ _____	❑ _____
Odour	❑ _____	❑ _____	❑ _____	❑ _____
Surrounding skin				
Healthy	❑ _____	❑ _____	❑ _____	❑ _____
Erythema	❑ _____	❑ _____	❑ _____	❑ _____
Oedematous	❑ _____	❑ _____	❑ _____	❑ _____
Macerated	❑ _____	❑ _____	❑ _____	❑ _____
Fragile	❑ _____	❑ _____	❑ _____	❑ _____
Dry	❑ _____	❑ _____	❑ _____	❑ _____
Dermatitis/Eczema	❑ _____	❑ _____	❑ _____	❑ _____
Other	❑ _____	❑ _____	❑ _____	❑ _____
Pain	_____	_____	_____	_____
Severity(score0-5)	❑ Intermittent †	❑ Intermittent †	❑ Intermittent †	❑ Intermittent †
Frequency	❑ Continuous †	❑ Continuous †	❑ Continuous †	❑ Continuous †
RN Signature				

Appendix 4:

Community Nursing Service
Medication Chart

Client name: _____ DOB: _____ Client address:_____

GP:	**Allergies:**

Drug (generic name) **GP signature(print & sign)**	**Dose:** **Frequency**: **Route:** **Date:**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Drug (generic name) **GP signature(print & sign)**	**Dose:** **Frequency**: **Route:** **Date:**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**

Doctors Instructions: .....
.....
.....