



SANCARLO

HOMES FOR THE AGED

Admission paperwork



Instructions for Completing Paperwork

Please complete the attached forms as soon as possible. Once we receive the Admission Paperwork forms, Financial Paperwork forms and a copy of the Aged Care Assessment, the applicant will be placed on the waiting list.

1. Personal Details Form (green form).

The information on this form is used to record all personal details for the resident, i.e. Next of Kin, POA Details, Centrelink, Medicare and preferences for receiving accounts etc.

Please provide copies of Power of Attorney documentation or Guardianship details if applicable.

2. Financial Statement

Please complete these details with all information that is available. Please have the statutory declaration signed. Please attach any relevant documentation.

3. Direct Debit Request

Please complete the form and return as soon as possible. This is our only method of payment of consumer accounts.

4. Request for Laundry Labels

Please complete this form to have laundry labels printed for consumer's clothing. The costs will be charged to your first account.

5. Donation Permission Form

Please sign this form if you are happy to donate \$6 per month towards the social/cultural activities provided by this facility. This will be added to your monthly account.

6. Resident Privacy Agreement

Please have Resident/POA/Guardian sign this form.

7. Resident Consent Form

Please complete this form if Resident consents to photos and/or personal information being used in newsletters, iCare, medication charts, assessments etc.

8. Permission for Transfer of Medical Information Transfer

This form allows us to request transfer of medical information from your current GP to our clinic - Lalor Clinic.

9. Emergency Evacuation Plan

This form needs to be completed so in the event of an emergency, there is an evacuation plan in place.

10. Policy for Medication and Herbal Remedies (including creams and lotions)

Please complete this form as acknowledgement of policies regarding medicines, herbal remedies and lotions stored in this facility.

11. Residents Dietary Preferences

Please complete this form so that the kitchen is aware of the dietary requirement/ preferences and any food allergies.

Cont. PTO



Cont.

12. Proof of COVID Vaccination status

It is San Carlo's policy for admission that a prospective resident is either fully vaccinated for COVID 19 /has had at least the 1st and 2nd dose for COVID 19.

13. Medication

Please have your GP complete and sign the Medication Chart supplied (unless they are coming from hospital).

Bring your medications in a Webster Pack, it has to be a "single dose" Webster Pack not a "multi dose" pack.

14. Advance Care Plan

Please complete this form to enable nurses to act according to your loved one's wishes in the event of a medical emergency. This form also needs to be signed by the persons doctor as a witness to the document.



Other Paperwork that is required before Admission

Centrelink - Compulsory

When entering an Aged Care Residential Facility, it is a requirement that you be assessed financially by the government.

A Pre-Assessment should be done by submitting a SA457 form (Permanent Residential Aged Care Request for a Combined Assets and Income Assessment). Once you receive your Pre-Assessment letter, it is valid for a period of 120 days.

If you enter care before a pre – assessment can be completed, you are still required to submit your forms to Centrelink as soon as possible. Until we receive notification from them you are liable to pay all accommodation payments. Failure to submit financials can also result in higher Means Tested Care Fees.

If you require further information, the following site: www.myagedcare.gov.au may be of assistance. Alternatively, you can contact them by phoning: **1800 200 422**. It may also be beneficial to seek help from a financial advisor who can give you advice on all your options available regarding payment of residential aged care costs.

Medical Information

Please ask your GP to print out a complete medical history including medications and dosages, surgical history etc.

***A Resident Handbook has also been provided to you
for further information about our facility.***

We acknowledge the traditional custodians of this land, the Wurundjeri people, and pay our respects to the elders both past and present.





RISPONDETE A TUTTE LE DOMANDE
ALL QUESTIONS MUST BE FULLY
ANSWERED

COME HAI SENTITO PARLARE DI SAN CARLO?
HOW DID YOU HEAR ABOUT SAN CARLO? _____

PARTICULARS RELATING TO PERSON SEEKING ADMISSION

NOME _____ NOME PREFERITO _____
FULL NAME (BLOCK LETTERS) _____ PREFERRED NAME _____

IO SONO (CERCHIA LA RISPOSTA / LE RISPOSTE) UN'UOMO UNA DONNA ETEROSESSUALE
I DESCRIBE MYSELF AS: (Please circle appropriate answer) MALE FEMALE HETEROSEXUAL

OMOSESSUALE BISESSUALE TRANSESSUALE INTERSESSUALE PREFERISCO NON DIRE
LESBIAN GAY BISEXUAL TRANSGENDER INTERSEX PREFER NOT TO SAY

ALTRO
OTHER _____

INDIRIZZO
PRESENT ADDRESS _____

NUMERO DEL TELEFONO - LAVORO CASA
PHONE NUMBERS - BUSINESS/MOBILE _____ PRIVATE _____

DATA DI NASCITA DATA DELL'ARRIVO IN AUSTRALIA
AGE AND DATE OF BIRTH _____ DATE OF ARRIVAL IN AUSTRALIA _____

LUOGO DI NASCITA AVETE LA CITTADINANZA AUSTRALIANA?
BIRTHPLACE _____ ARE YOU A NATURALISED CITIZEN? _____

RELIGIONE SPOSATO, SINGOLO, VEDOVA, DIVORATO O SEPARATO
RELIGION _____ MARRIED, SINGLE, WIDOWED, DIVORCED/SEPARATED _____

NOMI ED INDIRIZZI DEI PARENTI STRETTI:
NAMES AND ADDRESS OF NEAR RELATIVES:

NOME	INDIRIZZO	PARENTELA	POA	YES/NO	NUMERO TELEFONICO
FULL NAMES	ADDRESS	RELATIONSHIP	POWER OF ATTORNEY		PHONE NO.

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



SANCARLO
HOMES FOR THE AGED

FIGLI – CHILDREN

NOME E COGNOME NAME IN FULL	INDIRIZZO ADDRESS	EMAIL EMAIL	NUMERO TELEFONICO PHONE NOS.
1.			
2.			
3.			
4.			

COME VORRESTE RICEVERE LA SUA FATTURA? ☐ POSTA ☐ EMAIL
MAIL **EMAIL**

COME VORRESTE RICEVERE LA NEWSLETTERE / ALTRE INFORMAZIONI? ☐ POSTA ☐ EMAIL
MAIL **EMAIL**

HOW WOULD YOU LIKE YOUR INVOICES SENT TO YOU? ☐ ☐

HOW WOULD YOU LIKE THE NEWSLETTER/OTHER INFORMATION SENT TO YOU? ☐ ☐

L'INDIRIZZO EMAIL:
EMAIL ADDRESS: _____

PERSONA RESPONSABILE DEGLI AFFARI FINANZIARI DEL CANDIDATO
PERSON/S RESPONSIBLE FOR HANDLING APPLICANT'S FINANCIAL AFFAIRS _____

ESISTE UNA DELEGA O QUALCHE FORMA DI PROCURA LEGALE? (FORNIRE I DETTAGLI)
HAS ANYONE RECEIVED AN EDURING POWER OF ATTORNEY AND/OR GUARDIANSHIP OR ADMINISTRATION POWER? (give details)

NUMERO DELLA PENSIONE
AUSTRALIAN PENSION No. _____

NUMERO ASSICURAZIONE MEDICA
MEDICARE No. _____
VALIDO PER:
VALID TO: ____/____/____

PHARMACY SAFETY NET NUMBER _____ CURRENT PHARMACY _____

DO YOU HAVE A HOMECARE PACKAGE? Yes / No **IF YES, COMMENCEMENT DATE** ____/____/____

DO YOU RECEIVE CAPS FUNDING Yes / No

ASSICURAZIONE PRIVATA MEDICO/OSPEDALIERA
PRIVATE HEALTH INSURANCE (Nome) _____ No _____

NUMERO SERVIZIO AMBULANZA
AMBULANCE No. _____

IN CASO DI MORTE INDICATE LA DITTA DI POMPE FENERBRI PREFERITA.
IN THE EVENT OF DEATH, PLEASE STATE PREFERRED FUNERAL AGENCY. _____



Resident Privacy Agreement Consent Form

This form is consent to collect, use and disclose personal information of Residents/clients for the purpose of providing residential aged care.

The Australian Privacy Principles (APP), as set out in the *Privacy Act 1988* (Cth) and the *Privacy Amendment (enhancing Privacy Protection) Act 2012* (Cth).

In order that our establishments as Health Care Providers can provide you with the quality care/services outlined in your agreement with us, we collect from you or your designated representative, particular details.

We will use all reasonable efforts to protect the privacy of individuals' personal information and to comply with the obligations imposed by the *Privacy Act 1988* (Cth) (**Privacy Act**), the Australian Privacy Principles (**APP**), the Aged Care Act and the Aged Care Principles.

This policy applies to all staff (including contracted agency staff) and volunteers.

We will only collect personal information by lawful and fair means and will only collect personal information that is necessary for one or more of our organisation's functions or activities.

If it is reasonable and practicable to do so, we will collect personal information about an individual only from that individual.

In meeting our obligations with respect to the privacy of our clients we will acknowledge that people with vision or hearing impairments and those of culturally and linguistically diverse people may require special consideration.

Purpose of Policy

The purpose of this policy and procedure is to:

- i) ensure personal information is managed in an open and transparent way;
 - ii) protect the privacy of personal information including Health Information of clients, Residents and staff;
 - iii) provide for the fair collection and handling of personal information;
 - iv) ensure that personal information we collect is used and disclosed for relevant purposes only;
 - v) regulate the access to and correction of personal information; and
- ensure the confidentiality of personal information through appropriate storage and security.



Resident Privacy Agreement Consent Form cont.

Use and disclosure of information

a) Permitted disclosure

We may not use or disclose Personal Information for a purpose other than the primary purpose of collection, unless:

- i) the secondary purpose is related to the primary purpose (and if Sensitive Information directly related) and the individual would reasonably expect disclosure of the information for the secondary purpose;
- ii) the individual has consented;
- iii) the information is Health Information and the collection, use or disclosure is necessary for research, the compilation or analysis of statistics, relevant to public health or public safety, it is impractical to obtain consent, the use or disclosure is conducted within the privacy principles and guidelines and we reasonably believe that the recipient will not disclose the Health Information;
- iv) we believe on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to an individual's life, health or safety or a serious threat to public health or public safety;
- v) we have reason to suspect unlawful activity and use or disclose the Personal Information as part of our investigation of the matter or in reporting our concerns to relevant persons or authorities;
- vi) we reasonably believe that the use or disclosure is reasonably necessary to allow an enforcement body to enforce laws, protect the public revenue, prevent seriously improper conduct or prepare or conduct legal proceedings; or
- vii) the use or disclosure is otherwise required or authorised by law.

If we receive Personal Information from an individual that we have not solicited, we will, if it is lawful and reasonable to do so, destroy or de-identify the information as soon as practicable.

Resident Privacy Agreement Consent Form cont.

b) Cross border disclosure

We will not disclose an individual's Personal Information to an overseas recipient. If we do, we will take all steps that are reasonable in the circumstances to ensure that the overseas recipient does not breach the Australian Privacy Principles, unless:

- i) the overseas recipient is subject to laws similar to the Australian Privacy Principles and the individual has mechanisms to take action against the overseas recipient;
- ii) we reasonably believe the disclosure is necessary or authorised by Australian Law; or
- iii) the individual has provided express consent to the disclosure.

Some individuals may not want to provide information to us. The information we request is relevant to providing them with the care and services they need. If the individual chooses not to provide us with some or all of the information we request, we may not be able to provide them with the care and services they require.

Access

You have a right to request that we provide you access to the Personal Information we hold about you (and we shall make all reasonable attempts to grant that access) unless providing access:

- i) is frivolous or vexatious;
- ii) poses a serious threat to the life or health of any individual;
- iii) unreasonably impacts upon the privacy of other individuals;
- iv) jeopardises existing or anticipated legal proceedings;
- v) prejudices negotiations between the individual and us;
- vi) be unlawful or would be likely to prejudice an investigation of possible unlawful activity;
- vii) an enforcement body performing a lawful security function asks us not to provide access to the information; or
- viii) giving access would reveal information we hold about a commercially sensitive decision making process.

Requesting access

Requests for access to information can be made in writing and addressed to the Privacy Officer. We will respond to each request within 30 days.



Resident Privacy Agreement Consent Form cont.

Grievance Procedure

How to make a complaint

If you wish to make a complaint about the way we have managed your Personal Information you may make that complaint verbally or in writing by setting out the details of your complaint to any of the following:

Our Privacy Officer or Delegate

Phone: 03 9404 1490

Fax: 03 9404 4390

Email: rhonda@sancarlo.com.au

Privacy Officer

We have appointed a Privacy Officer to manage and administer all matters relating to protecting the privacy of individual's Personal Information.

The Privacy Officer can be contacted if any relevant person wishes to obtain more information about any aspect of this policy or about the way in which we operate to protect the privacy of individual's Personal Information.

As stated above, complaints may also be made to the Privacy Office if any person suspects we have breached this Privacy Policy, the Australian Privacy Principles or they are otherwise unhappy with the management of their or if they are responsible for another person, that person's Personal Information.

Resident Name: _____ Date of Birth: _____

I, the under signed, understand that I have been provided with this Resident Privacy Agreement that explains all responsibilities as noted in the APP the Australian Privacy Principles (APP), as set out in the *Privacy Act 1988* (Cth) and the *Privacy Amendment (enhancing Privacy Protection) Act 2012* (Cth) and approve the collection and usage of my personal information including sensitive health information from all practical sources including my family, doctor and hospital and consent the collection and use of such information where necessary to meet my needs. I also acknowledge that a copy of my Agreement to Pay will be provided to any person guaranteeing and/or paying my accounts

Date: ____/____/____

<p>Name: _____</p> <p><input type="checkbox"/> Resident <input type="checkbox"/> POA/NOK (please tick one)</p> <p>Signature: _____</p>	<p>Witness Name: _____</p> <p>Witness Signature: _____</p>
----------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------



**Permission for Medical Information to be faxed to San Carlo
for our Doctors from Lalor Clinic (if using our doctors whilst residing San Carlo)**

Applicant or Power of Attorney/Guardian to complete the details below:

Dear Dr.	(Your Current GP's Name)
Of:	(Clinic's Name)
	(Clinic's Address)
Ph:	(Clinic's Phone Number)
Fax:	(Clinic's Fax Number)

I (name of person requesting information) _____
request that the information regarding -

Title ____ First Name _____ Surname _____

D.O.B. _____

Address _____

Be forwarded to:

**Dr Claude Baldi / Dr John Portelli (Lalor Clinic)
c/o San Carlo Homes for the Aged Ltd
970 Plenty Road South Morang, Vic 3752
or by Fax: 9404-4390
Email: sancarlo@sancarlo.com.au**

☐ I am the applicant's Power of Attorney /Guardian /NOK
(Please attach a copy of POA/Guardianship)

☐ I am the applicant

Signature _____ Date _____

Information required:

- Current Medical Surgical and Care Issues requiring interventions
- Past medical and surgical history
- Immunisation History
- Current medication regime
- Recent pathology and other tests as applicable



Medication and Herbal Remedies Including Creams and Lotions

San Carlo Homes for the Aged respects the Resident rights to independence in both administrations of medications where safely possible and decision making in relation to care including medication use.

We are however obliged to ensure safe and appropriate administration and storage of medications. Residents requesting to self-administer will be formally assessed by medical staff as to their capacity to do so.

We therefore request Residents and families inform the facility of all medications in their possession and also inform us if they wish to have other items supplied or use other products. The medications can then be discussed with the treating GP and any interactions with prescribed medications addressed.

All medication items will need to be stored in a safe an appropriate manner which may be outside of a resident's own room. This includes over the counter products, creams, lotions and herbal remedies. Should medications be brought into the facility by the family or requested by Residents, we request the facility staff be informed.

I _____ on

(Date)_____

HAVE READ THE ABOVE CONTENT AND AM AWARE OF THE FACILTY REQUEST.

Signature_____



Request for Laundry Labels

As part of the laundry service and to help our staff to keep track of your clothing, it is a requirement upon entry to San Carlo Homes for the Aged Ltd that all items of clothing are labeled with the specific label designed for you. These labels can be provided on/or prior to admission. Extra labels may have to be purchased from time to time if new clothing is brought in.

Staff will attach labels to the clothing for a fee. \$100 for 200 or \$50 for 100 \$25 for 50 (fee includes labels). These labels are heat sealed onto the clothing, the process does not harm the garment and the labels are printed by computer in indelible ink.

Name of Resident:				
Date of admission:				
Number of labels requested:	200	100	50	(please circle)
Applicable Fee:	\$100	\$50	\$25	(please circle)
This fee will be invoiced to your Resident account				
Signature Authorising Request: _____				

(Office use)

Email for request of labels sent (date): _____

Resident/relative provided information regarding laundry: _____

Labels delivered and attached: _____



Consent Form

For Use of Photos/And Or Personal Information

Permission for Resident's photo and/or personal information to be used by San Carlo for the purpose of Medication Charts, assessments, iCare Resident management program and newsletters etc.

Resident Name _____

POA/Guardian (if applicable) _____

Permission given: ☐ Yes ☐ No

Signed: _____ Date: ____/____/____

Resident/Resident's POA/Guardian

Do you wish to have your name on your door?

Permission given: ☐ Yes ☐ No

Signed: _____ Date: ____/____/____

Resident/Resident's POA/Guardian



Emergency Evacuation Plan

To Whom It May Concern

As part of our Emergency Evacuation Plan, San Carlo Homes for The Aged is compiling individual Emergency Plans for each Resident. This will include a relocation place that each Resident will be taken to.

To assist us with this, could you please complete the information required below and return to San Carlo as soon as possible.

Residents Name: _____

If an emergency evacuation of San Carlo is required are you able to take Resident home?

Please tick answer:

Yes ☐

No ☐

- If Yes how long could you have Resident home for: _____
- Name of Person taking Resident home: _____
- Address/Telephone No. that Resident will be going home to:

Telephone No: _____

Will you be able to pick Resident up from San Carlo?

Yes ☐

No ☐

If No, would you require San Carlo to organize transport i.e. Maxi Taxi.

Yes ☐

No ☐

If yes, please see Nurse in Charge of your loved ones unit to complete the Emergency Evacuation Care Plan.





Australian Government
Department of Health



Australian Government
Aged Care Quality and Safety Commission

Charter of Aged Care Rights

I have the right to:

1. safe and high quality care and services;
2. be treated with dignity and respect;
3. have my identity, culture and diversity valued and supported;
4. live without abuse and neglect;
5. be informed about my care and services in a way I understand;
6. access all information about myself, including information about my rights, care and services;
7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk;
8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;
9. my independence;
10. be listened to and understood;
11. have a person of my choice, including an aged care advocate, support me or speak on my behalf;
12. complain free from reprisal, and to have my complaints dealt with fairly and promptly;
13. personal privacy and to have my personal information protected;
14. exercise my rights without it adversely affecting the way I am treated.

Consumer

.....
Consumer (or authorised person)'s signature (if choosing to sign)

.....
Full name of consumer

.....
Full name of authorised person (if applicable)

Provider

.....
Sandra Richardson
Signature and full name of provider's staff member

.....
San Carlo Homes for the Aged
Name of provider

/ /2024

Date on which the consumer was given a copy of the Charter

/ / 2024

Date on which the consumer (or authorised person) was given the opportunity to sign the Charter



Charter of Aged Care Rights

Consumers

Consumers have the option of signing the Charter of Aged Care Rights (the Charter). Consumers can receive care and services even if they choose not to sign.

If a consumer decides to sign the Charter, they are acknowledging that their provider has given them a copy of the Charter, and assisted them to understand:

- information about consumer rights in relation to the aged care service; and
- information about consumer rights under the Charter.

Providers

Under the aged care law, providers are required to assist consumers to understand their rights and give each consumer a reasonable opportunity to sign the Charter. Providers must give consumers a copy of the Charter that sets out:

- signature of provider's staff member;
- the date on which the provider gave the consumer a copy of the Charter; and
- the date on which the provider gave the consumer (or their authorised person) the opportunity to sign the Charter;
- the consumer (or authorised person)'s signature (if they choose to sign); and
- the full name of the consumer (and authorised person, if applicable).

The provider will need to retain a copy of the signed Charter for their records.



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Australian Government
Department of Health



Australian Government
Aged Care Quality and Safety Commission

La Carta dei Diritti di Assistenza per gli Anziani

Ho il diritto a:

1. servizi e cure sicure e di alta qualità;
2. essere trattato/a con dignità e rispetto;
3. avere la mia identità, cultura e diversità valorizzate e sostenute;
4. vivere senza abuso e negligenza;
5. essere informato/a sulle cure e sui servizi in modo comprensibile;
6. accedere a tutte le informazioni su me stesso/a, compresi i miei diritti, le cure e i servizi;
7. avere controllo e prendere decisioni sulla mia cura, e sulla mia vita personale e sociale, compreso ove tali scelte comportino dei rischi personali;
8. avere controllo e prendere decisioni sugli aspetti della mia vita personale, sui miei beni finanziari e i miei possedimenti;
9. la mia indipendenza;
10. essere ascoltato/a e compreso/a;
11. avere una persona di mia scelta, compreso un aged care advocate, che mi sostenga o parli per conto mio;
12. sporgere reclamo senza essere penalizzato/a, e avere i miei reclami trattati con equità e prontezza;
13. la mia privacy personale e la protezione delle mie informazioni personali;
14. esercitare i miei diritti senza che compromettano negativamente il modo in cui vengo trattato/a.

Consumatore

.....
Firma del consumatore (o persona autorizzata)
(se si sceglie di firmare)

.....
Nome per esteso del consumatore

.....
Nome per esteso della persona autorizzata
(se applicabile)

Fornitore

.....
Sandra Richardson

.....
Firma e nome per esteso del membro del personale del
fornitore

.....
San carlo Homes for the Aged

.....
Nome del fornitore

.....
/ /2024

.....
Data in cui viene data una copia della Carta al
consumatore

.....
/ /2024

.....
Data in cui viene data l'opportunità di firmare la Carta al
consumatore (o persona autorizzata)

La Carta dei Diritti di Assistenza per gli Anziani

Consumatori

I consumatori hanno l'opzione di firmare la Carta dei Diritti di Assistenza per gli Anziani (la Carta). I consumatori possono ricevere la cura e i servizi anche se scelgono di non firmare.

Se un consumatore decide di firmare la Carta, riconosce che il suo fornitore gli ha dato una copia della Carta, e lo ha aiutato a capire:

- Informazioni sui diritti dei consumatori in relazione al servizio di assistenza per gli anziani; e
- Informazioni sui diritti dei consumatori ai sensi della Carta.

Fornitori

Ai sensi della legge sulla cura degli anziani, i fornitori devono assistere i consumatori a comprendere i loro diritti e a dare a ciascun consumatore un'opportunità ragionevole di firmare la Carta. I fornitori devono dare al consumatore una copia della Carta che contiene:

- la firma del membro del personale del fornitore;
- la data in cui viene data una copia della Carta al consumatore (o persona autorizzata); e
- la data in cui il fornitore dà l'opportunità di firmare la Carta al consumatore (o persona autorizzata);
- La firma del consumatore (o persona autorizzata) (se scelgono di firmare); e
- il nome per esteso del consumatore (e della persona autorizzata, ove applicabile).

Il fornitore deve conservare nei propri archivi una copia della Carta firmata.

Advance Care Plan

Assessment form for (Residents Name) _____ D.O.B
____/____/____

Please tick ✓ what is applicable.

✓

This document is completed and signed by:	Resident self	
	Medical Treatment Decision maker/POA	
	(Representative) Person usually making decisions on behalf of the resident	
Medical Treatment decision Maker/POA	Name (Please Print):	
(Representative) Person usually making decisions on behalf the person (resident)	Name (Please Print):	
The person (resident) main health problems		
The person's preference and values		
Are there treatments that they (person) would NOT WANT in event of becoming critically ill?	Does not want CPR	
	Does not want Naso Tracheal intubation and mechanical ventilation	
	Does not want Vein access	
	Does not want Dialysis	
	Does not want any active treatment	
Are there treatment, intervention they (person) would want to be carried out?	Would want effective pain management	
	Would want comfort care	
	Would want antibiotic treatment for symptomatology management	
	Would want aromatherapy	
	Would want Spiritual care	
If I am critically ill, I want the following directives to be respected	Would want Religious care	
	If I am suffering from a chronic condition and I become critically ill I want to be transferred to hospital and diagnostic and medical treatment, life sustaining interventions implemented.	
	If I suffer from a chronic condition and I become critically ill, I want my appointed Medical decision Maker and my treating GP make decision on regard of treatment and interventions required.	
If I am suffering from a chronic disease and I become critically ill I want to stay at the facility and be provided with comfort care, effective pain management and End of life care. I do not want life sustaining intervention and treatment.		
Resident/ Appointed Substitute Medical Decision Maker/Representative	Name (Please Print): _____ Signature: _____ Date: ____/____/____	



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Resident's Dietary Preferences/Information

Name: _____

Please circle what is appropriate

What are the resident's
Special Dietary Needs?

Diabetic Diet / Vegetarian Diet / Dysphagia / Gluten Free / Lactose Free /

What Meal Type does the
resident want?

Normal Diet (Regular)/ Soft Diet (Easy to Chew) / Minced & Moist Diet /
Pureed Diet / Cut Up

Does the resident want a
meal type that may cause
them problems?

What meal size does the
consumer want?

Small size meal / Medium size meal / Large size meal

What Fluids Type does the
resident want?

Thin Fluids / Slightly Thick Fluids / Moderately Thick Fluids /
Extremely Thick Fluids

Does the resident want a
fluid type that may cause
them problems?

What are the resident Dietary
Likes?

What are the resident Dietary
Dislikes?

What assistance does the
resident want ?

What aids does the resident
want?

Normal Plate / Soup Plate / Small bowl / Plate Guard / Normal Tea Cup /
Two Handled Mug / Special Cutlery / Normal Cutlery

Are there any cultural /
religious dietary
preferences, Please specify

Does the resident have any
Food allergies? If Yes Please
specify Type and Reaction

If the resident does have a
food allergy has it been
diagnosed by a doctor?

If the resident does have a
food allergy have you ever
had an Anaphalactic
reaction?

Resident/POA/NOK Name: _____

Signature: _____

Date: ____/____/____



SAN CARLO

HOMES FOR THE AGED

We acknowledge the traditional custodians of this land, the Wurundjeri people, and pay our respects to the elders both past and present.

Visitor Code of Conduct		
Policy number: 5.2.2	Version: 1.3	Date of Issue: 15-02-2024
Authorised by: Chief Executive Officer	Distribution: All visitors	Risk level: High
Date last reviewed: 15-02-2024	Reviewed by: Helen Spyt Agnes Loffeleya	Date of next review: February 2027

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APPLICATION OF THE POLICY	ERROR! BOOKMARK NOT DEFINED.
DEFINITIONS	ERROR! BOOKMARK NOT DEFINED.
VISITOR	ERROR! BOOKMARK NOT DEFINED.
PREMISES	ERROR! BOOKMARK NOT DEFINED.
WORK-RELATED VIOLENCE	ERROR! BOOKMARK NOT DEFINED.
OUR RESPONSIBILITIES	ERROR! BOOKMARK NOT DEFINED.
POLICY AWARENESS	ERROR! BOOKMARK NOT DEFINED.
VISITOR RESPONSIBILITIES	ERROR! BOOKMARK NOT DEFINED.
EXPECTED BEHAVIOUR	ERROR! BOOKMARK NOT DEFINED.
RESPONDING TO BREACHES OF CONDUCT	ERROR! BOOKMARK NOT DEFINED.
EMPLOYEE RESPONSE	ERROR! BOOKMARK NOT DEFINED.
ORGANISATIONAL RESPONSE	ERROR! BOOKMARK NOT DEFINED.
RELATED POLICIES AND LEGISLATION	ERROR! BOOKMARK NOT DEFINED.
POLICIES AND PROCEDURES	ERROR! BOOKMARK NOT DEFINED.
LEGISLATION	ERROR! BOOKMARK NOT DEFINED.
DOCUMENT VERSION CONTROL AND REVIEW HISTORY	ERROR! BOOKMARK NOT DEFINED.
AUTHORITY	ERROR! BOOKMARK NOT DEFINED.

COMMENCEMENT OF POLICY

This policy will commence from 15th February 2024. It replaces all other San Carlo Visitor Code of Conduct policies (whether written or not).

APPLICATION OF THE POLICY

This policy applies to all visitors (excluding employed or contracted staff) to San Carlo. A separate Code of Conduct & Ethics exists for staff, inclusive of volunteers and agency personnel.

Definitions

Visitor

A visitor refers to any person (other than staff members, volunteers, and agency personnel) who interacts with San Carlo's workforce, residents, and/or environment. This includes (but is not limited to):

- Residents' families and friends;
- Contractors;



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- Visiting health professionals; and
- Representatives of other organisations.

Premises

For the purpose of this policy, 'premises' includes the internal, external, physical, and electronic environment of San Carlo. For example, interactions on or within the premises could involve:

- Emails sent to the organisation or individual staff members;
- Phone or video calls made to the organisation; or
- Discussions held in-person anywhere on the facility grounds.

Work-Related violence

Work-related violence involves incidents in which a person is abused, threatened, or assaulted in circumstances relating to their work.

Our Responsibilities

As an organisation San Carlo is committed to protecting the rights of all persons, including residents, employees, volunteers, and visitors. This includes the right to:

- Not be discriminated against on the basis of culture, religion, sexual identity, values, and/or beliefs;
- Be treated with respect and dignity at all times;
- Experience physical and emotional safety at all times;
- Work in or visit an environment free of harassment and anti-social behaviour;
- Work in a professional and supportive environment; and
- Have personal privacy and confidentiality maintained.

San Carlo has specific legal, ethical and moral responsibilities to ensure these protections exist for all persons while on the premises. This includes, but is not limited to, our responsibilities under the *Occupational Health and Safety Act 2004*.

San Carlo does not tolerate violence perpetrated by visitors or any other persons.

Policy Awareness

This policy is available in the Admission Information Pack and on our website (www.sancarlo.com.au)

Visitor Responsibilities

Expected Behaviour

Whilst on or interacting within the premises, visitors are asked to:

- Engage respectfully and courteously with all persons and not behave in ways that may be considered harassing or offensive.
- Remain calm when managing personal frustrations to limit the impact on the work or care of others.
- Speak at a volume appropriate for the environment and circumstances, and avoid shouting.
- Not use language directed at, or about, another individual that may be considered offensive or abusive in any culture. This includes the use of threats, expletives, profanities, and swearing in any language.
- Ensure written communication is courteous and polite.
- Avoid gestures that may be considered aggressive (such as eye rolling, sneering, and intimidating hand gestures).
- Refrain from any behaviour that may be considered physically intimidating (such as invading someone's personal space or standing over them).



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- Refrain from any form of physical assault (such as biting, scratching, spitting, pushing, shoving, tripping, or grabbing another person)
- Respect the personal privacy of residents, staff, and other visitors. San Carlo employees are not able to provide visitors with personal information regarding residents, employees, or other visitors without consent of the individuals concerned.
 - This includes refraining from capturing videos and photographs of residents or staff without their express permission. Visitors must note that unauthorised filming/photography in certain areas of the facility may be in breach of Australian privacy laws.
- Adhere to all organisational advice regarding visiting arrangements. Limitations San Carlo places on visiting may result from external regulatory requirements and are regularly reviewed in relation to current risks (such as active outbreaks of COVID-19 or influenza).
- Never attend the facility grounds when feeling unwell and/or knowingly infected with a condition that can be easily transmitted to others (such as influenza, COVID-19, gastroenteritis).
- Exercise tolerance and understanding of staff members' best efforts to provide care to all residents. The needs of our residents are prioritised, which may impact on service timeframes to visitors in some instances.

Nothing in this policy restricts the right of visitors to provide feedback or make a complaint about the care or services delivered by San Carlo. However, feedback should be delivered in ways that are keeping with this Visitor Code of Conduct.

Information our feedback and complaints policy is available in the Resident & Relative handbook, on the San Carlo website (www.sancarlo.com.au), and on request.

Responding to Breaches Of Conduct

Employee Response

Employees who observe or are affected by visitor behaviour not in keeping with the expectations outlined in this policy should bring this to the attention of their relevant Manager and complete a Staff Incident Report.

The Chief Executive Officer (CEO) and Human Resources (HR) Manager should also be informed of such incidents so that they can be addressed as soon as possible.

Organisational Response

If a complaint is received from any persons regarding offensive, harassing or inappropriate behaviour of a visitor whilst on the premises, San Carlo will endeavour to contact the person(s) in writing, advising them of the concerns raised and bringing the requirements of this policy to their attention.

An offer to discuss the matter with the CEO or delegate will also be provided. This gesture is made in good faith with the wellbeing of residents, employees and other visitors as the highest priority.

In extreme circumstances where the behaviour continues and jeopardises the occupational health and safety of residents, employees, or other visitors, serious measures will be considered, including limiting access to San Carlo premises for the individual(s) concerned. If the behaviour persists, involvement of law enforcement and/or other legal avenues of redress may be pursued by the CEO.

RELATED POLICIES AND LEGISLATION

Policies and Procedures

Full copies of all the policies listed below can be provided on request.

- 1.6 Resident Privacy & Confidentiality
- 5.2.1 Occupational Violence and Aggression
- 6.1 Resident & Visitor Feedback



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- 7.7 Employee & External Privacy Policy
- 7.17 Bullying & Harassment
- Code of Conduct and Ethics (for staff)

Legislation

- *Equal Opportunity Act 2010* (Vic)
- *Human Rights and Equal Opportunity Commission Act 1986* (Cth)
- *Charter of Humans Rights and Responsibilities Act 2006* (Vic)
- *Sex Discrimination Act 1984* (Cth)
- *Racial and Religious Tolerance Act 2001* (Vic)
- *Age Discrimination Act 2004* (Cth)
- *Disability Discrimination Act 1992* (Cth)
- *Workplace Gender Equality Act 2012* (Cth)
- *Occupational Health and Safety Regulations 2007* (Vic)
- *Occupational Health and Safety Act 2004* (Vic)
- *Surveillance Devices Act 1999* (Vic)
- *Privacy Act 1988* (Cth)

DOCUMENT VERSION CONTROL AND REVIEW HISTORY

Version	Date	Sections Modified	Author	Approved By	Next Review
1.0	13-07-2022	All	San Carlo	Rhonda Joiner	July 2024
1.1	20-12-2022	Expected Behaviour	San Carlo	Rhonda Joiner	November 2024
1.2	20-05-2023	All	San Carlo	Rhonda Joiner	January 2025
1.3	14-2-2024	Dates	San Carlo	Rhonda Joiner	February 2027

AUTHORITY

This policy is authorised under delegation by:

Rhonda Joiner
Chief Executive Officer

I _____ POA / NOK agree to abide by the above San Carlo's Visitor Code of Conduct.
(Print Name)

Signature: _____ Date: ____/____/____



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LEISURE AND LIFESTYLE RESIDENT CONSENT FORM

Resident Name: _____ D.O.B: _____	
<u>Resident and/or POA/NOK permission to...</u>	
For staff to lock resident's room on their behalf when resident is not inside?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no , on a Dementia Unit do you understand that another resident could intrude into your room when unattended and left unlocked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A small facility kiosk is available for residents to purchase items of convenience. Do you wish to utilise this service and agree that purchases will be paid in cash or added to the monthly account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to attend the Hairdresser (Spoleto Design) who attends the facility on Thursdays and do you agree to paying for the service as an extra cost on the account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Beauty Therapy, where possible is provided by the leisure team. Please give details of any beauty requests like Nail Painting (inc. preferred colours?), Hair Removal (inc. preferred method) and/or Pamper Sessions?	
<u>Resident Name and Photo Use Permission:</u>	
I understand that during the time that I/the resident resides at San Carlo Homes for the Aged, my/their name and/or photo may be printed and placed in general areas that other residents, families and staff will be able to see (i.e. bedroom doors, noticeboards, displays in unit/reception areas).	Initial: _____
I understand that my/their name and/or photo may be used in newsletters and on the Centrim Application for the purpose of communication between staff and residents/representatives, and that these avenues are meant for the San Carlo Community including Residents, Families and Staff of San Carlo HFTA	Initial: _____
I understand that San Carlo HFTA has a duty of care in regards to my/their privacy and dignity and that use of names and/or photos in any form outside of these internal means of communication will be discussed with me/my representative prior to being used.	Initial: _____
<u>Resident consent for bus trips:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
I give permission for (Name) _____ to be included in selected outings to community venues	
I understand that I/they will be transported on a facility bus, but in case of any issue (i.e. bus breakdown, resident wish to return prior to outing completion) a taxi (or maxi taxi) will be the replacement form of transport, and there may be a cost associated with this.	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial: _____
I understand that there may be an amount (cost) associated with the outing and that that amount will be on charged to the next monthly account total.	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial: _____
POA/NOK wishes to be contacted before resident goes on an outing	<input type="checkbox"/> Yes <input type="checkbox"/> No
USE OF CENTRIM APPLICATION	
I understand that the use of the Centrim Application is for communication between staff and families. I, the POA/NOK/Resident understand that I am only to send access for the Centrim Application, to immediate family members (Spouse and/or Children of Resident) or nominated representative/s, and that the information accessed on the Application is not to be reproduced in any way.	
Initial: _____	
POA/NOK: (Print Name) _____ Signature: _____ Date: ____/____/____	
Lifestyle (Print Name): _____ Signature: _____	



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DIRECT DEBIT REQUEST FORM (DDR)

I / We request you, San Carlo Homes for the Aged Ltd ABN 57 131 178 759 (User ID 408347), to debit funds from my / our nominated account at the financial institution shown below according to the details specified.

YOUR DETAILS

Name(s)		
Address		
		Postcode
Telephone	Home	Work

DETAILS OF YOUR BANK ACCOUNT

Account Holder	
Name and Branch of Financial Institution where account is held	
BSB No.	-
Account Number	

DETAILS OF THE AMOUNT TO BE DEBITED

Commencing on you are authorised to debit a maximum of (the full amount of account) from the above account on the 15th day of each month.

YOUR AUTHORISATION

Signature(s)	<div>.....</div>
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If debiting from a joint bank account, all signatures may be required

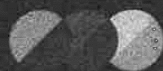
Date	
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Pharmacy Programs
Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW PATIENT CONSENT

COLLECTION AND USE OF YOUR PERSONAL INFORMATION

The Service Provider is collecting and using this personal information about you in order to determine your eligibility, and if eligible, provide you a service under the Seventh Community Pharmacy Agreement. The Service Provider may also collect your personal information from your Community Pharmacy.

The Service Provider can be contacted using the details below:

Service Provider Name	Andriana Vamvakinos		
Telephone Number	0417543783		
Date of Service		Time of Service	

The Service Provider will disclose your personal information such as your Medicare Number, name, date of birth, details about your eligibility for the service and other health information to the Pharmacy Programs Administrator and the Australian Government in order to claim a payment for the delivery of the service to you. The Service Provider may also disclose your personal information to your Community Pharmacy, other members of your healthcare team and another Service Provider as a requirement of conducting the service.

The Pharmacy Programs Administrator has a privacy policy that you can read at www.ppaonline.com.au. You can also obtain a copy of the privacy policy by contacting the Pharmacy Programs Administrator using the contact details on the website above. The privacy policy contains information about:

- How you may access the personal information that the Service Provider, the Pharmacy Programs Administrator or the Australian Government holds about you and how you can seek to correct it
- How you may complain about a breach of the Australian Privacy Principles.

The Australian Government is unlikely to disclose your personal information to overseas recipients.

If you do not wish to provide all of the personal information or consent to the collection and disclosure of the personal information required, the Service Provider will not be able to provide you with a funded service.

WRITTEN PATIENT CONSENT

This may be filled in by the patient / individual who has the legal authority to consent and sign on the patient's behalf (for example, a guardian, a person appointed under an enduring power of attorney or a person otherwise authorised to give this consent in your State or Territory).

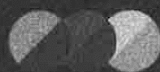
I consent to the Service Provider (including all accredited and registered pharmacists undertaking the service on behalf of the Service Provider) collecting and disclosing personal information for the purpose indicated above for:

Patient Name			
Signature		Date	
Name, relationship and address of Person providing consent on Patient's behalf (if not patient) including details of the basis of their ability to give consent			



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Pharmacy Programs
Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW PATIENT CONSENT

AUTHORISED LEGAL REPRESENTATIVE - VERBAL CONSENT

In some instances where consent must be obtained from an individual who has the legal authority to do so on the patient's behalf (such as a guardian, a person appointed under an enduring power of attorney or otherwise authorised to give this consent in your State or Territory), it is acknowledged that written consent may be difficult to obtain.

In these scenarios, where provision of the RMMR service is at risk of being delayed, verbal consent may instead be obtained from the legal representative.

A patient's personal details must NOT be passed on by the Service Provider if verbal or written consent has not been obtained for this to occur.

After explaining both the RMMR Service and the purpose of this consent form to the legal representative, the person who obtains the verbal consent should fill in the section below.

To Read to Patient's Authorised Legal Representative

Do you consent to the collection of the patient's personal information by the Department of Health and Aged Care (the Department) and Pharmacy Programs Administrator to verify the patient's eligibility to receive the RMMR Service so that the Service Provider may provide this funded service to the patient?

The patient's personal information includes:

- details about the patient's eligibility for the service,
- the medications the patient is taking and
- other health information.

If you do not provide your consent to the collection of the patient's personal information, the Service Provider will not be able to provide the patient with a funded RMMR Service.

The person who obtains the **verbal consent** should fill in the section below:

- ☒ I have explained to the patient's authorised legal representative how the information will be used for the purpose of conducting a RMMR Service under the Seventh Community Pharmacy Agreement
- ☒ The patient's authorised legal representative has verbally provided consent for the Service Provider to collect and disclose the patient's personal information to the PPA, the Department, the Patient's Community Pharmacy and, if required, other Service Providers for the purpose indicated above.

Patient Name			
Name, relationship and address of Person providing consent on Patient's behalf (if not patient) including details of the basis of their ability to give consent			
Name of person who obtained verbal consent		Date	