- Transport was raised as an issue due to the length of time on the buses, taxis and the healthcare needs of the young people during this time.
- Students with complex physical care needs who require equipment and therapies at school need to have established links between school, Therapy ACT and the Hospital Loan Service.
- Parents to have input into selection of staff that will provide their young person's personal care.
- Training of school staff in providing personal care at school was raised.
- The number of people a family has to get feedback from every day in relation to their child's day a school.
- Will Education and Training policies be updated to facilitate the proposed model?
- Staff training to meet complex and invasive healthcare requires a lot of time, family would like input into staff training to feel confident in their skills.
- Transition planning and support from hospital to school to hospital.
- Students with cancer who have long absences from school due to illness and treatments need to have not only their educational needs met but also their social and emotional needs as well as their feeling of still belonging to their school. There is no framework to support these students it is dependent on individual teachers and school as to what support is given.

Community Consultation Feedback and Submissions

Feedback forms: Two returned

1. All questions ticked as *very important* and this comment; *It is the times when things wrong that higher levels of care are required. The system must be able to manage the extremes as well as the norm.*

2. All questions ticked as *very important* and comments written for each section.
   - ✓ *We are not confident that our child's ongoing healthcare needs will be met under the proposed system.*
   - ✓ *Highly skilled medically qualified staff i.e. nurses are a vital requirement to ensure our child's ongoing healthcare needs are met.*
   - ✓ The 3rd question was altered to read 'Registered nurse support for (Staff) removed and replaced with Child' then this comment; *Our child requires Medical intervention at least 4-5 times a day.*
   - ✓ *The same care-givers give us a sense of security that our child is safe while at school.*
   - ✓ *Having the nurse/s contact us when our child requires medical intervention adds to the feeling of security*

The general comment; *The fact that the only Special School that caters for high-school aged students on the southside of Canberra does NOT have a similar level of care-givers as the school on the northside is a matter of discrimination, lack of planning, and holds the parents of disabled children on the southside in contempt, severely limits the options available to them, and forces them into situations that are untenable.*

Submissions

MISSINGSCHOOL Keeping Seriously Sick Kids Connected; wrote a comprehensive well referenced submission that focused on the wellbeing of students who have critical and chronic illness and experience long absences from school. They welcomed the partnership approach between Directorates, students' families and health professionals in developing healthcare plans. The main focus involves the educational needs and the student connection to their peers and school.

A recommendation that meets the complex and invasive healthcare model in school was to have a process to recognise a medical need that has a sudden onset and make the appropriate referrals in a timely manner.

E-mails received

Two related to Missing school with concerns about the students staying connected to their school and peers.

An e-mail from a gentleman in Queensland focused on the provision of support teachers to students resuming their studies after illness.

An e-mail was sent out through the education network requesting feedback to enable the Australia Education Union to provide an accurate perspective for the consultation process. No submission was received.

The issues and concerns that were raised during the community consultation around therapies, personal care and long absences from school are beyond the scope of this project. However, they are obviously important to the community and should be considered by the Education and Training Directorate and relevant government agencies as another partnership relationship.

What next?

The findings of this community consultation and the research done as part of this project are being used to inform the development of a model for meeting the complex and invasive healthcare needs of students in ACT schools with the view to piloted in 2013.

Appendix 1: Power Point Presentation

Meeting Healthcare Needs in ACT Schools

Our Aim

- build capacity and sustainability with enhanced healthcare services
- provide best practice healthcare that is equitable with all students having access to the appropriate supports in ACT schools.

Background

- increasing demand for healthcare in schools
  - ✓ nationally one third of students will require healthcare
  - ✓ Similar trends in ACT
- increasing challenges to provide evidence based, equitable and sustainable care
- declining numbers of health professionals

Currently in ACT Schools

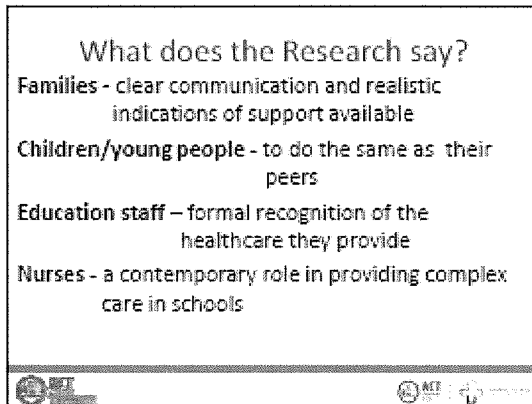
- student maybe identified requiring complex healthcare
- once identified there is no cross government framework
- Lack of sufficient data for identifying the extent of complex healthcare needs or the way in which the care is provided

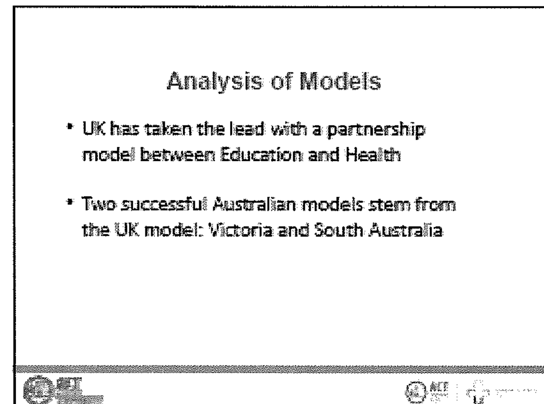
Currently in ACT Schools

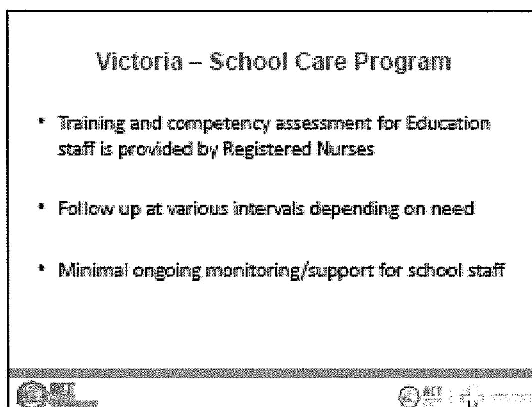
- The Health Directorate provides nurses in various roles in some ACT Schools:
  - ✓ three specialists schools
  - ✓ four nurses providing adolescent health promotion
  - ✓ some isolated individual situations
- other services
  - ✓ universal kindergarten screening
  - ✓ School immunisation program

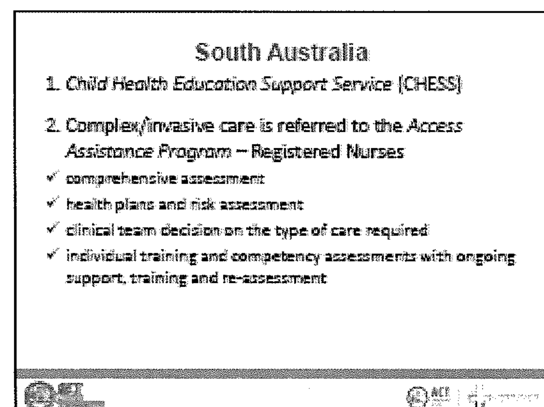
Work to date

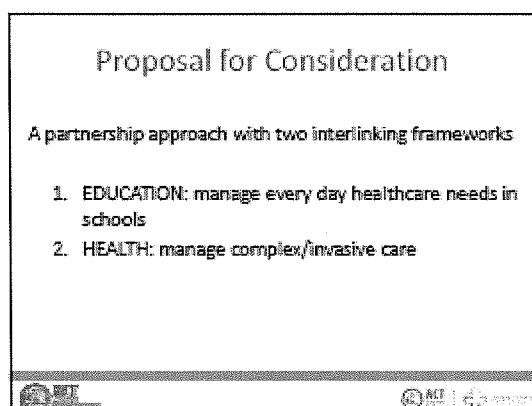
- A partnership with Education and Health
- A health project officer appointed
- Research incorporating overseas and national information
- Steering Committee established
- Site visits to South Australia and Victoria
- Working group established
- Consultation process

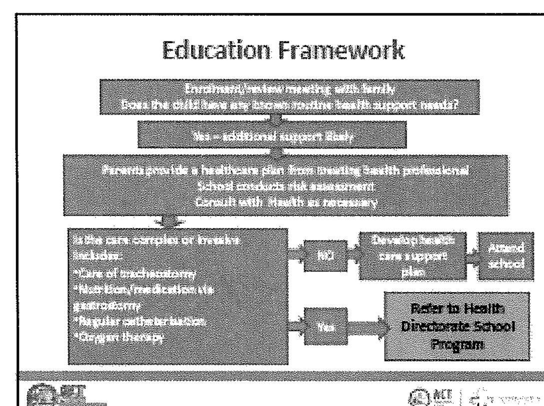












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Health Framework

- Referral received from school – care is complex or invasive
- Registered Nurse contacts parents to discuss healthcare needs and develop support plan
- Referral tabled at team intake meeting. Health support plan ratified or if discrepancies between support plan and parent request, elevated for higher level review
- Registered Nurse contacts school:
  *Environmental assessment conducted
  *Staff requirements identified – education, guidance and ongoing support
  *Communication pathway established – linking home/school/nurse/other health professionals
  Ongoing monitoring and review strategies established
- Student attends school

Models of Care

The framework will be supported by:

- a comprehensive, integrated model
- consistent responses with
  - ✓ clear definition of roles and responsibilities
  - ✓ standardised assessment tools
  - ✓ levels of care required

Useful websites

- http://www.chess.sa.edu.au/index.htm
- http://www.education.vic.gov.au/management/governance/spag/default.htm
- http://www.education.vic.gov.au/healthwellbeing/wellbeing/disability/programsupp.htm
- http://www.det.act.gov.au/publications_and_policies/policy_a-z

List of References

- [illegible]
- [illegible] Health Support Planning for Children and Students with Complex and/or Invasive Health Care Needs.
- Student medical and health care. Administration of medication. Training and Credentialing of staff [illegible]
- [illegible]
- [illegible]
- Complex Needs. [illegible]
- [illegible]
- [illegible]
- [illegible] The Journal of School Nursing [illegible]
- [illegible] The Journal of School Nursing [illegible]

Where to from here?

healthcareinschools@act.gov.au

Appendix 2: Fact Sheet and Comparison Table

MEETING HEALTHCARE NEEDS IN ACT SCHOOLS

What we want to do

Provide all students access to appropriate health care support by working in partnership with the schools, families' and their health professionals.

Why the need for change

Families have the right to choose the school their children attend this can include schools without health care professionals.

The current system to provide complex healthcare lacks equity and sustainability.

There is a need for cross government funding to staff and resource the student's healthcare needs in schools.

What is proposed?

After reviewing international and Australian research as well as looking at the unique needs of the ACT, we have put forward a framework for consideration (see adjacent charts).

The foundation is an alliance between Education and Health with two interlinking frameworks:

1. EDUCATION: manage every day healthcare needs in schools
2. HEALTH: manage complex/invasive care

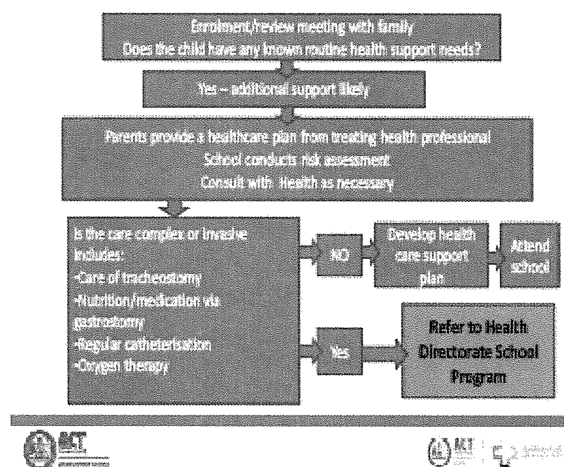
The framework will be supported by a comprehensive, integrated model that links schools, students, parents and their health professional. Allowing for consistent responses to complex healthcare needs with clear definitions of roles and responsibilities and the level of care required and who will provide the service.

More information

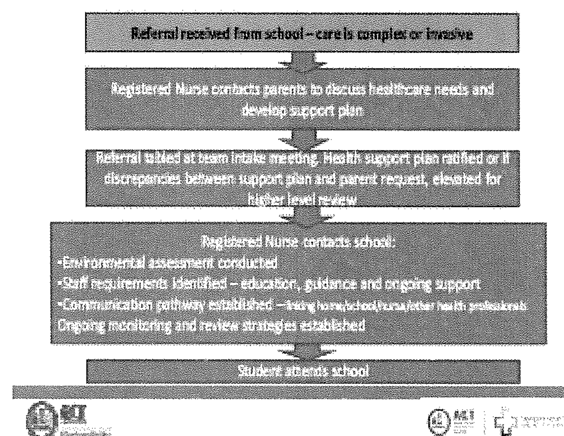
A discussion paper giving details of the project and suggested model is available on the Health Directorate's websites
http://www.health.act.gov.au/consumer-information/community-consultation/

Education and Training Directorate website.
http://www.det.act.gov.au/publications_and_policies/publications_a-z

Education Framework



Health Framework



We welcome your feedback

Please see over page for details on giving feedback.

November 2012

Giving feedback

Your comments and suggestions are welcomed and can be given by email (complete, save and then attach this questionnaire or just write your comments) at healthcareinschools@act.gov.au

or

Complete questionnaire and place in the feedback box near the door for Community Consultation sessions

or

Complete this questionnaire and send to: 'Meeting Healthcare Needs in ACT Schools'
GPO Box 825, Canberra ACT 2601

Completing the following questions will assist us to understand your needs. Please mark the appropriate box and comment on the following points:

What makes you feel confident that your child/young person is having their healthcare needs met while they are at school?

1. Always included in talks about my child/young person's healthcare at school

€very important €somewhat important €not important

....

....

2. Skilled staff

€very important €somewhat important €not important

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3. Registered Nurse support for staff

€very important €somewhat important €not important

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4. Regular team of care givers

€very important €somewhat important €not important

....

....

5. Have consistent contact person/s to discuss my child/young person's care

€very important €somewhat important €not important

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Is there anything else you believe should be included?

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Please note that feedback needs to be received by COB 30/11/2012

November 2012

COMPARISON OF VARIOUS MODELS TO MEET COMPLEX HEALTHCARE IN SCHOOLS

Victoria Schoolcare	South Australia Access Assistant Program	Others Interstate and Overseas	What is happening in the ACT	Suggestion for ACT Model
Funding: Families have to arrange brokerage prior to being eligible for Schoolcare program.	**Funding:** The Child Health Education Support Services (CHESS) alliance is an interagency commitment to improve the health care and learning of all students. Funded by both State and Federal Monies.	**Funding:** Ireland; 'Inclusion' fund specific to meet a particular need.	**Funding:** Once a need is identified there is no cross government framework to fund, staff or resource the student's needs.	**Funding:** An 'Inclusion' fund specifically to provide complex healthcare needs in community settings
Eligibility Criteria: The program has a Clinical Operations meeting at RCH@ Home to determine eligibility for Schoolcare.	**Eligibility Criteria:** The program provides services for children with invasive and complex healthcare needs e.g. tracheotomy, gastrostomy feeding and medication, catheterisation and oxygen therapy.		**Eligibility Criteria:** No standardised criteria to identify complex/invasive healthcare other than technologically dependant students.	**Eligibility Criteria:** A standardised criterion for complex healthcare. Followed by a comprehensive assessment using standardised processes and tools to assess eligibility.
Referral Process: Schoolcare has set referral dates prior to the commencement of the school year.	**Referral Process:** Referrals are made by the school to the Access Assistance Program (AAP) once a complex healthcare need is identified.		**Referral Process:** At enrolment a student maybe identified as having a complex healthcare needs with a Management and Emergency Treatment Plan.	**Referral Process:** Referral is made by the school once a complex healthcare need is identified. This would be prior to the student starting school.
Assessment Process: As above in eligibility criteria.	**Assessment Process:** Standardised client and environmental assessment carried out by Registered Nurse (RN) with the results presented to a clinical panel. There are standardised protocols for the levels of care and who can provide the care. There is a clinical governance process to monitor level of care assessments.		**Assessment Process:** No process in place it is often met in an adhoc manner.	**Assessment Process:** South Australia's (SA) process, procedures, protocols, assessment tools and clinical governance process are readily available.
Healthcare plans: See education below re client manuals.	**Health Plans:** Developed with family, student and their healthcare professional by the RN. There is one portable healthcare plan that goes with the student across all settings. This maybe a delegated care model.		**Healthcare plans:** No interlinking plans between Education and Health.	**Healthcare plans:** Utilise Health Directorate existing protocols when developing Healthcare Plans with the assessment processes from South Australia.

Victoria Schoolcare	South Australia Access Assistant Program	Others Interstate and Overseas	What is happening in the ACT	Suggestion for ACT Model
Training: Provided by RNs from the RCH to school staff only (Teachers/LSAs) Limited to specific care - Tracheotomies, Tube/PEG feeding, oxygen therapy, suctioning, ileostomy and colostomy care. Competency assessments only.	**Training:** A number of Health Support Officers (HSO) will be trained to meet a specific need, followed by a competency assessment, ongoing support and assessment as required by a RN. The RN is responsible for support to the HSOs, liaising with the families, making changes to healthcare plans and updating training and competencies as required.	**Training:** Research in Ireland's made a recommendation of a hybrid role of HSO/LSA to provide care in schools. They receive training and assessments of a specific healthcare task.	**Training:** Inconsistent can be provided by specialist health professional, support organisation or the student's family.	**Training:** The RN would provide training to meet the student's specific need, followed by a competency assessment, ongoing support and assessment.
Education: Client specific manuals that have healthcare details, problem solving steps and when to call families. Referrals yearly at the end of year with manuals developed/updated and education given in January.	**Education:** SA is in the process of developing education packages to provide consistence amongst the RN delivering the sessions.		**Education:** Specialist health professional or organisation would be using evidence based education materials without competency assessments.	**Education:** Evidenced based education packages and competencies tools or other health professional with expertise on the subject.
Nurses in School: Employed by education and in some cases under the education classifications of learning support. The Role provides training, health promotion, screening and support.	**Nurses in School:** RNs provide direct care usually in a 1:1 when the assessment deems the delegated care model unsuitable.	**Nurses in School:** USA and Canada provide health services to the whole school with specific models to meet complex healthcare needs that are similar to UK.	**Nurses in School:** The three specialists' schools, four nurses providing health promotion and referral in eight high schools. Some isolated individual situations. Other services include kindergarten screening and immunisation programs. Technologically dependent students have care provided under the Caring for Kids program delegation of care model.	**Nurses in School:** Providing a contemporary role in a holistic model, with ongoing support in partnership with the school and family. All students would have access to nurse led care.

Victoria Schoolcare	South Australia Access Assistant Program	Others Interstate and Overseas	What is happening in the ACT	Suggestion for ACT Model
Flexibility: Limited to school staff only. If retraining required for new care or new carers the students may have to stay away from school.	**Flexibility:** The partnership with Education allowed for flexibility e.g. AAP paying for the Learning Support Assistant (LSA) to do healthcare or a HSO was able to do a 'run' when healthcare is required in rural or isolated schools or for limited care in a nearby school.	**Flexibility:** The hybrid role of a school employee to provide both healthcare and education support. This allows the role to be flexible when the student is away or requires intermittent care and reduces the times a student is unable to attend school when a carer is away.	**Flexibility:** Nurses limited to certain schools. Healthcare Support Worker (HCSW) provides specific care to a specific student, if student absent they have no work. If either the nurses or HCSW are unable to be replaced the student may be unable to attend school.	**Flexibility:** Look at options for a carer to provide both healthcare and education support that is nurse led. This has potential to allow the student more flexibility with excursions and camps where the healthcare needs maybe able to be accommodated during these times.

Appendix 3: Discussion Paper

MEETING HEALTHCARE NEEDS IN ACT SCHOOLS DISCUSSION PAPER 2012

Our Aim

To provide evidence based healthcare so all students have access to the appropriate supports in ACT schools. The enhanced health services will be equitable capacity building and sustainable.

Background

All organisations endeavour to provide fair, equitable and appropriate care to all young people whether it is related to a disability or their healthcare needs. Since the introduction of the United Nations Convention on the Rights of the Child 1989, Disability Discrimination Act 1992, Convention on the Rights of a Person with Disability 2007 and the ACT Children's Plan, professionals described their commitment to these principles. The challenges they face due to the lack of adequate frameworks that may lead to inconsistent, unfair and inequitable decision making (Young et al 2004).

Research indicates the demand for healthcare in schools is increasing nationally with one third of students having a health condition or healthcare need that is either short or long term. This data is dependent on the definition and criteria used but it suggests that the need is increasing in number and complexity (Chris Robinson, Chief Executive for the South Australian Department of Education and Children's Services 2006).

This trend has been acknowledged in the ACT with discussion taking place between the Health and Education and Training Directorates during 2011 on need to provide complex healthcare in schools that is evidenced based, equitable and sustainable. A project to enhance current services for students with healthcare needs is now underway.

Globally there is concern with the declining numbers of health professionals and the possible negative impact it may have on timely access and quality of care. Nationally it has been predicted higher numbers of people will require long term care and support that will not be sustainable in the future with the current workforce. The ACT is part of the national workforce reform program and has aligned their strategies with the National Health Workforce Innovation and Reform Strategic Framework for Action 2011 -2015.

Currently in ACT Schools

At enrolment a student maybe identified as having a complex healthcare needs with a Management and Emergency Treatment Plan, however once this need is identified there is no cross government framework to fund, staff or resource the student's needs. The current ACT policy is available on http://www.det.act.gov.au/publications_and_policies/policy_a-z

The ACT does not have sufficient data for identifying the extent of complex healthcare needs in schools or the way in which the care is being provided to the students.

The Health Directorate provides nurses in various roles in some ACT Schools:

- three specialists schools
- four nurses providing an adolescent health promotion and brief intervention/referral service for eight mainstream high schools. This pilot program is currently being evaluated
- some isolated individual situations

Other services provided in a school environment by the Health Directorate include the universal kindergarten screening and immunisation programs.

What has happened to date?

- A partnership between the two Directorates of Education and Health was established at the end of 2011
- A health directorate project officer was appointed in February 2012
- A review of relevant research from international and national sources has been undertaken
- A Steering Committee was established in April 2012
- Site visits to South Australia and Victoria were undertaken in May 2012 to establish networks and to observe their models in practice.
- A Working Group established in July 2012
- A consultation process commenced in early August 2012 and is being rolled out to professional bodies, community groups and individuals. This includes face to face sessions and this discussion paper being available on government websites.

SUMMARY OF PROJECT FINDINGS

A literature search was the first step in the project. A number of health data bases and e-journals were sourced producing 24 papers that were relevant to the project.

What does the Research say?

Families want clear communication and realistic indications of support that is available without having to fight for their child/young person's healthcare needs (McConkey et al 2007).

Children and young people want to do the same as their peers in school and community settings. They want to receive quality healthcare and learn how to manage and understand their healthcare needs as part of their individual education plan (De Plessis Erickson et al 2006).

Education staff reported that they experienced less anxiety when they received comprehensive training for student's healthcare needs prior to them starting school. They want formal recognition of the healthcare support that they provide (Clayton Barrett 2001).

Nurses want a contemporary role in providing complex healthcare within a holistic model of care that provides ongoing support in partnership with the school and family (McConkey et al 2007).
The care would be evidence based, equitable and sustainable with eligibility criteria. Standardised processes and tools would be used to do a comprehensive assessment of the healthcare needs and the environment where the healthcare will be provided. The care providers should receive training and competency assessments with nurse led support and follow up as required (Moore et al 2003, McConkey et al 2007).

Analysis of Models
The United Kingdom (UK) initiated major changes for the inclusion of students in education settings and developed guidance policies that have been widely used in the UK and Australia. The key to the success of these programs is a well established partnership with Education and Health whether they are Government or Non Government agencies.
South Australia was the first to develop their model for complex healthcare in childcare, preschool, schools and community settings. Victoria followed using the work done by South Australia to develop their model. Both have a well established partnership between Health and Education.

Victoria's School Care Program is part of the Royal Children's Hospital 'RCH @Home' program. Their clients are children and adolescents who have ongoing medical care needs in community settings. The registered nurses provide child/adolescent and task specific training and competency assessment for staff that has been selected by the school. There is minimal ongoing monitoring/support for school staff if they have concerns or questions. There are some follow up visits to the school at various intervals to assess competency of the school staff, this is dependent on the complexity of the task and staff changes. See Guidelines
http://www.education.vic.gov.au/healthwellbeing/wellbeing/disability/programsupp.htm

South Australia's model involves two frameworks.

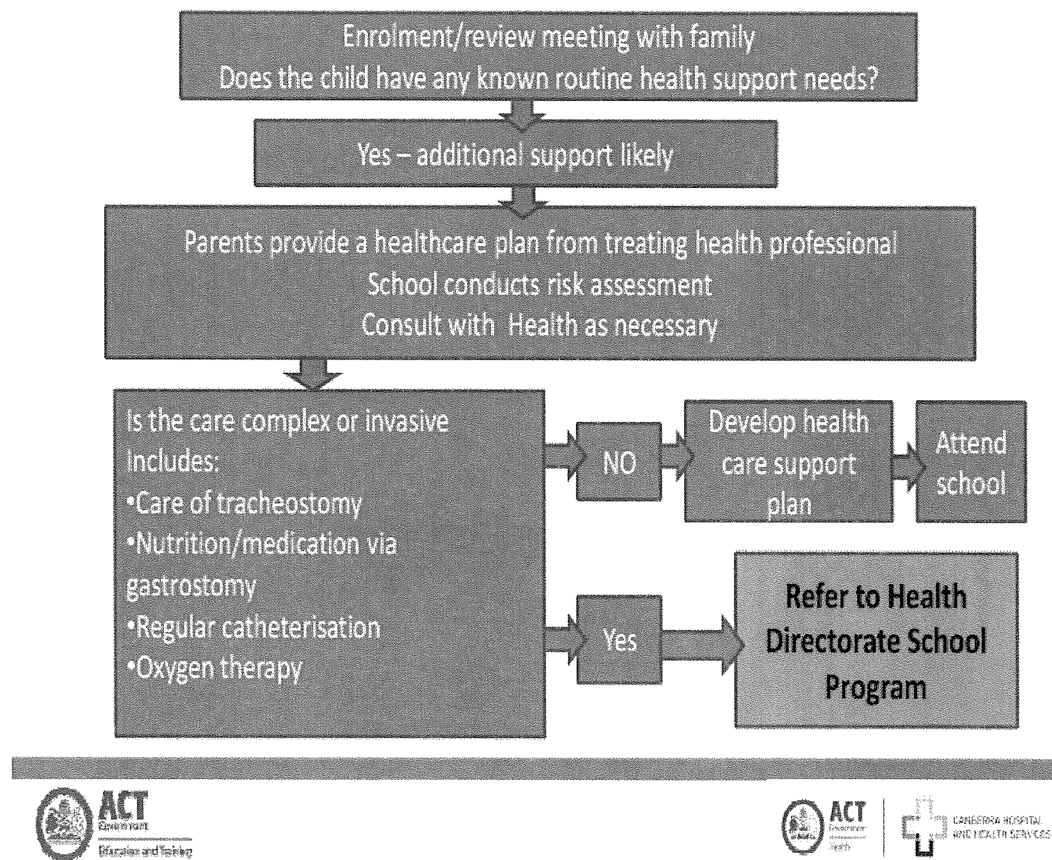
1. The *Child Health Education Support Service* (CHESS). This is a strong interagency commitment with funding that is interdepartmental from both State and Federal monies.
2. Once a student is identified as requiring complex healthcare they are referred to the second part of this framework, the Access *Assistance Program* (established 1993). Registered Nurses carry out comprehensive assessments with program guidelines and policies. A health plan is completed with the families and their health professional using a comprehensive risk assessment tool. A clinical team decision is made to establish the type of care required. This includes one to one care, intermittent care and whether the care needs to be delivered by a Registered Nurse, an Enrolled Nurse or Health Support Worker. In the Nurse led model the Health Support workers receive individual training and competency assessments with ongoing support, training and re-assessment. See website for more information http://www.chess.sa.edu.au/Pathways/hspfactsheetfinal.pdf

PROPOSAL FOR CONSIDERATION

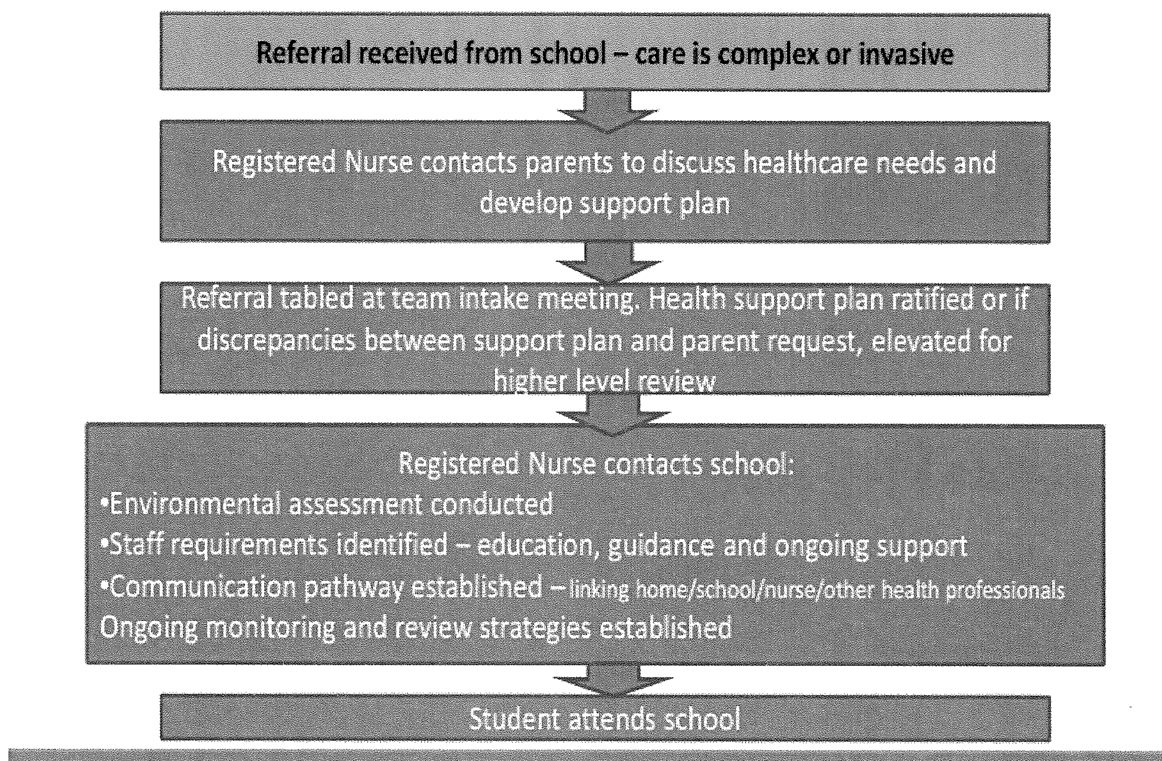
The ACT is in the fortunate position able to draw from a range of well established models in developing a best practice approach to the provision of healthcare in schools.

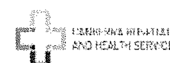
At the foundation of this model is a partnership between Education and Health with two interlinking frameworks:

1. EDUCATION: manage every day health care needs in schools



2. HEALTH: manage complex/invasive care





These two frameworks are to be bought together in a partnership to achieve our aim. This will provide clear pathways for the provision of healthcare in schools.

This framework will be supported by:

- a comprehensive, integrated model linking schools, students, parents and their health professional
- consistent responses to complex healthcare needs with standardised assessment tools, clear definition of roles and responsibilities, levels of care required and who will provide the services

Feedback

We really welcome your feedback. Your might like to use this question as a guide for your feedback.

What makes you feel confident that your child/young person is having their healthcare needs met while they are at school?

1. Always included in talks about my child/young person's health care at school

€very important €somewhat important €not important

....

....

2. Skilled staff

€very important €somewhat important €not important

....

....

3. Registered Nurse support for staff

€very important €somewhat important €not important

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4. Regular team of care givers

€very important €somewhat important €not important

....

....

5. Have consistent contact person/s to discuss my child/young person's care

€very important €somewhat important €not important

....

....

Is there anything else you believe should be included?

....

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To provide your feedback please e-mail to healthcareinschools@act.gov.au your feedback will be treated as confidential and will not be made publicly available without your permission.

Feedback can be made until 5pm on Friday 30 November 2012

To help you gain further information here are some useful websites and list of references with web links to the full document.

WEBSITES

- http://www.chess.sa.edu.au/index.htm
- http://www.education.vic.gov.au/management/governance/spag/default.htm
- http://www.education.vic.gov.au/healthwellbeing/wellbeing/disability/programsupp.htm
- http://www.det.act.gov.au/publications_and_policies/policy_a-z

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Guidelines for Registered Nurses, Registered Midwives and Enrolled Nurses

INTRODUCTION

In 1998, the Board, then known as the Nurses Registration Board commissioned a project to develop guidelines on the boundaries of professional practice. Today the Nurses and Midwives Board believes these Guidelines for Professional Practice are just as relevant to nurses and midwives. The guidelines assist nurses and midwives in making decisions about the boundaries of professional and personal relationships in professional practice.

The guidelines are comprised of the following elements:

- Information relating to guidelines and boundaries
- Boundary Framework
- Four categories of concern
- Principles of Safe Practice.

INFORMATION ABOUT GUIDELINES AND BOUNDARIES

What are guidelines?

Guidelines are statements that are developed to provide professionals with guidance in making decisions about a specific practice situation, while allowing flexibility in professional judgment. The guidelines regarding the boundaries of professional nursing and midwifery practice focus on assisting nurses and midwives with decision-making processes for appropriate behaviour in a nurse-client or midwife-woman relationship. Validity of the guidelines is enhanced because they are based on sound professional judgements as well as consideration of clients' values and preferences, and they meet National Health and Medical Research Council (NHMRC, 1999) criteria for guideline development. Guidelines are different from standards or procedures. Standards are broader in focus and describe the appropriateness of nursing or midwifery care to be adhered to at all times, while procedures usually describe step-by-step actions and are narrower in focus than guidelines.

Why do we need guidelines?

Because of the complex nature of professional relationships many health professional bodies have, in the last decade, experienced difficulties developing clear standards or rules for boundaries. The nursing and midwifery professions recognise that each nurse-client and midwife-woman relationship is unique. However, the provision of safe and effective nursing and midwifery care is optimised and legal risks reduced if nurses and midwives are well informed about the fundamentals of boundaries and are able to make sound decisions about appropriate behaviour.

By examining a profession's boundaries and developing guiding principles for responding to identified issues, education about safe boundaries can be successfully implemented. In New South Wales, the Nurses and Midwives Board is the statutory nursing and midwifery body entrusted with a duty to protect the public safety. Nurses and midwives, registered or enrolled by the Nurses and Midwives Board, accept a responsibility to adhere to the profession's standards of professional conduct by maintaining the trust and integrity inherent in a professional relationship.

The Nurses and Midwives Board supports nurses and midwives in making thoughtful and ethical decisions relating to personal and professional boundaries by providing them with guidelines regarding the boundaries of professional nursing and midwifery practice.

Where did the information for the guidelines come from?

The consultants commenced the project with a review of the national and international literature. A search revealed that while 'boundaries'-related publications have flourished in the last decade, they mostly emphasise sexual misconduct as an outcome rather than addressing problems dealing with boundary maintenance.

Consultation with the professions initially occurred at a number of levels in order to collect information from which to develop the guidelines. A Discussion Paper was developed and used to stimulate debate and thought, prior to wider consultation with nurses and midwives from a range of geographical locations, clinical settings and nursing and midwifery designations. Approximately 220 nurses and midwives attended workshops in various remote, rural, regional and urban areas of New South Wales.

Consultation also occurred with 40 consumers in four group interviews conducted throughout New South Wales. While the consultants developed the structure of the Boundary Framework (Figure 2) and the Principles of Safe Practice, the content and language remain largely the work of nurses, midwives and consumers.

THE GUIDELINES

The boundary-related issues identified by the project's participants were about problems at both ends of the spectrum of professional behaviour, that is over-involvement and under-involvement with a client or woman. The issues grouped readily into four categories, which describe the major areas of boundary concern in nursing and midwifery practice. From the following four categories of concern, the Principles of Safe Practice and Indicators of Boundary Crossing / Violation were developed:

- therapeutic relationships
- access to / disclosure of information
- gifts / services and financial relationships
- dual relationships.

A definition or explanation of each of the categories, as well as other terms used in the guidelines, are included in the following section. Definitions have been adopted and / or modified from current literature to maintain the consistency of meaning.

What is meant by 'boundaries'?

Nurses and midwives are not unfamiliar with the idea of boundaries. We may think of them as lines or restrictions that separate concrete things such as fences around a paddock, or as abstract concepts such as competencies in our scope of practice. They are also limits to appropriate behaviour in our personal and professional relationships. In Australia, phrases such as 'crossing the line', 'overstepping the mark' or 'going over the top' are commonly used to describe inappropriate behaviour.

Professional boundaries in nursing and midwifery are defined as 'limits which protect the space between the professional's power and the client's vulnerability' (Peterson, 1992). Selection and maintenance of appropriate boundaries in a nurse-client or midwife-woman relationship facilitate safe and therapeutic practice and result in safe and effective care.

What is meant by safe and therapeutic practice?

Our professions require that we provide a caring service to those clients or women with whom we work. The nature of the interactions that occur between a nurse or midwife and a client or woman is a helping one. Clients and women trust that nurses and midwives will act in their best interests by basing care on an assessment of their needs. A nurse or midwife enters a nurse-client or midwife-woman relationship with skills, knowledge (often a great deal of personal information) and the authority to provide the care required by the client or woman. A therapeutic relationship is one in which planned and goal-directed interactions occur between a nurse and a client or a midwife and a woman with the aim of providing help to the client or woman. The power imbalance present in a professional relationship places the client or woman in a position of vulnerability and of potential exposure to exploitation or abuse if trust is not respected. There is a professional onus for nurses and midwives to maintain a relationship that is therapeutic. This means that it is the responsibility of the registered nurse, registered midwife or enrolled nurse to maintain his / her professional and personal boundaries as well as to assist colleagues, clients and women in maintaining theirs.

One frame of reference which can be used to illustrate the range of professional behaviour is the Continuum of Professional Behaviour (National Council of State Boards of Nursing, 1996). It depicts a Zone of Helpfulness in the centre, which is delimited by flexible boundaries.

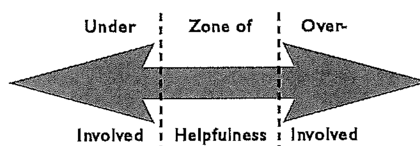

Figure 1: Continuum of Professional Behaviour

On the left is the zone of under-involvement that refers to those nursing and midwifery activities and behaviours that lead to and include neglect and assault. On the right of the zone of helpfulness is the zone of over-involvement that refers to 'caring about' rather than 'caring for'. It may lead to a situation where the relationship between nurse and client or midwife and woman takes priority over the client's or woman's care needs.

What purpose do boundaries serve?

Boundaries assist in maintaining practice within the Zone of Helpfulness where safe and effective care will result. Nurses and midwives can err on either end of the continuum - on the one hand being too cold, distant or formal so as to not be caring enough to be helpful, and on the other end to be overly involved, too 'touchy-feely', or invasive (Schoener, 1999). Brief excursions across boundaries are known as boundary crossings. They may be inadvertent, thoughtless or even purposeful if done to meet a special therapeutic need. A boundary violation however, refers to the misuse of power or the betrayal of trust, respect or intimacy between a nurse and a client or a midwife and a woman. Violations can cause physical, emotional and / or economic harm to the client.

THE BOUNDARY FRAMEWORK

A Boundary Framework (illustrated in Figure 2) has been developed in this project as an extension of the Continuum of Professional Behaviour. This provides a multi-dimensional approach for boundary decision-making for Australian nurses and midwives. As a conceptual tool it demonstrates how practice behaviours and client expectations can be viewed. The Framework is presented as a bilateral continuum with areas or zones into which nursing behaviours and client perceptions of experience can be categorised. On the continuum of professional behaviour, the zones range from the 'safe' centre, to activities of over involvement at the top and activities of under involvement at the bottom. The ellipse or bubble surrounding the zones is a figurative representation of the essence of the nurse-client, midwife-client relationship upon which contextual influences will impact. An interpretation of any behaviour in relation to this framework will be most strongly influenced by context.

The use of 'traffic light' colours assists in highlighting the appropriateness of a behaviour or activity. The green zone signifies safe practice and care while movement across a boundary into the orange zone indicates caution should prevail. Appropriate assessment and monitoring of behaviours and activities are necessary where practice is potentially risky. Exploitative and abusive behaviours and activities fit within the red zone and may indicate boundary violation from which the client is at risk of neglect and / or abuse. The colour black represents unacceptable practice and care.

There is no clear boundary (see dashed lines) between the critical areas of safe and therapeutic practice / care, and the adjacent areas of risky behaviours and intrusive / insensitive care. Recognition of the boundary between risky behaviours

and exploitative or abusive behaviours requires knowledge and skills acquired through experience. The dashed lines here represent a delineation between these zones. While in many situations there is a firm delineation (represented by the unbroken line) between illegal behaviours and others, for example assault, there may be behaviours that are not so clear, for example self-defence.

Principles of Safe Practice and Indicators of Boundary Crossing / Violation have been derived from the categorisation of reported behaviours and are used in conjunction with the Framework for boundary decision-making.

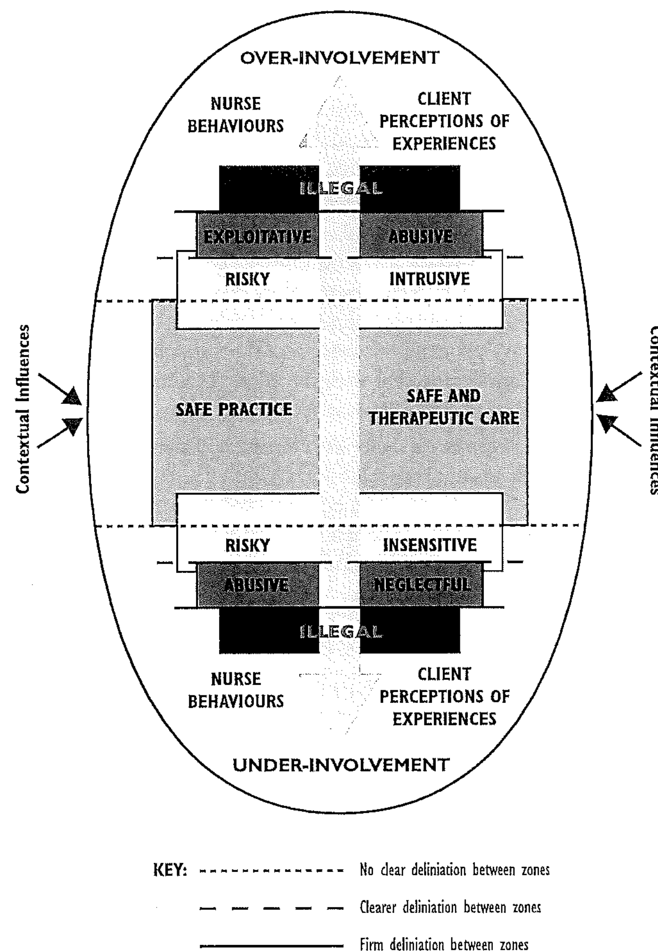

Figure 2: Boundary Framework. A framework for illustrating the boundaries in nurse-client and midwife-woman relationships.

How have the reported behaviours been categorised?

Nurses and midwives have identified four major areas of nursing and midwifery practice in which boundary determination is of concern. The following categories represent those areas where practice can be informed by guidelines:

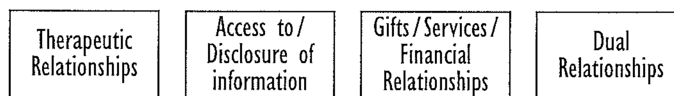

Figure 3: Major Categories of Concern

Boundary-related issues dealing with *Therapeutic Relationships* are the greatest concern to nurses, midwives, clients and women. Examples of some boundary-related issues in this category include nursing or midwifery behaviours relating to favouritism, touch, friendship, socialising, dating, chastising, use of coercion to gain compliance and meeting one's own needs. Issues of client-initiated or woman-initiated physical and verbal abuse are also considered in this category.

The categories relating to *Access to / Disclosure of Information and Gifts / Services and Financial Relationships* also constitute a large number of boundary issues for nurses and midwives in New South Wales. Issues relating to access to, and disclosure of, information concern nurses' and midwives' right to use and reveal clients' and women's personal information. The issues relating to gifts / services and financial relationships deal with the giving / receiving of gifts or favours and involvement in financial transaction for, or with, clients or women.

The category of *Dual Relationships* deals with boundary issues, which occur when a nurse or midwife has another relationship with a client. This may include being a neighbour, friend, family member, business associate, teacher or sexual partner while simultaneously being engaged in a nurse-client or midwife-woman relationship. Dual relationships are of particular concern to nurses and midwives who live and work in small communities.

The impact of context on boundary determination

It may seem like common sense that a nurse or midwife will know the differences between a professional and a personal relationship and be able to recognise boundaries between them. However boundaries are seldom clear because the interactions in each nurse-client or midwife-woman relationship are moderated by the context in which they occur.

Examples of some contextual influences identified by nurses and midwives which may impact on the determination of boundaries in a nurse-client or midwife-woman relationship include:

- organisational issues such as staffing numbers and lack of regular staff
- cultural / religious issues
- clinical setting issues such as sole practitioner versus team approach, or type of service such as mental health, aged care and community nursing
- significant other people such as relatives or other health professionals.

The following principles of safe practice have been developed from the behaviours reported by nurses, midwives and consumers, in this project.

PRINCIPLES OF SAFE PRACTICE

The sixteen (16) principles of safe practice are an integral part of the guidelines regarding the boundaries of professional nursing and midwifery practice. A set of principles specific to each category of concern has been identified, and is listed in the following case study section. There may also be clues or warning signs to indicate that a nurse or midwife is at risk of a boundary crossing or violation. These are known as Indicators of Boundary Crossing / Violation.

INDICATORS OF BOUNDARY CROSSING / VIOLATION

Indicators of Boundary Crossing / Violation tell a nurse or midwife how to recognise actual or potential movement outside the zone of safe practice. The indicators discussed in this booklet are taken from nurse, midwife and consumer information and are specific to each category of concern. Stories from nurses, midwives and consumers are included to illustrate how the guidelines may be applied.

HOW TO USE THESE GUIDELINES

The guidelines can be applied in any practice situation where you may be unsure if your practice or that of your colleagues is safe and therapeutic. The following flow chart can be used to combine all the elements of the guidelines and arrive at decisions about the appropriateness of nursing or midwifery behaviours.

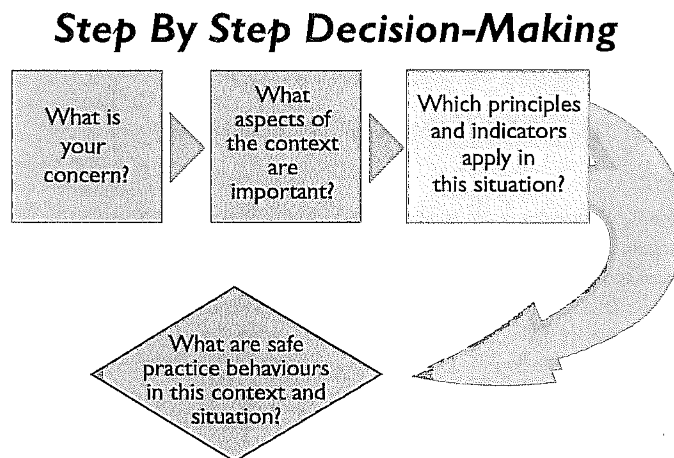

Figure 4: Decision-making Flowchart

The following practice story is from a nurse:

A nurse lives next door to an elderly lady who knows the neighbour is a nurse. The lady has an operation that involves a colostomy. When at home she decided she would like a shower one hot night at 1am. She decided that to shower she needed to completely take off the colostomy. Her son who lives with her panicked and ran next door to wake the nurse and ask her to reapply the colostomy.

Step 1. Consider the actual description of practice and identify the major area of concern. In the story a boundary concern relating to dual relationships is evident.

Step 2. Consider the context and determine the important aspects. In the story the short-term nature, timing and the immediacy of the client's current need are factors that may influence the nurse's decision to initiate a nursing action.

Step 3. Refer to the Principles of Safe Practice and Boundary Crossing / Violation listed under the category of Dual Relationships and consider which ones apply in the situation. In this story both principles seven and eight are applicable.

Step 4. Determine where the practice fits against the Boundary Framework by looking at the safe practice behaviours that apply in this situation and context.

Application of the guidelines to the Story

This story is an example of a boundary crossing. The nurse needs to explain that she is responding as a neighbour but using nursing skills. After assisting the woman, the nurse should direct her to professional consultation regarding help with self-care.

Case Studies

In this section each of the four categories of concern, the Principles of Safe Practice and Boundary Crossing / Violation are discussed. Stories, or case studies are used to illustrate how the Guidelines may be applied.

CATEGORY ONE: THERAPEUTIC RELATIONSHIPS

Preamble

Therapeutic relationships are goal directed to promote self-care and independence. Nurses and midwives need to recognise their own values, recognise clients' and women's values and the potential for value conflict, and act in a way which does not diminish care of the person for whom they are caring. A power imbalance exists in the nurse-client or midwife-woman relationship, which makes clients or women vulnerable and open to exploitation. Consumers can perceive themselves as powerless. The actions / omissions of nurses and midwives can either enhance or violate the trust and respect inherent in that relationship.

Principles of Safe Practice

1. The priority of nurses and midwives is to plan care around meeting the therapeutic needs of the client or woman.
2. Nurses and midwives need to be aware of their own needs, values and attitudes in a professional relationship.
3. Nurses and midwives must have an awareness of and an ability to describe the therapeutic purpose of nursing or midwifery actions that are interpreted against a client's or a woman's responses.
4. Nurses and midwives are responsible for ensuring that nursing and midwifery care is never withheld from a client or woman as a punishment. Any intent to cause pain / suffering, as punishment based on punitive judgement is unacceptable.
5. Coercing client or woman compliance may be an abuse of the power imbalance.
6. Nurses and midwives need to be aware of the comfort zones for both client and nurse, and midwife and woman regarding therapeutic touch.

Indicators of Boundary Crossing / Violation for therapeutic relationships:

Presence of:

- favouritism / minimal care / neglect
- judgemental attitudes
- burn out: cynicism
- co-dependence
- possessive / secretive behaviours
- rudeness / patronising attitude
- roughness / bullying
- assault.

Absence of:

- sensitivity
- individualised assessment of care
- listening / taking time
- presence (being there)
- concern
- noticing
- accountability
- understanding
- putting self into others' shoes
- aware of clients' rights
- effective communication.

CLINICIAN STORIES

Story A ...

I was caring for a woman with a disfiguring, painful, fungating cancer. In my role, I was offering care to the family. The husband mistook my offers of support and care as a personal interest in him. He offered a sexual relationship, claiming I had 'come on' to him. When I explained my role and function and what was actually being offered, i.e. nursing care, he was offended. I talked to my palliative care CNC [Clinical Nurse Consultant] and a social worker re action for this man who was obviously in need of 'affection'. The consensus was to talk to his Pastor, confidentially, about his needs and in my further actions, make it clear what my focus of care was. The outcome was OK in that the wife did not hear or become distressed. The husband received confidential help, and I was allowed to air my concerns. It could have gone horribly wrong if he had pressed the issue.

Application of the guidelines to Story A

Principles one and three were applied in this situation. Appropriate organisational support and referral was given.

Story B ...

[I was] taking a patient who was quadriplegic on an outing with two other nurses with the intention of improving their [the client's] social life. The patient, however, took a fancy to me despite the thought that there was safety in numbers and was broken hearted when the professional personal boundaries were explained to him.

Application of the guidelines to Story B

Principle three was applied. This situation could have been improved by explanation of the therapeutic goal before the outing. Such a decision is always easier with hindsight.

Story C ...

I remember this guy who lived alone in the scrub with his dogs, was having a tough time and a social worker with me gave him a hug - dirt and all. I looked at his face over her shoulder. The tears came to his eyes and he said, 'It's so long since I've had a hug'. Really important with dying people to maintain that touch that they may lose when they get sick - same with sexuality stuff.

Application of the guidelines to Story C

Principle six applied effectively. Although the professional is a Social Worker, the nurse's observation of appropriate touch was congruent to the guideline.

Story D ...

Touching can be a problem. e.g. one client I was really close to - we became close - same ages, likes etc. She would always give me a kiss at arrival and departure - this was fine in the house confines yet I felt uncomfortable when it happened in a hospital. Situation observed by other staff - I felt that they were looking and judging me with over involvement - maybe I was.

Application of the guidelines to Story D

It seems that the nurse had unconsciously moved into the zone of risky practice in relation to touch and recognised this only when the context (in the hospital) emphasised her professionalism. It would be important to observe the client's form of greeting for others. There are some people who routinely kiss when greeting others.

Story E ...

A clinical nurse consultant providing home based clinical services to paediatric oncology clients and families is found to be over involved with some clients and under involved with others. By giving out her home phone number and being available 24 hours. She also will not refer to other health professionals or services when appropriate. Her visits are often not therapeutic and outside the role of a nurse, i.e. attending to clients banking, shopping, taking siblings to school and driving long distances to bring clients into hospital for treatment.

Application of the guidelines to Story E

This story clearly demonstrates Boundary Crossing / Violation in that there is evidence of favouritism, minimal care and neglect. There is a breach of principles one and two.

CONSUMER STORIES

Consumer Story A ...

It's important that nurses take an interest in patients without being intrusive. To actually put some time aside each day to sit down and talk, if the patient wants ... I was very withdrawn and the nurses would come up a couple of times a day and say 'would you like to talk about it?' Most times I would say 'no' but I felt very cared for that they'd taken the effort to search beyond and say 'well I'm available if you'd like to talk to me'.

Application of the guidelines to Story A

This is an example of working within safe practice guidelines and demonstrates the application of principle three.

Consumer Story B ...

When I was going through radiation [therapy], I ended up with a severe burn that was this big and raw and I got up and asked the sister for help. She told me to sit down and be quiet because she was busy. This went on for a few more days and in the end they had to suspend treatment because it got so bad.

Application of the guidelines to Story B

This story illustrates evidence of insensitivity and abuse and requires the application of principles one, two and four.

Consumer Story C ...

Listen to patients about what is happening, and show some interest. What I find is that people think that because they've got the piece of paper that says 'I trained in whatever' then they think 'I know everything about what you're experiencing'. And they wouldn't have a clue. They need to listen and take that on board as well. I think often people think you're imagining it.

Application of the guidelines to Story C

This story illustrates the necessity for nurses to listen effectively and be non-judgemental, as indicated by principles one, two and three.

Consumer Story D ...

Participant told a story of being concerned with another patient who was sitting with almost nothing on, on a cold day with bare feet resting on a tiled or linoleum floor. Participant asked the nurse to get another footstool for the patient. The nurse responded, 'If you are so concerned for her welfare I suggest that you give her yours'.

Application of the guidelines to Story D

This story illustrates evidence of rudeness and neglect and requires the application of principles one, two and three.

CATEGORY TWO: DUAL RELATIONSHIPS

Preamble

Nurses and midwives have multiple roles including family member, friend, community member and health professional. The creation of a platonic or non-sexual relationship, e.g. friendship or socialising with a client during a therapeutic relationship increases client vulnerability, as does living in the same community as a client. Hence, there is a need to ensure that the nurse-client or midwife-woman relationship is always conducted with the sole intent of benefiting the client or woman. *A sexual or intimate personal relationship is unacceptable between a nurse and a client or a midwife and woman within the context of the provision of care.*

Principles of Safe Practice

7. Care is optimised when nurses and clients or midwives and women do not engage in dual relationships.
8. Where dual relationships are unavoidable there is a potential for prejudicial practice to occur.

Indicators of Boundary Crossing / Violation Behaviours

When social interaction with clients or women outside the therapeutic / professional relationship occurs, it is important to consider the following:

i. Potential harm to the client or woman and / or nurse or midwife with ongoing professional interactions

ii. Nurse's or midwife's professional standing (in the community)

iii. The client or woman is aware of the change in the nature of the relationship; i.e. no longer professional

iv. Clarifying client's or women's ongoing expectations in both professional and personal; i.e. negotiating relationship

v. Self-disclosure or inappropriate behaviour and their implications

vi. Confidentiality.

CLINICIAN STORIES

Story F ...

Staff member of a rural hospital. One RN / RM and two ENs on duty. Staff member's father-in-law died, other staff members busy in maternity unit. Enrolled nurse found it difficult to be on ward caring for patients and trying to be with husband and family as well.

Application of the guidelines to Story F

EN should advise nursing administration and ask for relief. The principle applies that at a minimum there should be an exchange with the EN in maternity unit until relief is available. EN needs to explain to the family her need to continue in the professional role until the requested relief is available.

Story G ...

Relatives rang me and asked me to visit a family member's home and encourage her to enter hospital, the person had mets [metastases] from lung cancer. Once in hospital they expected me to totally care for their mother and started complaining to me about other staff. I did go to her home and help get her to hospital. Once there I backed off and encouraged other staff to care for her. I felt smothered by the family; they talked to me at work / home / in the street. When she died, I felt really guilty because I felt like I had let the family down by backing off. I couldn't even go to the funeral so I felt like ultimately I had let the lady down. I still feel guilty and find it hard to look family members in the eye.

Application of the guidelines to Story G

This story demonstrates that the nurse has taken appropriate action, which is consistent with the guidelines. She needs professional support and referral for counselling to assist her to resolve personal turmoil.

Story H ...

Working as a community midwife in a small town, I have had boundary problems with friendship or women wanting to develop friendships with me after the midwife-woman relationship has expired. Also boundary problems in the same role where community members feel able to seek 'advice' or service in a casual way when I am not actually working, eg. stopped while shopping to answer breast-feeding problems / questions.

Application of the guidelines to Story H

It is important in this situation to meet the immediate need and advise the client about the appropriate time and venue for further consultation.

CATEGORY THREE: ACCESS TO / DISCLOSURE OF INFORMATION

Preamble

A degree of self-disclosure may be appropriate for the development of trust and rapport in the nurse-client or midwife-woman relationship. Determination of the appropriate balance for self-disclosure and non-disclosure must be based on the client's or woman's needs. The use of self-disclosure as a debriefing strategy for nurses' or midwives' owns unresolved issues are always inappropriate and potentially harmful to clients and women. The provision of adequate information about aspects of care can empower clients and women and impact positively on their care experience.

Access to or the disclosure of information includes:

- self-disclosure
- confidentiality
- provision of information.

Principles of Safe Practice

9. Self-disclosure should be limited to revealing information that has therapeutic value to the client or woman.
10. Self-disclosure should only occur within an established therapeutic relationship.
11. Nurses and midwives need to carefully consider their motives for disclosing personal information.
12. Nurses and midwives should apply the Code of Professional Conduct as the standard for confidentiality and must treat personal information obtained in a professional capacity as confidential.
13. Nurses and midwives should not use confidential information or their position of power to advantage themselves in any way.
14. Nurses and midwives have a professional responsibility to inform clients and women about the nursing or midwifery care which clients or women are receiving. Nurses and midwives should assess and negotiate individual clients' or women's needs for information relating to their care.

Indicators of Boundary Crossing / Violation Behaviours Relating to Disclosure / Self-disclosure:

i. Nurse or midwife may closely identify with a client's or woman's experience

ii. Nurse or midwife may be experiencing difficulties with unresolved issues in their personal life

iii. Dual relationships exist with client or significant others

iv. Early self-disclosure may inhibit the formation of a nurse-client or midwife-woman relationship.

CLINICIAN STORIES

Story I ...

An issue of self-disclosure on the part of a colleague - over hearing her disclose personal information about a family member [her mother] who had died of the same kind of cancer as the patient, who she was giving the information to, had been diagnosed with. The patient had not really asked for this information and was quite distressed by what she was told.

Application of the guidelines to Story I

Application of principle nine would have enabled the nurse to determine possible therapeutic effects of this disclosure. That it caused distress is not always an indication that it was not therapeutic. Perhaps the nurse could have disclosed progressively, testing client response.

Story J ...

A woman who was 16 weeks pregnant presented at Accident and Emergency with a miscarriage. The nurse taking the history in the unit was also pregnant. She disclosed to the woman that she didn't want to be pregnant, she should have had the pregnancy terminated, and 'wasn't the world a funny place'. The patient was very distressed by the incident.

Application of the guidelines to Story J

Application of principles nine and ten would have precluded this disclosure.

Story K ...

22-week gestation pregnancy loss. Family did not want extended contact with the baby. Midwife who was caring for the family had had a similar experience and related her feelings and the guilt she had had in not having contact with her miscarried baby. Family changed their views - had extended contact with their baby in hospital. Midwife continued the contact within the community until the family had to ask the hospital administration to intervene. Disclosure was therapeutic and welcomed early in the midwife-woman relationship but was carried to extremes and became non-therapeutic / harmful.

Application of the guidelines to Story K

The initial disclosure appears to have been appropriate and therapeutic. This is a good example of application of principle nine. However, the continued association reflects a boundary crossing (indicator two).

Story L ...

The difficulty that arose when I nursed a patient who was a relative of a friend. My friend (not a nurse) wanted / expected me to give her information that I felt was breaching confidentiality of the patient, she was using our friendship to obtain information that I felt extremely uncomfortable about giving out.

Application of the guidelines to Story L

There is a need for the nurse to explain to her friend the standard outlined in the Code of Professional Conduct.

CONSUMER STORIES

Consumer Story E ...

I was visiting an Aboriginal family down in Sydney last year. She had had a major operation, but a lot of family went to stay with her. In aboriginal families, we can have up to 40 or 50 relatives come to visit. So with this lady, everyone from around the State was ringing and that bugged the staff and they said 'look, this has to stop'. The patient was really upset and wanted to sign herself out and the person whose call they had refused was her husband... These sorts of things shouldn't happen to anyone.

Application of the guidelines to Story E

This story indicates evidence of insensitivity to the cultural context of the situation (i.e. need for information). There is also a lack of recognition by nurses that their responsibility to the client included their family and significant others. Principles one, three and fourteen needed to be applied here.

CATEGORY FOUR: GIFTS/SERVICES and FINANCIAL RELATIONS

Preamble

Society recognises the giving of a gift as a normal expression of appreciation for a service that has been rendered.

Principles of Safe Practice

15. Nurses and midwives should recognise that the giving and receiving of gifts and involvement in financial transactions within the nurse-client or midwife-woman relationship has the potential to compromise the professional relationship.
16. The giving of a gift to a nurse or midwife by a client or woman may have an impact on the client's or woman's significant others.

INDICATORS OF BOUNDARY CROSSING / VIOLATION

The following elements may be used to assess the appropriateness of the gift / transaction:

i. Timing: before, during or after the care episode

ii. Personal gain: relative value to the giver and the recipient

iii. Intent: was the gift solicited or coerced from the client or woman? Is there an expectation of different care?

iv Consequences: e.g. refusal, family response, emotional discomfort

v. Cultural / religious factors, emotional discomfort.

CLINICIAN STORIES

Story M ...

Working in small community as sole clinician being given vegetables, eggs etc. at different times and then small gifts from clients at Christmas or birthday. These clients see this as a small token of their appreciation for the care they are given and would be very hurt if thrown back in their face. Often make the statement 'this is for you - not the centre'.

Application of the guidelines to Story M

There is an appropriate application of the guidelines in this story.

Story N ...

Unit where two staff members systematically asked the occupation of all clients with a view to exploiting them. Example used was finding a client's husband who concretes driveways, contracting him to do so, then beating him down in price.

Application of the guidelines to Story N

This story indicates a breach of the guidelines, as the nurse is deliberately exploiting the nurse-client relationship for personal gain.

Story O ...

A casual EN [Enrolled Nurse] at nursing home befriends elderly gentleman who subsequently purchases new car so the EN is the only valid driver for this vehicle, with the object of taking him on outings and subsequently attends auction sale to purchase boat with motor for fishing (gentleman 92 - dependent on O_2 therapy).

Application of the guidelines to Story O

The EN in this story has crossed the boundary, and needs to be aware of the potential for violation of principle fifteen.

Story P ...

A client's relatives offer personal gifts of perfume and night gowns to a nurse in the assumption that mum 'will be well cared for' by the nurse and given extra special care. The nurse initially objected to the gifts but was encouraged by relatives to accept and then did so. Client continually requests favours from a nurse stating that 'no-one else can do it as well as she'. This has caused other clients' to feel 'left out' not getting as much attention.

Application of the guidelines to Story P

This story indicates the relatives may believe they are 'buying' better care by giving gifts to certain nurses. This needs to be addressed by all concerned, as there is a potential for a violation of principle fifteen in this situation.

Story Q ...

Incident with patient's relative; patient unable to speak much English. Her son trying to show his gratitude virtually pulled me behind curtain of bed stuffing $70 in my shirt pocket. To onlookers it must have looked underhand – I came out feeling guilty.

Application of the guidelines to Story Q

The nurse in this situation should not have accepted the money, but cultural issues are a factor here. In order for principle fifteen to be preserved, this situation needs to be handled sensitively, but it must be addressed.

Story R ...

A client gave me a necklace, it was worthless from a monetary point of view but meant a lot to her. It was given to me because she wanted to be remembered by me not as the sick person I knew, but as a young person purchasing it on her travels (we had both travelled extensively and had often discussed this). The issues that worried me were:

- She had two daughters and many grandchildren they might have wanted this necklace and felt it should be kept in the family.
- I believed it not to be of any monetary value but was it?
- I knew it was her wish for me to have it but did not feel comfortable keeping it.
- The outcome was that after she died I returned it to the family with an explanation.

Application of the guidelines to Story R

This story indicates appropriate application of principles fifteen and sixteen.

CONCLUSION

Applying the guidelines helps to move practice towards the safe and therapeutic zone. If you need further advice or help with any boundary issues, please refer to the following supports:

- Immediate supervisor
- Organisational policy and protocol
- Professional and industrial organisations.

REFERENCES

Australian Nursing Council Inc. (1995). Code of professional conduct for nurses in Australia. Canberra, ANCI.

National Council of State Boards of Nursing, Inc. (1996). Professional boundaries: A nurse's guide to the importance of appropriate professional boundaries. Chicago: National Council of State Boards of Nursing, Inc.

National Health and Medical Research Council. (1999). A Guide to the Development, Implementation and Evaluation of clinical Practice Guidelines. Canberra, AGPS.

Peterson, M. (1992). At personal risk: Boundary violations in professional-client relationships. New York: W W Norton and Company.

Schoener, G. R. (1999) Personal communication.

This project was undertaken for the Nurses and Midwives Board by:

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Ms Elizabeth Bujack

Mr Charles Harmon

Professor Diana Keatinge

Ms Lorinda Schultz

Dr Ron Sharkey

Principles of Safe Practice

1. The priority of nurses and midwives is to plan care around meeting the therapeutic needs of the client or woman.
2. Nurses and midwives need to be aware of their own needs, values and attitudes in a professional relationship.
3. Nurses and midwives must have an awareness of and an ability to describe the therapeutic purpose of nursing or midwifery actions that are interpreted against a client's or a woman's responses.
4. Nurses and midwives are responsible for ensuring that nursing and midwifery care is never withheld from a client or woman as a punishment. Any intent to cause pain / suffering, as punishment based on punitive judgement is unacceptable.
5. Coercing client or woman compliance may be an abuse of the power imbalance.
6. Nurses and midwives need to be aware of the comfort zones for both client and nurse, and midwife and woman regarding therapeutic touch.
7. Care is optimised when nurses and clients or midwives and women do not engage in dual relationships.
8. Where dual relationships are unavoidable there is a potential for prejudicial practice to occur.
9. Self-disclosure should be limited to revealing information that has therapeutic value to the client or woman.
10. Self-disclosure should only occur within an established therapeutic relationship.
11. Nurses and midwives need to carefully consider their motives for disclosing personal information.
12. Nurses and midwives should apply the Code of Professional Conduct as the standard for confidentiality and must treat personal information obtained in a professional capacity as confidential.
13. Nurses and midwives should not use confidential information or their position of power to advantage themselves in any way.
14. Nurses and midwives have a professional responsibility to inform clients and women about the nursing or midwifery care which clients or women are receiving. Nurses and midwives should assess and negotiate individual clients' or women's needs for information relating to their care.
15. Nurses and midwives should recognise that the giving and receiving of gifts and involvement in financial transactions within the nurse-client or midwife-woman relationship has the potential to compromise the professional relationship.
16. The giving of a gift to a nurse or midwife by a client or woman may have an impact on the client's or woman's significant others.

Hagan, John (Health)

From:	Jackson, Helen
Sent:	Thursday, 13 December 2012 10:12 AM
To:	Neverauskas, Daina; Byrnes, Sue; Thomas, Carolyn; O'Connor, Narelle
Subject:	Referral Process and Referral Form for Complex and Invasive Healthcare in Schools
Attachments:	Process for Referring Students with Complex and Invasive Healthcare in Schools.doc; Draft 3 ACT Referral Form.doc

Good morning all,
Please find attached the paperwork for referral to the Complex and Invasive Healthcare in Schools program.
Thanks Helen

Helen Jackson | Clinical Nurse Consultant
Project Position: Children at School with Complex Healthcare Requirements
Phone (02) 6207 7631
e-mail: helen.jackson@act.gov.au
Central Team| **Division of Women, Youth & Children Community Health Programs**
Health Directorate| ACT Government
1 Moore St Canberra ACT| GPO Box 825 Canberra ACT 2601| www.health.act.gov.au
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Process for Referring Students with Complex and Invasive Healthcare in Schools

Request for Healthcare: General Medical Information and Consent Form completed (First Aid Policy – Appendix 1 (3)

☐ Yes ☐ No (If no one must be completed by parent/guardian)

The appropriate Emergency Treatment Plan completed (First Aid Policy)

☐ Yes ☐ No (If no one must be completed by parent/guardian)

Is this healthcare complex and invasive? ☐ Yes ☐ No

The student requires this healthcare to attend school? ☐ Yes ☐ No

Will school staff require extra training and skills to provide this healthcare? ☐ Yes ☐ No

Have you have ticked the yes box three times?

☐ Yes (The Referral Form attached is to be completed by parent/guardian)

☐ No (This healthcare can managed within current school policies and procedures)

Completing Referral process:

Referral Form: Parent/guardian has completed consent and Part A student's details? ☐ Yes

The Health Professional has completed Part B? ☐ Yes

Principal has completed Part C? ☐ Yes

Send referral to

The families will be contacted by the Complex and Invasive Healthcare in Schools Programs to organise a time/s for the nurses to complete an assessment, identify the training and skills assessment required and develop a healthcare plan.

Healthcare Support Plan

For use in schools

Confidential

The information contained in this document was written by a Registered Nurse and is specific to meet the health support needs of the nominated student and is specific to the Women Youth and Children Community Health Programs (WY&CCHP). The Health Plan for this student can only be altered or reviewed by a WY&CCHP Registered Nurse in consultation with the family and the students' health care provider. This Health Plan and its supporting documents remain valid until the close of the ACT 2013 school year. The actions outlined in the document do not replace prescribed treatment by a Medical Practitioner or the implementation of first aid.

Name of student:

Date of birth:

Name of School:

CONTACT DETAILS:

Role	Name	Phone	Mobile phone
Parent/Guardian			
Parent/Guardian			
Registered Nurse			
Clinical Nurse Consultant			
Nurse Manager			

sticker

Health Support Needs

Allergies/sensitivities

Supporting Documents

1.
2.
3.

The healthcare outlined in this healthcare support plan will be provided by ....School staff members who have been trained and assessed as competent to deliver this care by a registered nurse. The registered nurse will also provide follow up support for staff and ongoing communication with parents.

Registered Nurse

Name.. Designation.......................................

Signature... Date..

ACT Health Directorate Medical Officer

Name.. Designation.......................................

Signature... Date..

AUTHORISED COPIES TO

☑ Student and/or parent/guardian.

☑ Student School file

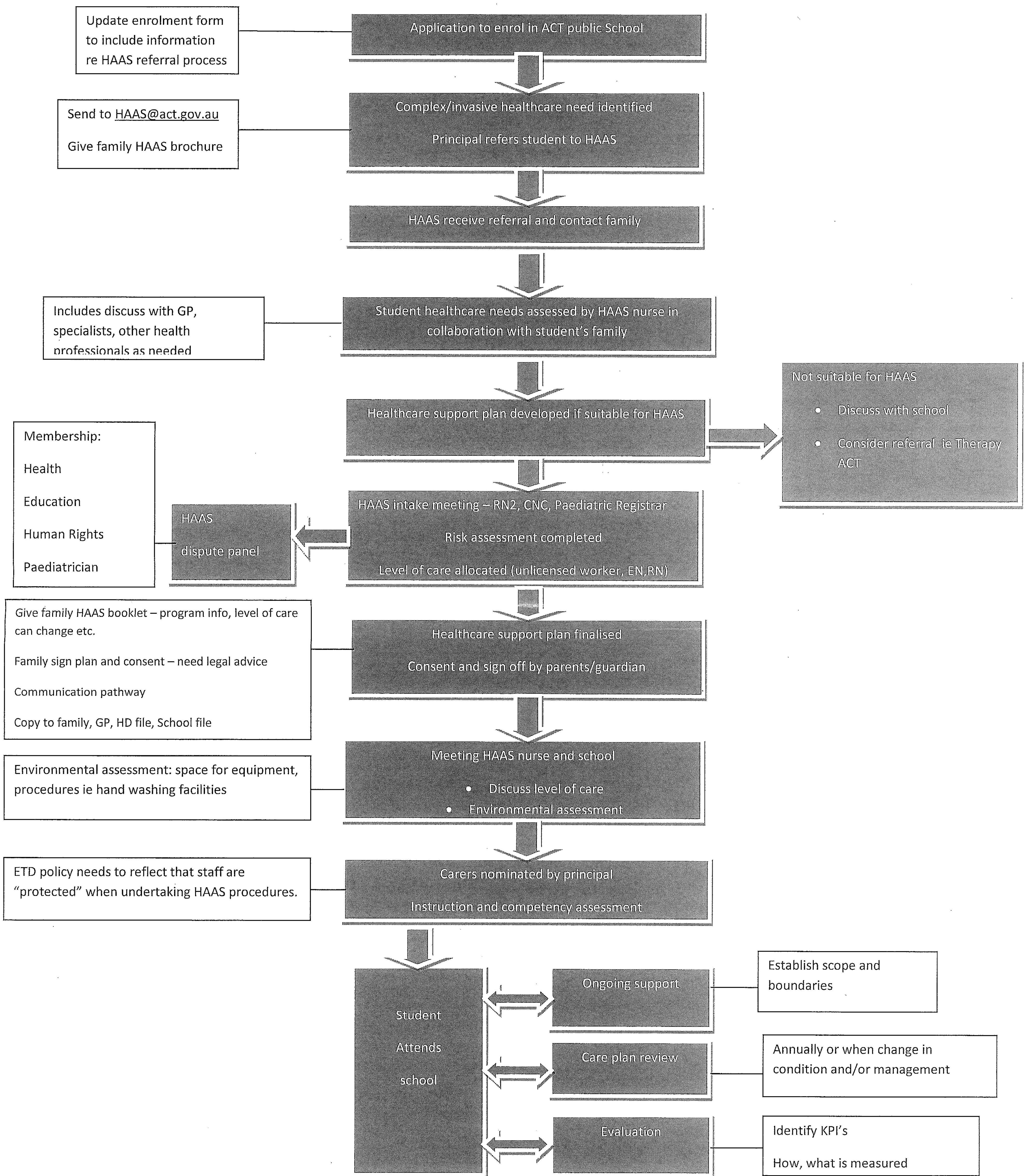
☑ WY&CCHP's Client file

I have read and agree with this Healthcare Support Plan and any supporting documents indicated above.

	NAME	SIGNATURE	DATE
Parent/Guardian			
Parent/Guardian			

Version Number: Draft 2 Valid To: ....../....../......

Healthcare Access At School (HAAS) Process



Governance considerations:

- MOU and Schedule E H
- Program guidelines E H
- Interagency Reference Committee E H
    - Terms of reference
    - Membership
    - Inclusion fund: equipment, RN; EN
- HAAS dispute panel E H
    - Process
    - Membership
- Clinical records H
- ACTPAS activity – how is program reported H
- KPI's – indentify how, what is measured E H
- Enrolment form to include HAAS referral information E
- Review of ETD policy to include HAAS activity by staff E
- Dissemination of information to relevant schools E

KEY:

E Education Directorate task

H Health Directorate task

Agenda for meeting this afternoon 12th February 2013

Healthcare Access At School (HAAS) program update

Attendees:

Chair: Daina Neverauskas

Minutes: Carolyn Thomas

Agenda Items

1. HAAS Background: Daina Neverauskas
2. Work to date: Sue Byrnes
3. HAAS program update: Narelle O'Connor
4. The pilot program update: Narelle O'Connor
5. Caring for Kids: Katie/Fiona

Meeting ended:

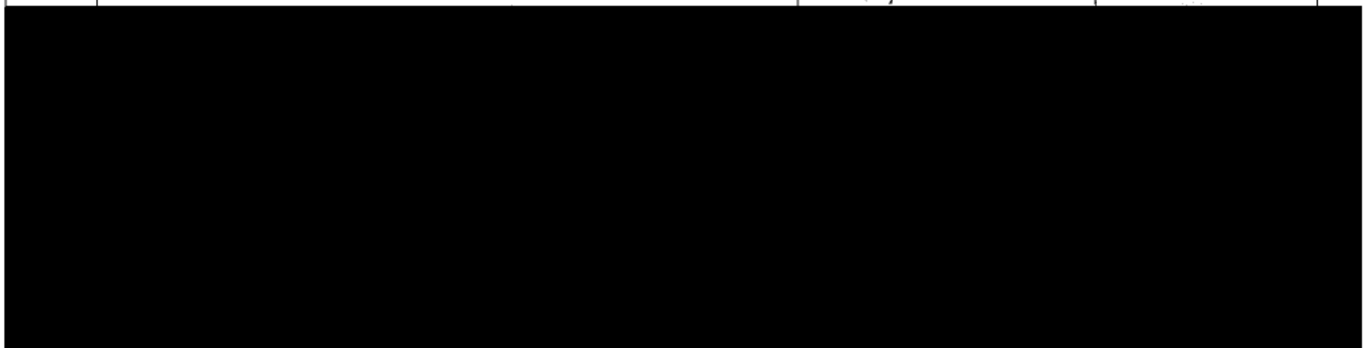
Disability Education Reference Group

Tuesday 19 February 2013

11 am – 1 pm

Hedley Beare Centre for Teaching and Learning, Stirling
Meeting Room 10

9	Healthcare Access at School Program - Update	Carolyn Thomas and Sue Byrnes	10 min

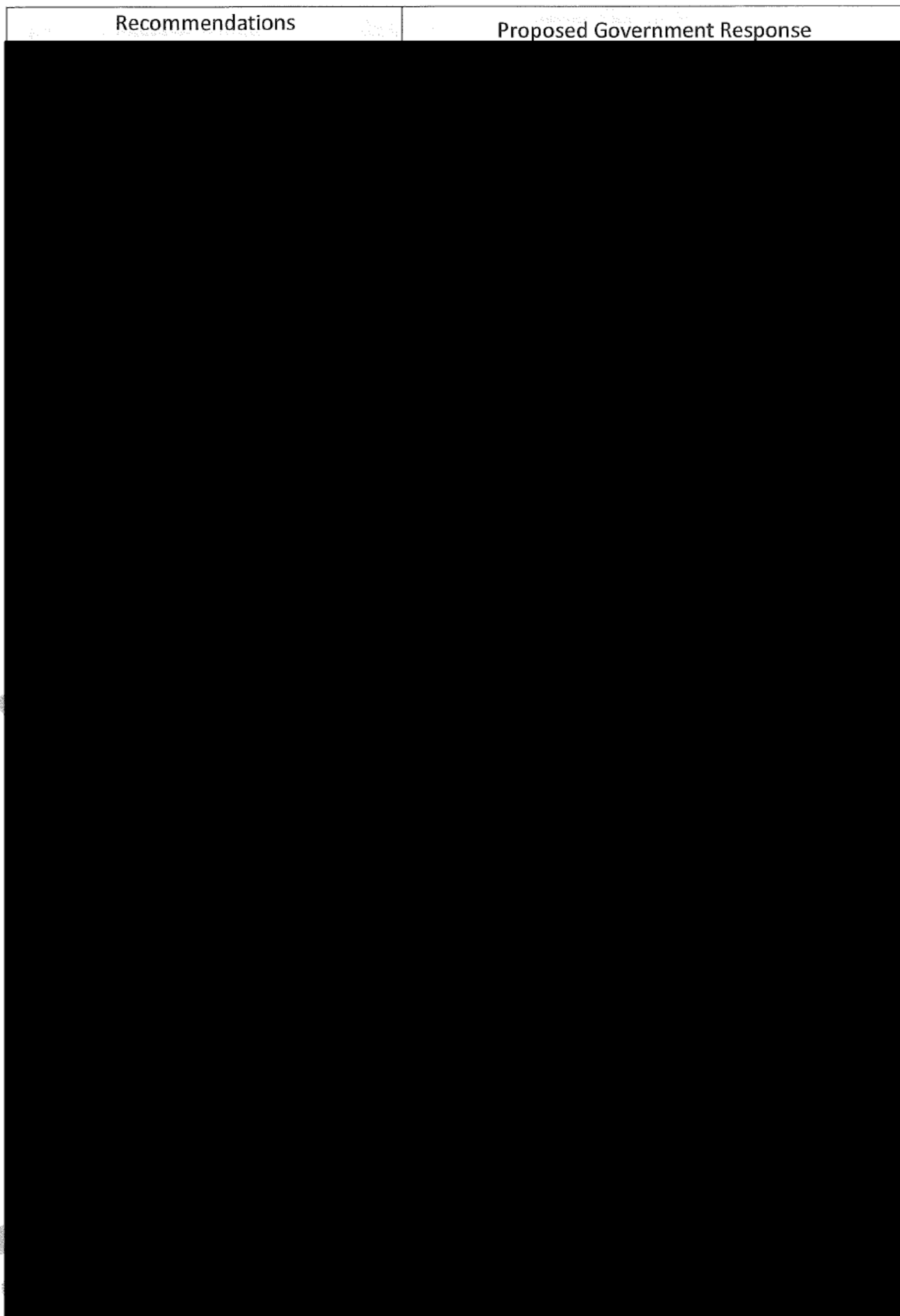


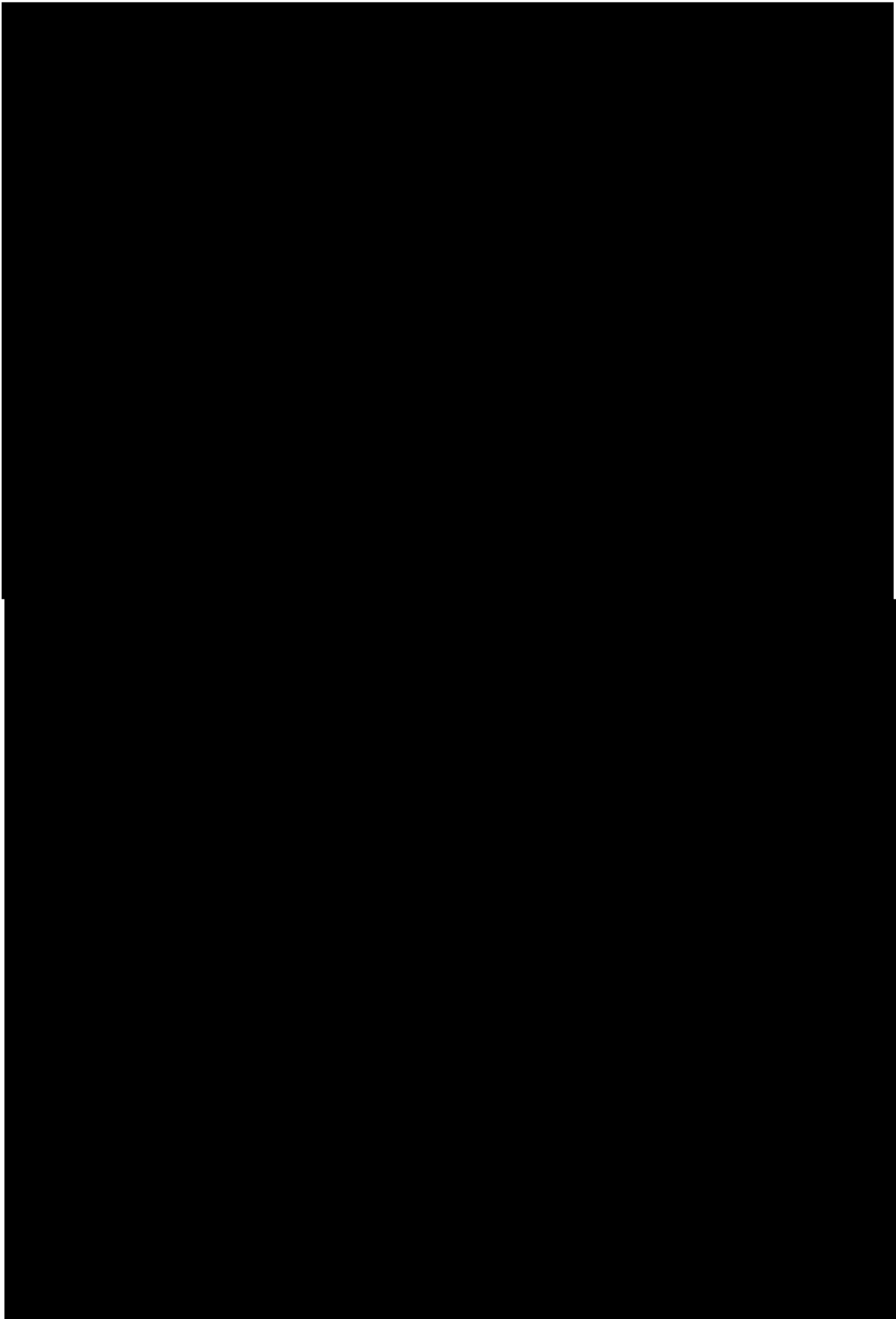
Apologies to Sharon Hough, 620 58219

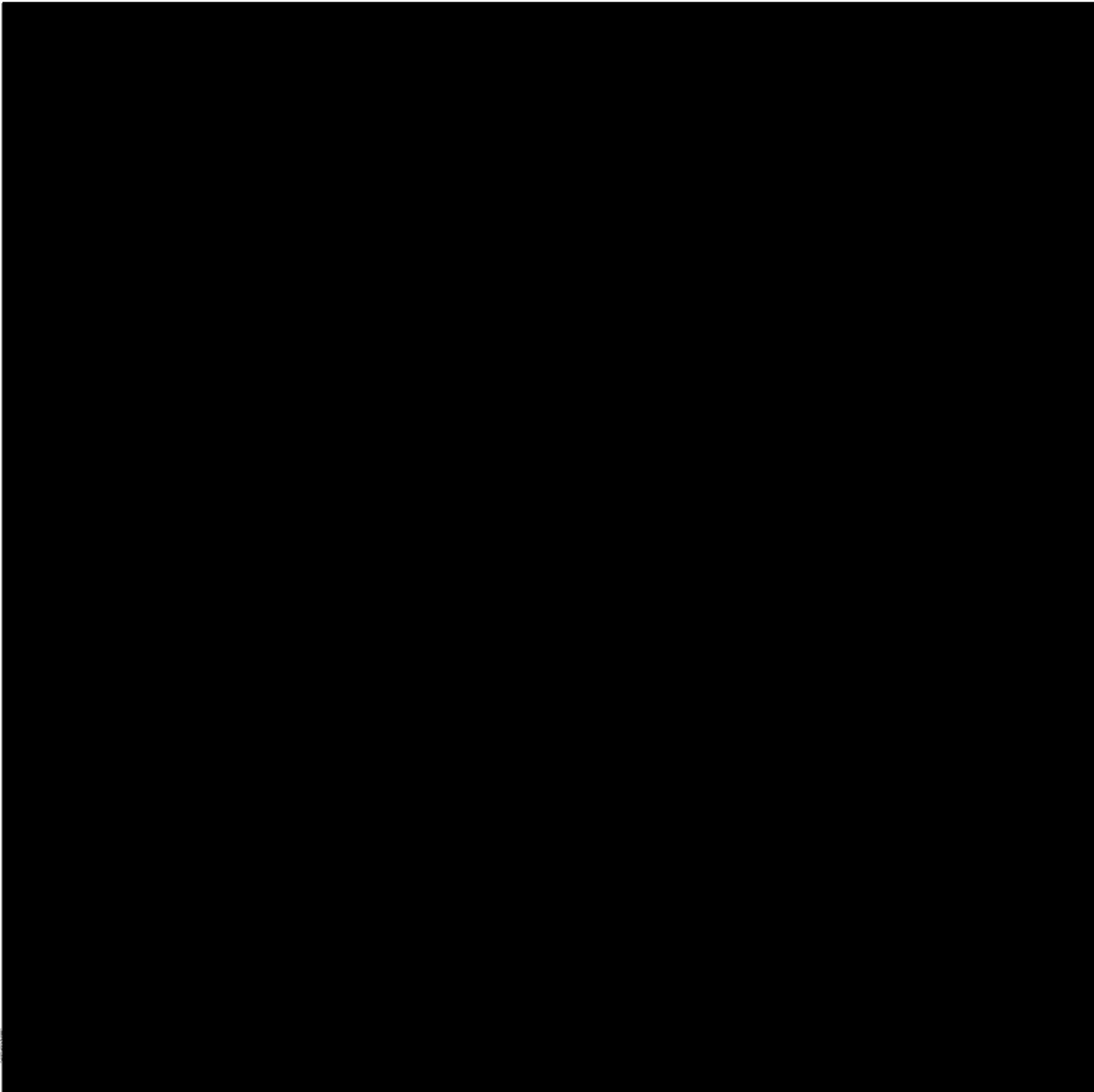
Apologies:
Mimi Dyall (Rex O'Rourke to attend)
Glenn Fowler (Sasha Colley to attend)

Standing Committee on Education, Training and Youth Affairs

Recommendations	Proposed Government Response







HAAS Meeting

Action Items from meeting 25/2/13

HEALTH

1. Awaiting information from Maribyrnong primary school regarding potential HAAS students. Health will send Lindy Abbott the new HAAS referral form for these students.
2. HAAS panel terms of reference required. Health will see if South Australia has some for their panel we can adapt.
3. HAAS intake panel – Daina will follow up on paediatrician representation on this panel
4. Daina organise that the draft Education/Health MOU be sent to Iain
5. The draft HAAS schedule which will sit under the MOU is in development. Health will send very early draft work to ETD for their input. This schedule is the 'program guidelines' for HAAS and as such it is imperative we get it right.
6. An EOI for a RN2 to work in the HAAS program closes on Thursday 28th February

EDUCATION

7. ETD catheter and medication policy – under which HAAS sits – is with ETD legal now. Health has provided some information and are happy to assist if needed in developing this policy (and first aid policy). It is acknowledged that the HAAS process is superior to previous.
8. HAAS panel: ETD will look at options for representation from their Directorate

GENERAL

9. Inter-agency Reference Committee (IRC) members identified. **ETD**: Kerry Heath, Iain Barr, Ros Donohue. **Health**: Sue Byrnes, Carolyn Thomas, Narelle O'Connor. TOR will be similar to SYHN IRC – health will draft HAAS IRC TOR.
10. Draft information sheets for families and schools can be used at Maribyrnong school but need to insert version control and make clear this is a draft and subject to review.

Hagan, John (Health)

From: Thomas, Carolyn
Sent: Tuesday, 26 February 2013 8:41 AM
To: Neverauskas, Daina; Heath, Kerrie; Byrnes, Sue; O'Connor, Narelle; Barr, Iain; Barr, Iain (ACTEDU)
Subject: HAAS meeting 25/2/13

Hi,

Just listing the pertinent points from our meeting yesterday (in lieu of minutes)

Attendance: Kerry Heath, Iain Barr (ETD project officer) Daina Neverauskas, Narelle O'Connor, Carolyn Thomas.
Apologies: Sue Byrnes

1. Awaiting information from Maribyrnong primary school regarding potential HAAS students. Health will send Lindy Abbott the new HAAS referral form for these students.
2. Draft information sheets for families and schools can be used at Maribyrnong school but need to insert version control and make clear this is a draft and subject to review.
3. ETD catheter and medication policy – under which HAAS sits – is with ETD legal now. Health have provided some information and are happy to assist if needed in developing this policy (and first aid policy). It is acknowledged that the HAAS process is superior to previous.
4. HAAS panel: Some discussion regarding representation. ETD will look at options for representation from their Directorate and Health from theirs. Daina will speak with the commissioners for Children and Disability regarding potential representation on the HAAS dispute panel from their departments.
5. HAAS panel terms of reference required. Health will see if South Australia has some for their panel we can adapt.
6. HAAS intake panel – Daina will follow up on paediatrician representation on this panel
7. Daina organise that the draft Education/Health MOU be sent to Iain
8. The draft HAAS schedule which will sit under the MOU is in development. Health will send very early draft work to ETD for their input. This schedule is the 'program guidelines' for HAAS and as such it is imperative we get it right.
9. An EOI for a RN2 to work in the HAAS program closes on Thursday 28th February
10. Inter-agency Reference Committee (IRC) members identified. ETD: Kerry Heath, Iain Barr, Ros Donohue. Health: Sue Byrnes, Carolyn Thomas, Narelle O'Connor. TOR will be similar to SYHN IRC – health will draft HAAS IRC TOR (Acronym city!!!) It was thought that IRC meetings could be at similar times to the SYHN IRC meetings.

I will arrange another meeting in March via outlook.
Please let me know if any of the above is not correct or needs changing/additions.
We are getting there!

Cheers

Carolyn Thomas

Manager | Division of Women, Youth & Children | Community Health Programs
Specialist School Nurses|School Youth Health Nurses|Community Asthma Support Service (CASS)
Nurse Audiometry|High School Immunisation|Kindergarten Health Check/Healthcare Access At School (HAAS)
Phone: 6205 1575
Mobile: 0408 648 945
e-mail: carolyn.thomas@act.gov.au

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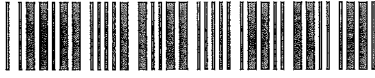
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ACT Government Health Directorate

Healthcare Access at School Assessment Form

Complete details or affix label

URN: ______________________

Surname: ______________________

Given name: ______________________

DOB: ____________ Gender: ____________

Assessment Details	☐ Initial Assessment	☐ Reassessment
Date: ________ Time: ______		☐ Consent documented
Person(s) Present:		
Health Professionals And Support Services		

Profession	Name	Contact Details
General Practitioner		
Paediatrician		
Immunologist		
Neurologist		
Cardiologist		
Oncologist		
Neurovascular Specialist		
Respiratory Specialist		
ENT Specialist		
Intensive Care Unit Specialist		
Physiotherapist		
Endocrinologist		
Diabetes Nurse Educator		
Gastroenterologist		
Home Enteral Nutrition Scheme		
Dietitian		
Speech Pathologist		
Urologist		
Renal Specialist		
Orthopaedic Surgeon		
Occupational Therapist		
Dermatologist		
Psychologist		
Psychiatrist		
Behaviour Therapist		
Palliative Care		

Diagnosis / Family History
Development History
Likes / Dislikes
Weight
Allergies / Sensitivities
Family/ Psychosocial Factors
Cultural Factors
NEUROLOGICAL
Seizures / Convulsions
Hydrocephalus / Shunt
Level Of Consciousness
Communication / Cognition
Pain Management

Complete details or affix label

URN: ____________________

Surname: ____________________

Given name: ____________________

DOB: ____________ Gender: ____________

ACT Government Health Directorate

Healthcare Access at School Assessment Form

SENSORY: Vision/Hearing/Touch/Taste/Smell
CARDIOVASCULAR
Cardiac Condition
IMMUNE / LYMPHATIC SYSTEM
CIRCULATORY
Circulatory/Blood disorders
Intravenous / Central Venous Devices
RESPIRATORY
Asthma
Recurring Chest Infections / Pneumonia
Oxygen Requirements
Suction Requirements

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Airway: Upper/ Lower
Tracheostomy
Non Invasive Positive Pressure Ventilation / Intermittent or continuous ventilation via tracheostomy
METABOLIC - Diabetes / Thyroid Function / Pancreas / Adrenal / Electrolyte Balance
GASTROINTESTINAL
Bowel Management
NUTRITION
Oral
Enteral Nutrition
ORAL / DENTAL HEALTH
RENAL / URINARY
REPRODUCTIVE HEALTH
MUSCULO-SKELETAL

ACT Government Health Directorate

Healthcare Access at School Assessment Form

Complete details or affix label

URN: ______________________

Surname: ______________________

Given name: ______________________

DOB: ____________ Gender: ____________

SKIN CARE

MENTAL HEALTH/BEHAVIOUR

PALLIATIVE CARE

EQUIPMENT REQUIRED

Item	Maintenance

MEDICATIONS

Pharmacy prepared blister pack? ☐ Yes ☐ No If no, reason ______________________

Medication (not in a blister pack)

Medical Practitioner's order for medication form given (non blister pack only) to parent to be completed?

☐ Yes ☐ No By when? ____________

HEALTH ISSUES IDENTIFIED

Complex and/or invasive (Managed through HAAS)

Not complex and/or invasive (Managed by School)

RN Signature | Print name | Designation | Date

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Hagan, John (Health)

From:	Thomas, Carolyn
Sent:	Thursday, 21 March 2013 4:12 PM
To:	Garry, Jacinta
Cc:	O'Connor, Narelle
Subject:	Health care Access At School - ? suitability for QAC
Attachments:	Flow chart March 2013.pub; Brochure A4 version for families.docx; Brochure A4 version schools.doc; Risk assessment.doc; Canberra Health Assessment guide.doc

Good afternoon Jacinta,

Thanks for talking with me earlier. I have attached our draft information sheets for families and schools, the HAAS flowchart which outlines the steps involved from receiving a referral to HAAS to the student attending school, a draft guide to the HAAS health assessment and the Risk assessment tool.

Draft TOR (we have not got a detailed TOR as yet but basically this is what envision)

- **Review the health assessment that has been made.** A thorough assessment is undertaken in collaboration with the student (if applicable), their family and other relevant health professionals. This information would all be given to the HAAS dispute panel.
- **Review the proposed health care support plan** - given to the HAAS dispute panel
- **Consider the family's reasons for wanting a different level of care assigned**
- **Review the level of care that has been assigned/recommended** - using the risk assessment matrix tool
- **Make a decision either supporting or rejecting the level of care assigned**
  - If a different level of care is recommended – outline the level of care recommended and outline reasons for this decision
  - If the recommended level of care is found appropriate – outline reasons for support

We would like the HAAS panel decisions to be final and for the panel to sit in a 'structured framework' so its decisions are respected and so the Minister is aware of (and hopefully supports) any panel decisions.

The HAAS panel would only be convened if a family disputed the level of care assigned to their child.

I am very happy to assist with any other information required. I am situated on level 2, 1 Moore street (I think you are on level 3?) if you want to meet to discuss.

Kind regards

Carolyn Thomas

Manager | Division of Women, Youth & Children | Community Health Programs
Specialist School Nurses|School Youth Health Nurses|Community Asthma Support Service (CASS)
Nurse Audiometry|High School Immunisation|Kindergarten Health Check/Healthcare Access At School (HAAS)
Phone: 6205 1575
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HEALTH ACCESS AT SCHOOL – RISK MANAGEMENT ASSESSMENT TABLE

Contributing Factors	RN 1:1	EN 1: 1	School Support Staff 1:1	School Support Staff
Physical Condition • overall risk to airway/breathing and circulation • Specialist management required (tracheostomy etc) • risk of infection or illness	Multiple, complex issues involving several systems - respiratory, cardiac, renal, central nervous system etc Deteriorating health/unstable general health Requires frequent observation / assessment and care based on observations Palliative - requiring significant input with child/family and/or service provider agencies. Changing situation.	Complex issue of one or more systems Deteriorating health Requires frequent observation/and some level of assessment. Increased risk of instability Palliative +/- end of life stage, established management protocols	Requires frequent observation but not assessment May require several Level 3 procedures that are complex and time consuming. First Aid responses may include Level 3 procedure for management e.g. Oxygen , Suction	Disability + minimal invasive procedures required Stable condition, nil deterioration of health First Aid management for emergencies definable and able to be managed by other staff members
Stability of Health • Frequency of hospitalisation, serious illnesses • unpredictable or deteriorating health • Frequency of events requiring intervention • Level of consciousness	Frequent complicated admissions to hospital Unstable and unpredictable health Frequent events requiring intervention Altered level of consciousness requiring frequent assessment	Level of instability with health needs Frequent hospital admissions or illnesses May have frequent events which are manageable with minimal assessment Level of consciousness manageable with minimal assessment / intervention	May have had previous complicated hospital admissions but now stable Health is predictable but requires several level 3 procedures that are complex and time consuming Events predictable and interventions defined in Health Plan Stable level of consciousness	Minimal hospital admissions with straight forward management, illness easily resolved Routine medical management and support Stable level of consciousness

HEALTH ACCESS AT SCHOOL – RISK MANAGEMENT ASSESSMENT TABLE

Contributing Factors	RN 1:1	EN 1: 1	School Support Staff 1:1	School Support Staff
Airway • Stability • episodes of collapse • episodes of apnoea • episode of aspiration	respiratory events have occurred previously and continue to be likely experiences severe respiratory illness with high risk of airway compromise airway obstruction more than once and further high risk of obstruction Aspiration frequent and requires assessment and emergency management Ventilated client / unstable tracheostomy	Moderate to high risk of respiratory illness Moderate to high risk of respiratory compromise Some level of assessment required for airway management. Complicated tracheostomy care	Increased risk of infection previous respiratory events experienced but not for several months. May need level 3 interventions for care. e.g. Chest Physio / Suction / nebulised therapy/ oxygen which are both planned and PRN Stable tracheostomy care	Nil respiratory events experienced May have difficulty managing secretions but has swallow gag and cough reflexes May need some level 3 interventions for care. e.g. Chest Physio / Suction / nebulised therapy all of which are planned events and not in response to emergency
Amount and Type of Invasive Procedures • Scope of practice required to perform	Multiple complicated procedures e.g. oxygen, suction- Naso pharyngeal, Oropharyngeal airway management, gastrostomy, medication high risk procedure e.g. complex tracheostomy management /ventilation	Several and /or complicated or high risk procedures	More than 3 “invasive” procedures e.g. gastrostomy, oxygen, medication	1 - 3 straight forward procedures e.g. gastrostomy, medication
Assessment / Decision Making Required • Scope of practice required	Requires frequent assessment and management	Requires level of assessment and management	Requires observation of signs and symptoms and following of outlined responses in health plan Complex level 3 Health procedures required. Additional training required but follows set out plan.	No assessment required First aid responses Health plan outlines responses Simple procedures

HEALTH ACCESS AT SCHOOL - RISK MANAGEMENT ASSESSMENT TABLE

Contributing Factors	RN 1:1	EN 1: 1	School Support Staff 1:1	School Support Staff
Environmental Factors • Safety for child, support for Care Worker/EN/RN • Access to emergency assistance	Only child on site, no additional staff to support child Emergency procedures in place but require high level of complex health intervention prior to ambulance arriving	Only child on site, no additional staff to support child Emergency procedures in place, Nursing interventions required prior to ambulance arriving	Access to immediate phone or on site assistance Designated person to assist in emergencies. Interventions required prior to ambulance arrival are straight forward , stepped out in Health plan and are a competency assessed procedure	In a setting with other children and/or with multiple staff in immediate vicinity Health procedures planned and predictable. Staff member able to leave site in between
Equipment • Simple or complicated equipment • amount of equipment	Multiple equipment e.g. oxygen cylinder, suction, gastrostomy tubing or Complicated equipment e.g. tracheostomy, BiPAP, dialysis, ventilator	Multiple equipment e.g. oxygen cylinder, suction, gastrostomy tubing or Complicated equipment e.g. tracheostomy, BiPAP, dialysis	Multiple equipment and increased skill level e.g. oxygen, oximetry, suction unit, emergency Tracheostomy equipment	standard equipment e.g. gastrostomy lines and feeding equipment, syringes for medication
Other Contributing Factors • Staff concerns re ability to care for child • difficult relationships with families • behaviour of child	Complicated relationship with family and services requiring professional level of interaction High level of involvement with Palliative team. Extreme emotional distress within family unit. Child at high risk of harm	Complicated relationship with family and services requiring professional level of interaction Emotional factors relating to client health deterioration. High levels of stress as services become difficult to access.	Child at high risk of harming themselves or others due to behaviour Good communication with family and services. Staff feel comfortable working with client and believe they are working within scope of practice.	Basic age appropriate level of independence Communication with families via diary or phone Safe environment, independence appropriate to age level, capable of some decision making

HEALTH ACCESS AT SCHOOL - RISK ASSESSMENT FORM

URN:
Surname:
Given name:
DOB: Sex:

Clients Name: .... **Date of Assessment** ....

ASSESSMENT	Refer to Risk Management Assessment Table			COMMENTS	RECOMMENDED SUPPORT MODEL
	Likelihood	consequence	Risk rating		
Physical condition					
Stability of health					
Airway					
Amount and type of invasive procedures					
Assessment /decision making					
Environmental factors					
Equipment					
Other contributing factors					

Summary:

Recommended Support Model: **Recommended Timeframe for transition:**

RN Signature......................................

Designation....................................... **Date Completed:**....................................

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URN:	303
Surname:	
Given name:	
DOB:	Sex:

Health Assessment

HEALTH ACCESS AT SCHOOL

ASSESSMENT DETAILS

INITIAL ASSESSMENT ☐ **REASSESSMENT** ☐

DATE : **TIME:**

PERSONS PRESENT:

RELEASE OF INFORMATION RESTRICTIONS Yes ☐ No☐
Details:

HEALTH PROFESSIONALS

PROFESSION	NAME	CONTACT DETAILS
General Practitioner		
Paediatrician		
Neurologist		
Cardiologist		
Respiratory Specialist		
ENT Specialist		
Gastroenterologist		
HENS		
Palliative Care		
ENT		
Respiratory		
Dietician		
Speech Pathologist		
Physiotherapist		
Occupational Therapist		

FAMILY/ PSYCHOSOCIAL FACTORS

URN:	304
Surname:	
Given name:	
DOB: Sex:	

Health Assessment

HEALTH ACCESS AT SCHOOL

CULTURAL FACTORS
DIAGNOSIS / FAMILY HISTORY
BIRTH / DEVELOPMENT HISTORY
LIKES / DISLIKES
WEIGHT
ALLERGIES / SENSITIVITIES
NEUROLOGICAL
Seizures / Convulsions
Hydrocephalus / Shunt
Level of Consciousness
Mental Health / Behaviour

URN:		305
Surname:		
Given name:		
DOB:	Sex:	

Health Assessment
HEALTH ACCESS AT SCHOOL

Communication / Cognition
Pain Managment
Vision / Hearing
CARDIOVASCULAR
Cardiac Condition
IMMUNE / LYMPHATIC SYSTEM
CIRCULATORY
Intravenous / Central Venous Devices
RESPIRATORY
Asthma
Recurring Chest Infections / Pneumonia
Oxygen Requirements

URN: 306
Surname:
Given name:
DOB: Sex:

Health Assessment

HEALTH ACCESS AT SCHOOL

Suction Requirements
Airway
Tracheostomy
Non Invasive Positive Pressure Ventilation / Intermittent or continuous ventilation via tracheostomy
METABOLIC - Diabetes / thyroid function
GASTROINTESTINAL

URN: 307
Surname:
Given name:
DOB: Sex:

Health Assessment
HEALTH ACCESS AT SCHOOL

NUTRITION
Oral
Enteral Nutrition
ORAL / DENTAL HEALTH
BOWEL MANAGEMENT
RENAL / URINARY
REPRODUCTIVE HEALTH
MUSCULO-SKELETAL

URN: 308
Surname:
Given name:
DOB: Sex:

Health Assessment

HEALTH ACCESS AT SCHOOL

SKIN CARE

PALLIATIVE CARE

EQUIPMENT REQUIRED

ITEM	MAINTENENCE

MEDICATIONS

MEDICATION AUTHORITY :

SINGLE ☐ MULTIPLE DAILY ☐ MULTIPLE PRN ☐

COMPLETED Yes ☐ No ☐

GIVEN TO PARENT TO BE COMPLETED Yes ☐ No ☐ By When

URN: 309
Surname:
Given name:
DOB: Sex:

Health Assessment

HEALTH ACCESS AT SCHOOL

HEALTH ISSUES IDENTIFIED
LEVEL 3 : (HAAS)
LEVEL 2 : (SCHOOL)

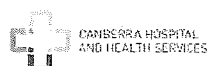
PLAN
Develop Level 3 Health Plan by: **Parent to have Level 2 Health Support Plans completed by:**

RN Name:

RN Signature:

RN designation:

Date for Review



HEALTH ASSESSMENT GUIDE-HAAS

GENERAL INFORMATION

IF PARENT / CARER DOES NOT HAVE ALREADY, ENSURE THEY ARE GIVEN A COPY OF THE FOLLOWING:

- "Complex and Invasive Healthcare in Schools Information Booklet
- The Australian Charter of Healthcare Rights pamphlet
- Explain access to relevant healthcare support plan documents
- Business Cards – Complex and Invasive Healthcare in School Program

ENSURE THE FOLLOWING ITEMS ARE DISCUSSED THROUGHOUT THE ASSESSMENT VISIT

- Inform parent / carer that RNs in the service are mandatory notifiers
- How delegation of care process works
- Process for training and skills assessment
- Process of developing HAAS Healthcare Support Plan
- Parent / carer responsibility re signing Healthcare Support Plan and related documents
- Process of reassessment - Annually unless any changes to health needs
- Communication pathway ie Who to inform when child is sick or away, who to ring if there are changes to childs health and/or equipment
- Communication between parent / carer and RN and school staff (i.e. in person, communication book, diary)

FAMILY/ PSYCHOSOCIAL

CONTACT DETAILS OF PARENTS
Identify Immediate Family/Identify social support network
Are there any court orders or alerts to be aware of? Is the child a Guardian of the State?
Identify who will be responsible for signing Health Plan

CULTURAL CONSIDERATIONS

LANGUAGE SPOKEN AT HOME
CONTACT DETAILS OF INTERPRETER - DOCUMENT IN PROGRESS NOTES
Identify any factors that will affect service delivery / communication issues / Family wishes

DIAGNOSIS / FAMILY HISTORY

CONTACT DETAILS OF PAEDIATRICIAN AND GP
Document health related diagnoses / effects of diagnosis on client's daily living
Any new diagnoses since initial assessment
FAMILY HISTORY - Significant medical conditions
RELATED EDUCATION AND TRAINING DIRECTORATE (ETD) MANAGEMENT AND EMERGENCY TREATMENT PLANS

- **General Medical Information and Consent Form (if no specific plan for clients condition this can be used)**

BIRTH / DEVELOPMENT HISTORY

History of the birth noting any complications, gestation, prolonged admission
Developmental Milestones / Immunisation history
Hospital admissions - frequency and length of admissions, any recent admissions

LIKES / DISLIKES

Establish relevant information to include in "About Me" section of Health Plan

WEIGHT

To be obtained as a guide only to Medication doses / appropriate nutrition volumes etc

ALLERGIES / DRUG SENSITIVITIES

CONTACT DETAILS OF IMMUNOLOGIST OR MEDICAL PROFESSIONAL
Known allergies/sensitivities and reaction / Outline management of symptoms

RELATED ETD HEALTH MANAGEMENT AND EMERGENCY TREATMENT PLANS

- **Action plan for Anaphylaxis**
- **Anaphylaxis and Severe Allergy plan**
- **Individual First Aid Plan**

NEUROLOGICAL	
Seizures / Convulsions	CONTACT DETAILS OF NEUROLOGIST OR MEDICAL PROFESSIONAL Febrile convulsions or epilepsy /Seizure type/description Relevant medications ETD policy – When to call ambulance First Aid Policy RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Seizure plan** • **Midazolam Authority** • **Location of / Record of Midazolam administration** • **Seizure observation log**
Hydrocephalus/ Shunt	CONTACT DETAILS OF NEUROLOGIST OR MEDICAL PROFESSIONAL Type of shunt - VP/ VA /Date of last shunt review Signs & Symptoms of blockage / Emergency treatment RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan**
Level of consciousness	Does the client have an altered state of consciousness Establish base line Neurological status Identify sleep patterns during time of service - is client easy to rouse / able to protect airway etc. **NOTE:** Any concerns related to this must immediately be identified to CNC and risk assessment must take place
Mental health	CONTACT DETAILS OF PSYCHOLOGIST OR MEDICAL PROFESSIONAL Diagnosis of depression or anxiety/ other Medications required /desired effects / Presenting behaviours / risk to self or others
Behavioural Disorder	AUTISM,ASPERGERS,ADHD Is there a behavioural management plan in place? Does the client need referral for same? Any soothing/calming techniques
Communication/Cognition	CONTACT DETAILS OF SPEECH THERAPIST level of understanding / Methods of communication / Use of communication aids Likes and dislikes of the client if cannot communicate
Pain Management	Known causes of pain/ location Signs & Symptoms of pain /Management of symptoms Date of last review /Does the client experience any sensory impairment If DDA's (Schedule 8) required in ETD sites - Discuss with CNC for escalation RELATED ETD MEDICATION POLICY • **Medication Authority**
Vision / Hearing	Visual impairment diagnosis / Visual aids used Hearing impairment diagnosis or issues with infections Use of any hearing aids etc Grommets –? use of ear plugs for swimming

CARDIOVASCULAR	
Cardiac Conditions	CONTACT DETAILS OF CARDIOLOGIST OR MEDICAL PROFESSIONAL Diagnosis /Signs & Symptoms of potential emergency situations RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan**
IMMUNE / LYMPHATIC	
History of disorders	CONTACT DETAILS OF MEDICAL PROFESSIONAL Lowered immunity / preceding factors Lymphatic disorders / Cancer / treatment prescribed RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Oncology Care Plan**
CIRCULATORY	
Intravenous **Central Venous Devices**	CONTACT DETAILS OF MEDICAL PROFESSIONAL Reason for device /Type / size / measurement of device Taping / Dressings / Emergency management Intermittent or continuous access Medication Administration / Flushing frequency -where? RELATED MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Intravenous (IV) Care -Fact Sheet** • **Individual First Aid Plan**
RESPIRATORY	CONTACT DETAILS OF RESPIRATORY SPECIALIST OR MEDICAL PROFESSIONAL
Asthma	Signs, symptoms, known triggers / treatment history History of significant episodes / hospitalisation /Puffer/spacer or nebuliser RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Asthma Action Plan** • **Medication authority**
Recurrent Chest Infection **Pneumonia**	History of chest infections/ Contributing factors & management of same Does the client require chest physiotherapy RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** • **Oral Eating & Drinking Plan** **Chest physio plan – written by and trained by Physiotherapist**
Oxygen requirements	Continuous or PRN / rate /Signs & symptoms, indications for PRN use Method of administration / how is tubing secured / humidification / oximetry Assess for any skin irritation to ears / face etc Discuss safety and storage / Who is provider of oxygen RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Medication Authority** TRAINING NEEDS IDENTIFIED • **Oxygen – via concentrator** • **Oxygen - Via Cylinder** • **Oxygen - changing a cylinder** • **Oximetry monitoring**

Suction	Type of suction & indicators / How immediate is response required Equipment used - catheter size, Yankuer, unit etc Maintenance of equipment – testing/servicing dates Plan for equipment failure / Equipment manuals LEVEL 3 TRAINING IDENTIFIED • **Suction – oral** • **Suction - nasopharyngeal** • **Suction - oropharyngeal**
Airway- Upper	CONTACT DETAILS FOR ENT SPECIALIST OR MEDICAL PROFESSIONAL Any structural airway abnormalities e.g. laryngomalacia, tracheomalacia, vocal chord palsy, tracheoesophageal fistula, trauma Management of airway / safe swallow? / management of secretions
Tracheostomy	CONTACT DETAILS FOR ENT SPECIALIST OR MEDICAL PROFESSIONAL Relevance of diagnosis, date of initial cannulation, Type of tracheostomy tube General stoma condition (history of infection, granulation etc) Management of tube & stoma / humidification / how is tube secured / cleaning etc Frequency of planned tube changes performed (who, when, how) Use of manometer / cuff check Emergency plan for blockage accidental decannulation / how is emerg equipment presented - easy to find , easy to see equipment etc / note full list of equipment RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** RELATED NURSING DOCUMENTS • **Emergency equipment checklist** • **Support Model - Assessment table / Risk Assessment form** LEVEL 3 TRAINING IDENTIFIED • **Tracheostomy management** • **Suction – tracheostomy**
Non Invasive Positive Pressure Ventilation (NIPPV)	CONTACT DETAILS FOR RESPIRATORY SPECIALIST Diagnosis & history Hours of therapy required Level of dependence on NIPPV therapy (client's breathing effort) Signs indicating PRN therapy. Monitoring required- oximetry (indications for use, alarm limits, action plan) Type of unit & accessories / Equipment manual Emergency action plan in case of malfunction or power failure (especially relevant for overnight care) , battery backup Skin care/pressure area concerns to mask area Date of last sleep study RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** RELATED NURSING DOCUMENTS • **Emergency equipment checklist** • **Support Model - Assessment table / Risk Assessment form** LEVEL 3 TRAINING IDENTIFIED • **NIPPV** • **Oximetry monitoring**

Intermittent or continuous ventilation via tracheostomy.	CONTACT DETAILS FOR RESPIRATORY / INTENSIVE CARE UNIT SPECIALIST Diagnosis & history Make and model of unit - best contact for troubleshooting machine Mode of ventilation & settings / Alarm parameters Power supply – length of battery life, ACTEW critical customer, battery backup Routine equipment /Emergency equipment /Troubleshooting Circuit changes (who, when) / type -single/ double / adult / paediatric Circuit Filters - Heat moisture exchange / bacterial viral / changed how often Ventilator filters - how many / change / maintenance Daily maintenance/care of equipment / service schedule Emergency plan for unit malfunction Oxygen requirements Tracheostomy management RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** • **Medication authority** RELATED NURSING DOCUMENTS • **Emergency equipment checklist** • **Support Model - Assessment table / Risk Assessment form** LEVEL 3 TRAINING NEEDS IDENTIFIED • **Mechanical Ventilation (RN's only)** • **Tracheostomy Management** • **Suction – tracheostomy** **May also need to consider need for training school staff to assist with hand ventilation for routine procedures**
METABOLIC	
Diabetes	CONTACT DETAILS OF MEDICAL PROFESSIONAL, DIABETIC NURSE SPECIALIST Diagnosis, type & history Normal BGL ranges for client Medication and dietary regime Monitoring regime Equipment for monitoring/ administering insulin RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** • **Diabetes Management Plan** • **First Aid Flow charts: Diabetes- Low blood glucose** • **First Aid Flow charts: Diabetes- High blood glucose** LEVEL 3 TRAINING NEEDS IDENTIFIED • **Blood Glucose Monitoring**
Thyroid/ Pancreas/ Adrenal/ Electrolyte balance	CONTACT DETAILS OF MEDICAL PROFESSIONAL Diagnosis & history How does this affect the client and do we need to intervene? RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan**

GASTROINTESTINAL

CONTACT DETAILS FOR MEDICAL PROFESSIONAL
CONTACT DETAILS FOR HENS NURSES, DIETICIAN

Surgical history /relevant medical history- GORD, oesophagitis, thrush, medication management
RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS

- **Individual First Aid Plan**

NUTRITION

Oral	CONTACT DETAILS FOR SPEECH THERAPIST Document if client has impairment to chewing and swallowing and if modified food consistency is required. RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** • **Oral Eating & Drinking Plan**
Nasogastric/ Transpyloric	Estimated time of use /Plans for PEG/Jejunostomy procedure? Type of tube, length of insertion /Normal checking procedure Emergency plan for tube migration/ unable to confirm placement /Troubleshooting Skin care considerations / equipment used Details of nutrition and regime RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** • **Oral Eating & Drinking Plan** • **Medication Authority** RELATED NURSING DOCUMENTS • **Enteral Nutrition Regime** LEVEL 3 TRAINING NEEDS IDENTIFIED • **Nutrition via Nasogastric or Transpyloric – bolus** • **Nutrition via Nasogastric or Transpyloric – continuous** • **Water via Nasogastric or Transpyloric** • **Medication via Nasogastric or Transpyloric**
Percutaneous Endoscopic Gastrostomy (PEG) **Low Profile Gastrostomy Device** **Jejunostomy**	Date of insertion / Type of device, size /PEG Length/size of tube/ how fastened Emergency plan for accidental dislodgement /Stoma care Details of nutrition regime, mode of delivery e.g. syringe, flask or pump Equipment supplied /Degassing/decompression required? RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS • **Individual First Aid Plan** • **Oral Eating & Drinking Plan** • **Medication Authority** RELATED NURSING DOCUMENTS • **Enteral Nutrition Regime** LEVEL 3 TRAINING NEEDS IDENTIFIED • **Nutrition via PEG / Gastrostomy / Jejunostomy – bolus** • **Nutrition via PEG / Gastrostomy / Jejunostomy– continuous** • **Water via PEG / Gastrostomy / Jejunostomy** **Medication via PEG / Gastrostomy / Jejunostomy**

ORAL/ DENTAL HEALTH

Dental health issues /Oral health issues /Mouth care requirements

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS
- **Medication Authority**

TRAINING NEEDS IDENTIFIED
- **Oral hygiene** (please note only relevant if in conjunction with level 3 care i.e. Gastrostomy / Nasogastric)

BOWEL MANAGEMENT

Normal bowel pattern / regime / frequency / Management of constipation
Continence aids used /Level of independence
Colostomy or Ileostomy – type, normal routine & frequency of change, equipment required, level of independence

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS
- **Medication Authority**
- **Continence plan**
- **Ileostomy , Colostomy , Urostomy care and learning plan**

TRAINING NEEDS IDENTIFIED
- **Colostomy management** (please note this is often managed by school staff)
- **Ileostomy management**

RENAL/ URINARY

CONTACT DETAILS FOR MEDICAL PROFESSIONAL

Diagnosis & relevant medical history
Dialysis - type and details of management
Any surgical procedures e.g. ureteric implants, bladder augmentation, urostomy, urinary stoma
Continence status and continence aids used – discuss funding schemes available
Clean Intermittent Catheterisation (CIC) – details of regime, equipment required, level of independence, long term aims

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS
- **Continence Care Plan**
- **Ileostomy , Colostomy , Urostomy care and learning plan**
- **Intermittent catheterisation care and learning plan**

LEVEL 3 TRAINING NEEDS IDENTIFIED
- **CIC – stomal**
- **CIC - urethral**

REPRODUCTIVE HEALTH

Female	Detail menstrual cycle including pain management and use of hormones to regulate cycle. History of any anaemia, complications, trigger for seizures / contraception
Male	Any issues which will impact on health.

MUSCULO- SKELETAL

CONTACT DETAILS FOR PHYSIOTHERAPIST

Diagnosis & Relevant medical history (e.g. osteoporosis, Osteogenesis Imperfecta, scoliosis)
History of dislocations and/or fractures
Use of equipment /Use of orthotics /Plaster care / stretches etc - is an OT or physio plan available
Botox / how frequent

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS
- **Medication Authority**
- **Osteogenesis Imperfecta Plan**
- **Transfer & Positioning Plan**

SKIN CARE

History of skin care concerns
Identified risk factors (e.g. low body weight, bony prominences, wheelchair straps)
Any Community Nursing involvement for existing wound care management
Any creams used (ETD require authority for creams, lip balm etc)

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS

- **Medication Authority**

PALLIATIVE CARE

CONTACT DETAILS OF MEDICAL PROFESSIONAL
CONTACT DETAILS OF PALLIATIVE CARE NURSE

Is there a current palliative care order ***-(refer to CNC)***
Refer to palliative care services as required.
Explain to parent / carer that they will need to discuss plan with ETD in relation to the Basic Life Support policy and rescue breaths (Palliative Care Orders not kept in health plan folder)
Case conference may be required with Multidisciplinary team

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS

- **Individual First Aid Plan**

EQUIPMENT

Ensure parent / carer has provided adequate information on care and maintenance of all equipment required (ask for manuals). Stress importance of informing service of any planned / anticipated or actual change to equipment and devices as this will often result in additional training requirements which may potentially delay services

MEDICATIONS

Regular & PRN Medications - Medication, form, strength, dose, route, time and any other instructions
Medications not suitable for administration via Gastrostomy, alternative to be sought.

Discuss

- ETD Policy - Original container, school will store for the week and return to client at the end of the week.
- Parent awareness -has parent received explanation letter re medication with admission pack.
- Providing appropriate equipment
- Documentation- How administration is recorded
- Importance of Doctor's written authority matching pharmacy label
- Providing a cooler pack for excursions
- Indications for PRN medications

Offer assistance to help the family comply with procedures, Liaise with GP or Pharmacist as required.

RELATED ETD MANAGEMENT AND EMERGENCY TREATMENT PLANS

- **Medication Authority**
- **Medication Log**

RELATED NURSING DOCUMENTS
Procedure : Medication Management Policy

LEVEL 3 TRAINING NEEDS IDENTIFIED

- **Medication Via Nasogastric or Transpyloric**
- **Medication via Gastrostomy or Jejunostomy**
- **Medication via PEG**

ADDITIONAL CONSIDERATIONS	
FURTHER CONSULTATION	
Where planning is complex and requires further consultation, document all consultation sought in progress notes and refer to any correspondence e.g. letters or emails If during the assessment signs and symptoms are noted that suggest an unmanaged or unpredictable health issue , this should be followed up using the **Support Model - Assessment table / Risk Assessment form followed by** escalation procedure - CNC , Clinical Meeting, Grievance Panel as required	
ENVIRONMENTAL ASSESSMENT	
An assessment of the environment in which support is going to occur will often be required. This will include an assessment of the physical lay-out of the environment to see if it is safe and allows mobility and comfort for the client and any equipment they may have. There also needs to be an assessment of the ease of access for ambulance officers and other emergency personnel. Where the environment poses potential risks or compromise to a client, concerns need to be reported to the school principal.	
PROXIMITY TO EMERGENCY SERVICES	
Assessment of prolonged ambulance response time will need to be considered. For clients in remote areas including camps and other trips out of the metropolitan area, it will often be necessary to liaise with local ambulance services to establish likely response times in the event of an emergency. Sometimes it will also be necessary to liaise with local hospital and provide a Health summary in advance. It may be necessary to have a contingency plan for a remote setting that is different to that of a metropolitan setting.	
EMERGENCY CONTACT AVAILABILITY	
Establish if the parent/ carer are able and prepared to immediately take over from a care worker in an emergency situation. Such contingencies should be clearly documented in the Health Plan. The capacity of the parent/ carer to be able to immediately take over in an emergency may be a factor in determining the support model recommended for the client.	
SUPPORT STAFF AND RESOURCES	
Based on the Health Assessment, the Registered Nurse will make and document recommendations to the school principal for the training, skills assessment and resources required to support the student.	
Support Model	Many factors may affect the support model required to provide safe care for the student. This decision making process can be assisted by using the **Support Model - Assessment table / Risk Assessment form.** If unsure, a case review should be scheduled to discuss further at The Complex and Invasive Healthcare in Schools Clinical Meeting. Escalation to the Division of Women, Youth and Children's Healthcare in Schools Grievance Panel may be required to assist assessment.
ALERTS	
It is essential to enter dates of Alerts identified on Alerts form at front of client record, these must then be written in detail on the Health Assessment form	

HAAS Meeting
22/3/13
1500-1600hrs

Present:
Kerrie Heath, Ian Baar, Narelle O'Connor, Carolyn Thomas

Action Items from meeting 25/2/13
HEALTH

1. Awaiting information from Maribyrnong primary school regarding potential HAAS students. Health will send Lindy Abbott the new HAAS referral form for these students.
2. HAAS panel terms of reference required. Health will see if South Australia has some for their panel we can adapt.
3. HAAS intake panel – Daina will follow up on paediatrician representation on this panel
4. Daina organise that the draft Education/Health MOU be sent to Iain
5. The draft HAAS schedule which will sit under the MOU is in development. Health will send very early draft work to ETD for their input. This schedule is the 'program guidelines' for HAAS and as such it is imperative we get it right.
6. An EOI for a RN2 to work in the HAAS program closes on Thursday 28th February

EDUCATION

7. ETD catheter and medication policy – under which HAAS sits – is with ETD legal now. Health has provided some information and is happy to assist if needed in developing this policy (and first aid policy). It is acknowledged that the HAAS process is superior to previous.
8. HAAS panel: ETD will look at options for representation from their Directorate

GENERAL

9. Inter-agency Reference Committee (IRC) members identified. **ETD**: Kerry Heath, Iain Barr, Ros Donohue. **Health**: Sue Byrnes, Carolyn Thomas, Narelle O'Connor. TOR will be similar to SYHN IRC – health will draft HAAS IRC TOR.
10. Draft information sheets for families and schools can be used at Maribyrnong school but need to insert version control and make clear this is a draft and subject to review.

Specialist School Principal's Meeting

Agenda

Black Mountain School

27 March 2013

N.B. It is the responsibility of individual committee members to declare any conflict of interest as they arise.

Agenda item		Tabled by
1. 11:00am	Welcome and apologies	Beth Mitchell
2. 11:05am	Minutes of previous meeting and actions arising	Beth Mitchell
5. 11:30am	Consultation on HASS Model	Carolyn Thomas

ACT Government Health Directorate

Women Youth and Children Community Health Programs

HEALTHCARE ACCESS AT SCHOOL (HAAS) – SUPPORT MODEL ASSESSEMENT

Date of Assessment.............................

ASSESSMENT	COMMENTS	RECOMMENDED SUPPORT MODEL	RISK RATING
General physical health/diagnosis			
Stability of health			
Airway			
Amount and type of invasive procedures			

Assessment /decision making			
Environmental factors			
Equipment			
Other contributing factors			

Support model recommended:	
HAAS Intake Meeting Date:	Agreed
	For review (comment)

Nurse's name...

Signature..

Designation...

Date..

Tasks that may be delegated to staff at school under HAAS:

Needs to involve training and equipment use

- Complex dressings
- Enteral Feeding
  - Gastrostomy/jejunostomy – feed and flushing, medication, replacement in emergency, cleaning of equipment.

TRAINING NEEDS IDENTIFIED

- **Nutrition via Nasogastric or Transpyloric – bolus**
- **Nutrition via Nasogastric or Transpyloric – continuous**
- **Nutrition via PEG / Gastrostomy / Jejunostomy – bolus**
- **Nutrition via PEG / Gastrostomy / Jejunostomy– continuous**
- **Medication & Water via same**

- Suctioning – oral/nasal (part of seizure management?)

TRAINING IDENTIFIED

- **Suction – oral**
- **Suction - nasopharyngeal**
- **Suction - oropharyngeal**
  -

- Tracheostomy management – suctioning, emergency change, humidification & speaking valves

TRAINING IDENTIFIED

- **Tracheostomy management**
- **Suction – tracheostomy**

- Ventilation : NIPPV or Intermittent or continuous via a tracheostomy

TRAINING IDENTIFIED

- **NIPPV**
- **Oximetry monitoring**

TRAINING NEEDS IDENTIFIED

- **Mechanical Ventilation (RN's only)**
- **Tracheostomy Management**
- **Suction – tracheostomy**

May also need to consider need for training school staff to assist with hand ventilation for routine procedures

- Seizure management (complex)
- Oxygen – management (changes between inside/outside equipment), emergency situations (back up cylinder)
  - **TRAINING REQUIRED:**
    - **Oxygen - Via Cylinder**
    - **Oxygen - changing a cylinder**

- Oximetry monitoring

- Unstable diabetes – BGL's, insulin (pump, pen or syringe), hypo/hyper management

TRAINING NEEDS IDENTIFIED
- **Blood Glucose Monitoring**
- **Insulin administration**

- Catheterisation – intermittent (urethral or stoma)

TRAINING NEEDS IDENTIFIED
- **CIC – stomal**
- **CIC - urethral**
  -
- ? Specialised medication management (need to calculate as could be life threatening) – IV lines (Short or long term?)
- ? Palliative care (NFR/advanced care directive)

<u>First aid or personal care:</u>
- Medication administration
- Asthma and anaphylaxis plans
- Stoma care – Colostomy, Ileostomy, Caecostomy, Urostomy, SPC
- Airway– positioning only
- Emergency management of PICC/CVAD/Ports – dislodgement?, dressings

Seizure Observation Record

Student Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
EMS Called? (call time & arrival time)				
Observer's Name				

Please put additional notes on back as necessary.

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Seizure Observation Record

Please put additional notes on back as necessary.

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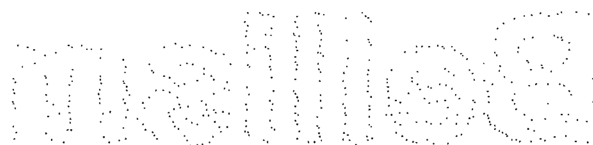
Seizure Observation Record

Student's name:______________________________

Date & time					
Seizure Length					
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)					
Conscious (yes/no/altered)					
Injuries (briefly describe)					
Muscle Tone/Body Movements	Rigid/clenching				
	Limp				
	Fell down				
	Rocking				
	Wandering around				
	Whole body jerking				
Extremity Movements	(R) arm jerking				
	(L) arm jerking				
	(R) leg jerking				
	(L) leg jerking				
	Random Movement				
Color	Bluish				
	Pale				
	Flushed				
Eyes	Pupils dilated				
	Turned (R or L)				
	Rolled up				
	Staring or blinking (clarify)				
	Closed				
Mouth	Salivating				
	Chewing				
	Lip smacking				
Verbal Sounds-describe (gagging, talking, throat clearing, etc.)					
Breathing-describe (normal, labored, stopped, noisy)					
Incontinent (urine or feces)					
Post-Seizure Observation	Confused				
	Sleepy/tired				
	Headache				
	Speech slurring				
	Other				
Length to orientation					
Parents notified? (note time of call)					
EMS called? (note call and arrival time)					
Observer's Name					

Please put additional notes on back as necessary.



What Teachers Need to Know

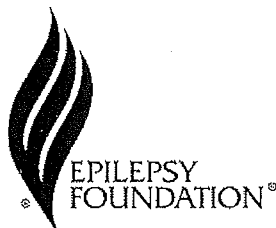
Managing STUDENTS *with* SEIZURES

Did you know that:

- Most seizures are NOT medical emergencies
- Students are often NOT aware they are having a seizure and will not remember what happened
- Epilepsy is NOT contagious
- Epilepsy is NOT a form of mental illness
- Students very rarely die or have brain damage during a seizure
- Students do NOT become violent during a seizure
- A student CAN'T swallow his/her tongue during a seizure
- You should NEVER put anything in the mouth of someone having a seizure

Epilepsy can impact learning and behavior.
Here are some things to keep in mind:

- Seizures may cause short term memory problems
- After a seizure, coursework may have to be re-taught
- Seizure activity, without obvious physical symptoms, can still affect learning
- Medications may cause drowsiness, inattention, concentration difficulties and behavior changes
- Students with epilepsy are more likely to suffer from low self esteem
- School difficulties are not always epilepsy-related



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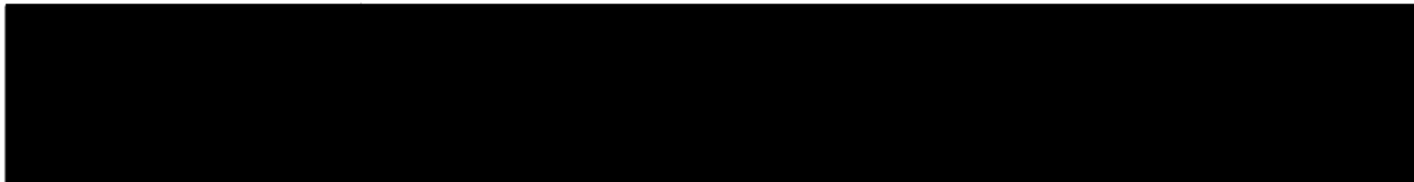
This product was made possible through a grant from the Centers for Disease Control and Prevention (Grant # U58/CCU322072). Its contents are solely the responsibility of the authors and do not necessarily represent the views of the CDC.

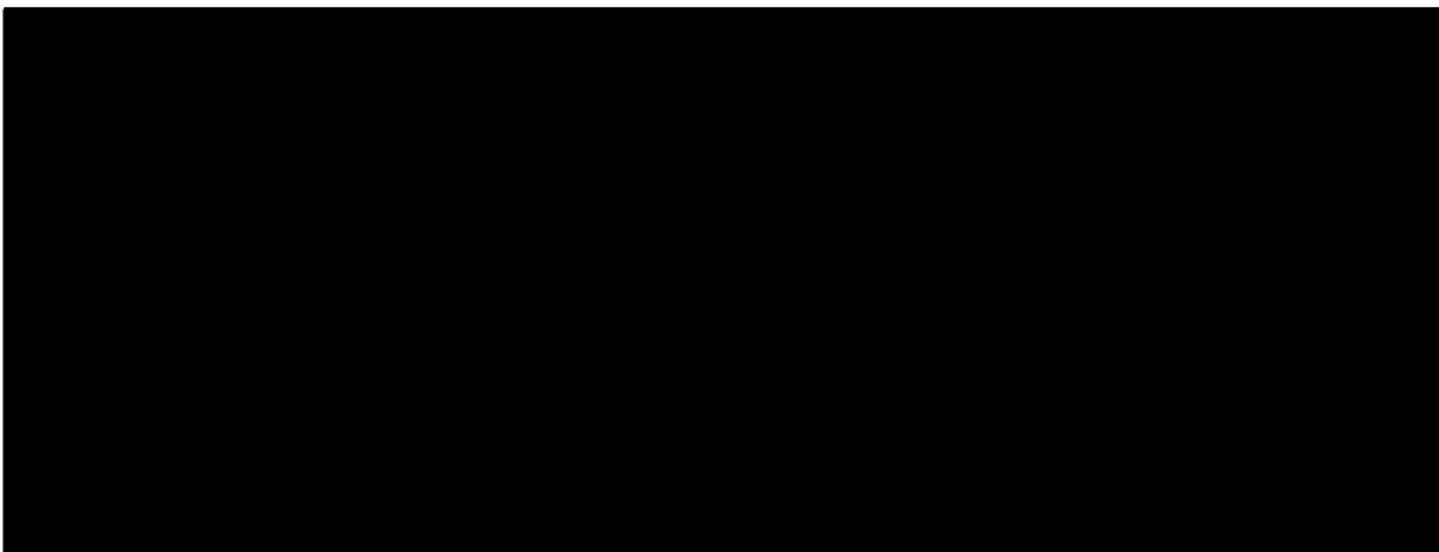
2/10/14

Statement of Collaborative Intent (Appendix 1)

Shared initiatives and services between ACT Health and the Education and Training Directorate as of May 2014 (listed in alphabetical order):



- Healthcare Access at School (HAAS)



CHESS Statement of Collaborative Intent (2005)

Statement of collaborative intent 2005-2010

child health and education support services (chess)

The Department of Education and Children's Services has formed the *child health and education support services (chess)* to support safe and non-discriminatory education and care for children and adolescents with physical and psychological health care needs.

The Department acknowledges that, at any time, one in three children has a health care need that could impact on their quality of life. Many of these children can be at risk of interrupted attendance and participation in education, and be disadvantaged in achieving their life goals.

The *chess* will work in partnership with families and communities, and government and non-government services across education, childcare, community, health and disability services, to support these young people in achieving their learning, recreational and vocational goals.

The signatories to this statement have agreed to work together in six areas:

- **Policy development:** to make policies more consistent between agencies and easier for families and communities to understand, use and influence
- **Information:** to make information about child and adolescent health support more consistent and accessible for services, families and communities
- **Training:** to develop more consistent and accessible training programs for all partners
- **Research:** to encourage and support research to inform improved services, and to implement the findings of that research
- **Service pathways:** to plan and monitor interagency service pathways that support children and adolescents with particular health care needs, and their families and communities
- **Education services:** to build effective links between education and hospital services to support children and adolescents with health care needs.

The work undertaken in these areas supports, and is framed by:

- The General Assembly of the United Nations Declaration of the Rights of the Child
- South Australia's Strategic Plan
- Departmental and agency strategic directions.

The services that have endorsed this statement express their commitment to:

- Build a safe and supportive community service environment
- Be family-centred and sensitive
- Be culturally aware and inclusive
- Intervene early to promote and protect child and adolescent learning, health and wellbeing
- Build workforce capacity for community health support planning that protects workers as well as the children and adolescents in their care.

The work of this interagency *chess* Alliance will be monitored through a representative steering committee, managed through the Department of Education and Children's Services. This group will meet at least four times per year and report annually to the signatories of this agreement.

Chris Robinson
CHIEF EXECUTIVE
Department of Education and Children's Services

Tony Sherbon
CHIEF EXECUTIVE
Department of Health

Sue Vardon
CHIEF EXECUTIVE
Department of Families and Communities

Anne Clark
CHAIRPERSON
South Australian Children's Care and Education Forum

John Singer
CHAIRPERSON
Aboriginal Health Council of South Australia

Garry Le Duff
EXECUTIVE DIRECTOR
Association of Independent

Allan Dooley
DIRECTOR
Catholic Education

First established: November 2005 Reconfirmed: November 2006

Carey, Megan

From:	Carey, Megan
Sent:	Tuesday, 7 May 2013 5:05 PM
To:	Washington, Christine; Cuzner, Jane; Laurent, Kristen
Subject:	FW: MIN13 293 QON Healthcare Access at School
Attachments:	MIN13 293 QON Healthcare Access at School.docx
Importance:	High

Tracking:

Recipient	Read
Washington, Christine	Read: 07/05/2013 5:08 PM
Cuzner, Jane	
Laurent, Kristen	

At last

Hi all

Here it is cleared by our DG Apologies for the delay.

Regards

Megan

Megan Carey
Manager
Executive Coordination
Health Directorate
62050850P

QUESTION NUMBER QON 93

Mr Doszpot – Health Care Access Program

Hi Megan

Steve Gniel, executive Director, ETD has cleared this response from ETD's viewpoint. He has requested that it be checked by the Health Directorate before it is sent to Minister Burch's office. Would you please arrange this.

Thanks

Jane

Jane Cuzner | Manager
Phone: 6205 9164| Fax: 6205 5425 |Email: jane.cuzner@act.gov.au
Ministerial and Commonwealth Relations | Education and Training | ACT Government
Level 6 220 Northbourne Avenue|GPO Box 158 Canberra ACT 2601 | www.act.gov.au

Carey, Megan

From: Summerrell, Jessica
Sent: Tuesday, 7 May 2013 10:46 AM
To: Carey, Megan
Subject: RE: request for document to be checked from ETD

Yep, it's done – went to Ian last night. We expect the pile back at lunch when he gets in after interviews.

Jess

Jessica Summerrell
Executive Officer
Office of the Deputy Director-General, Canberra Hospital & Health Services
Phone: 6244 2169
Mobile: 0466 770 201

Care ▲ Excellence ▲ Collaboration ▲ Integrity

From: Carey, Megan
Sent: Tuesday, 7 May 2013 10:42 AM
To: Summerrell, Jessica
Subject: RE: request for document to be checked from ETD

Hi Jess. Education have called asking how this is going. Can you please follow up?
Ta
m

From: Carey, Megan
Sent: Monday, 6 May 2013 9:40 AM
To: Summerrell, Jessica
Cc: Andersen, Jackie; Allen, Jonas
Subject: request for document to be checked from ETD

Hi Jess.

Can you please assist us and have this answer that Education provided checked please.

Thanks very much.
Megan

Jonas – Can you please TRIM this and the approval when it comes back.

Ta
M

From: Cuzner, Jane
Sent: Friday, 3 May 2013 12:06 PM
To: Carey, Megan
Cc: Dolstra, Anita; Burkevics, Nancye
Subject:

Peggy,
Education asked us to check this Ian has cleared it. For your OK also pls.
Ta Meg 7/5/13

OK
PB 7/5

MINISTER FOR EDUCATION AND TRAINING
LEGISLATIVE ASSEMBLY QUESTION

QUESTION NUMBER QON 93

Mr Doszpot – Health Care Access Program

MR DOSZPOT - asked the Minister for Education and Training on 10 April 2013:

MR DOSZPOT: To ask the Minister for Education and Training—

(1) When was the pilot Health Care Access Program started.
(2) Is this a pilot program only; if so, how long will it operate.
(3) What is the scope of the program, including (a) who is eligible, (b) what type of support is provided, (c) how many hours per child are provided, (d) is there a limit per child, (e) is there a restriction on which schools the program can operate, (f) how many children are able to access the program and (g) how are the children selected.
(4) How is the program funded.
(5) How will success be measured.
(6) How was the program promoted and to whom.
(7) What funds have been allocated for the pilot.

MS BURCH- the answer to **MR DOSZPOT's** question is:

1. **When was the Health Care Access Program started?**

   The Healthcare Access At School pilot commenced in February 2013.

2. **Is this a pilot program only; if so, how long will it operate?**

   The Healthcare Access at School is a pilot and no date has yet been set for the conclusion.

3. **What is the scope of the program, including**

   a. **Who is eligible** – the model supports ACT public school students with complex or invasive healthcare needs to attend school. This can refer to, for example, care of tracheostomy, provision of nutrition and/or medication via gastrostomy, catheterization, and oxygen therapy during school hours.
   b. **What type of support is provided** – support is provided according to the individual student's healthcare need.
   c. **How many hours per child are provided** – the model responds to each child's needs individually and does not use a time metric to support students.

d. **Is there a time limit per child** – the model is a school-based service for identified children. The model aims to continue while the student has complex or invasive health care requirements that need support to for them to remain at school.

e. **Is there a restriction on which schools the program can operate** – The model is currently restricted to ACT public schools.

f. **How many children are able to access the program** – Any child attending or enrolling in an ACT public school can access the HAAS program if they have a complex or invasive health care need that requires support to enable them to attend school.

g. **How are the children selected** – Identified students are referred to Healthcare Access At School. A health needs assessment is undertaken by ACT Health to identify suitability for the program.

4. **How is the program funded** – the pilot is jointly funded by ACT Education and Training Directorate and ACT Health.
5. **How will success be measured** – Students with complex or invasive health care needs are able to safely attend school
6. **How was the program promoted and to whom** – The program was put to public consultation over 4 days in November 2012. There has been discussion and promotion of the program at the DERG (twice) and at the Specialist Schools Principal meeting. Due to the pilot nature of the program, promotion is currently aimed at schools and families referred to the program. Broader promotion is being planned as the pilot gains momentum.
7. **What funds have been allocated to the pilot** – the ACT Education and Training Directorate are supporting the pilot out of the existing budget.

Approved for circulation to the Member and incorporation into Hansard.

Ms Joy Burch MLA
Minister for Education and Training **Date:.............................**

Hagan, John (Health)

From: Thomas, Carolyn
Sent: Thursday, 30 May 2013 11:15 AM
To: Heath, Kerrie
Cc: Barr, Iain; O'Connor, Narelle; Byrnes, Sue
Subject: RE: HAAS Meeting 30th May Agenda items

Hi Kerrie,

Yes I agree we need to evaluate Aranda. But we need to keep moving forward as well.

We already have a second student from Harrison school on the pilot.

As well:

- We are committed to taking the C4K students onto HAAS by the end of term 2 - assessed and ready to go the first day of term 3. They are at Duffy, Caroline Chisholm and Malkara schools
- We are now positioned to transitioning the Woden student to HAAS - I would like to do this ASAP
- There are 3 students at Maribyrnong, 1 student at Namadji and 1 student at Malkara awaiting HAAS assessment

Much to do!

Cheers

Carolyn

From: Heath, Kerrie
Sent: Thursday, 30 May 2013 11:00 AM
To: Thomas, Carolyn
Cc: Barr, Iain
Subject: RE: HAAS Meeting 30th May Agenda items

Hi Carolyn

I think our main discussion probably needs to be about evaluation of the pilot at Aranda... we need to then brief on that and get the go ahead to take next steps... I don't think we actually have real approval to take the model anywhere much further without that happening...

I also think we need to discuss what the NDIS might mean for HAAS....

Kerrie

From: Thomas, Carolyn
Sent: Thursday, 30 May 2013 9:49 AM
To: Barr, Iain; Heath, Kerrie
Cc: O'Connor, Narelle
Subject: HAAS Meeting 30th May Agenda items

Hi Kerrie and Iain,

Do you have anything to add to the agenda for this afternoon? (attached)

Cheers

Carolyn

AGENDA

For HAAS meeting 30th May - 2013

1. HAAS review panel TOR and members
2. New HAAS client at Harrison School
3. Narelle trip to Adelaide
4. ETD policy development – where is this up to?
5. Is a communication plan for schools, GP's, paediatricians, special schools (staff/parents), paediatrics, C4K and the general public around HAAS – what it is, who it is for, referral pathways – required?
6. Is a change management plan for the special schools required?
7. KPI's – start to plan what these will be
8. Plan to roll out HAAS
    1. to C4K clients - before end term 2 (school hours)
    2. to Woden student - before end term 2
    3. need to free up Woden RN to roll out HAAS to special schools + others
9. Client mapping undertaken by HAAS:
    1. Numbers of students potentially requiring HAAS support at the special schools
    2. activities currently undertaken by SS Nurses which are not in scope for HAAS

Hagan, John (Health)

From:	Byrnes, Sue
Sent:	Friday, 14 June 2013 4:38 PM
To:	Fletcher, Jeffery
Cc:	Neverauskas, Daina; Thomas, Carolyn; O'Connor, Narelle
Subject:	HealthCare Access at School
Attachments:	Flow chart March 2013.pub; Paediatrician info.doc; Risk assessment table and form.doc; SUPPORT MODEL ASSESSMENT.doc; Brochure A4 version for families.docx

Dear Jeff

Thank you so much for agreeing to be involved with the new Healthcare Access at School (HAAS) Program. Your involvement as a key member of the Review Panel is anticipated to be only occasional. This Panel would be convened if there is disagreement on the level of care required following the Intake process.

Attached are some background documents about the program and the assessment guides that are used. The HAAS program is the culmination of extensive research and site visits to South Australia and Victoria. The ACT model has been adapted primarily from the model used in South Australia where it has been functioning effectively for many years.

Happy to talk though the program in more detail at your convenience.

Kind regards

Sue

Sue Byrnes | Manager Nursing Services
Phone (02) 6205 2141 | Fax (02) 6205 1180 | Mobile 0419 162 291 | sue.byrnes@act.gov.au
Division of Women, Youth & Children Community Health Programs | Health Directorate | **ACT Government**
1 Moore St Canberra ACT | GP Box 825 Canberra ACT 2601 |www.health.act.gov.au

HEALTHCARE ACCESS AT SCHOOL (HASS)

Information for HASS Program Advisory Paediatrician

Background

Healthcare Access At School is a new program provided by the Women's Youth and Children, Community Health Programs (WY&CCHP) in partnership with the Education and Training Directorate. The program allows students with complex or invasive health care needs to attend school. The program uses a nurse-led model of care that meets the existing health care needs of students while attending school. Complex and invasive health care generally refers to healthcare that involves a procedure and use of equipment.

This may include, but is not limited to:

- Suctioning & care of tracheostomy
- Providing nutrition and/or medication via a feeding tube or gastrostomy
- Catheterisation at regular times during the day
- Oxygen therapy

Intake process

Intake and acceptance on the program will be informed by the nursing assessment and healthcare support plan using the risk assessment/matrix to decide on the level of support required for the student. The nominated level of support will indicate if the student requires one on one or intermittent care and if the care should be provided by a school staff member, such as a learning support assistant, enrolled or registered nurse. HAAS will develop recommendations on the level of care for the student and provide intake documentation and recommendation to the HAAS Program Advisory Paediatrician for consideration. HAAS will then inform the school and the student's parents of the determined level of care required in order for the student to safely attend school.

Review Panel

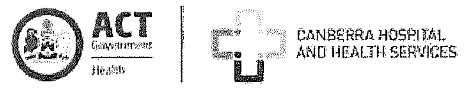
In the event that the family, school or student dispute the level of care allocated the case will be elevated to a HAAS Review Panel.

Nurse delegation model

Where the health tasks are appropriate to be provided by identified school staff these staff remain employees of the Education and Training Directorate (ETD), however for the identified health task only they are governed by Health using a delegation model. This involves the HAAS nurse providing instruction, assessment and ongoing support to three nominated ETD staff members; two staff will provide back up. Competency assessment is included in the instruction package. HAAS nurses will provide ongoing support to school staff and have a liaison role between the student's family and the school on health matters.

Complex case review

When a student's healthcare needs at school are particularly complex the nurse will provide an overview of the student's health care needs at a complex case review meeting. These meetings are held as needed. Membership of the complex case review group includes: HAAS Program Advisory Paediatrician, Schools Clinical Nurse Consultant and the HAAS Registered Nurse.



HEALTHCARE ACCESS AT SCHOOL - ASSESSMENT TABLE

Contributing Factors	RN 1:1	EN 1: 1	School Support Staff 1:1	School Support Staff
Physical Condition • Overall risk to airway/breathing and circulation • Specialist management required (tracheostomy etc) • Risk of infection or illness	Multiple, complex issues involving several systems - respiratory, cardiac, renal, central nervous system etc Deteriorating health/unstable general health Requires frequent observation / assessment and care based on observations Palliative - requiring significant input with child/family and/or service provider agencies. Changing situation.	Complex issue of one or more systems Deteriorating health Requires frequent observation/and some level of assessment. Increased risk of instability Palliative +/- end of life stage, established management protocols	Requires frequent observation but not assessment May require several procedures that are complex and time consuming. First Aid responses may include complex procedure for management e.g. Oxygen , Suction	Disability + minimal invasive procedures required Stable condition, nil deterioration of health First Aid management for emergencies definable and able to be managed by other staff members
Stability of Health • Frequency of hospitalisation, serious illnesses • unpredictable or deteriorating health • Frequency of events requiring intervention • Level of consciousness	Frequent complicated admissions to hospital Unstable and unpredictable health Frequent events requiring intervention Altered level of consciousness requiring frequent assessment	Level of instability with health needs Frequent hospital admissions or illnesses May have frequent events which are manageable with minimal assessment Level of consciousness manageable with minimal assessment / intervention	May have had previous complicated hospital admissions but now stable Health is predictable but requires several procedures that are complex and time consuming Events predictable and interventions defined in Health Plan Stable level of consciousness	Minimal hospital admissions with straight forward management, illness easily resolved Routine medical management and support Stable level of consciousness

Adapted for use in ACT with permission of SA Health Disability Services