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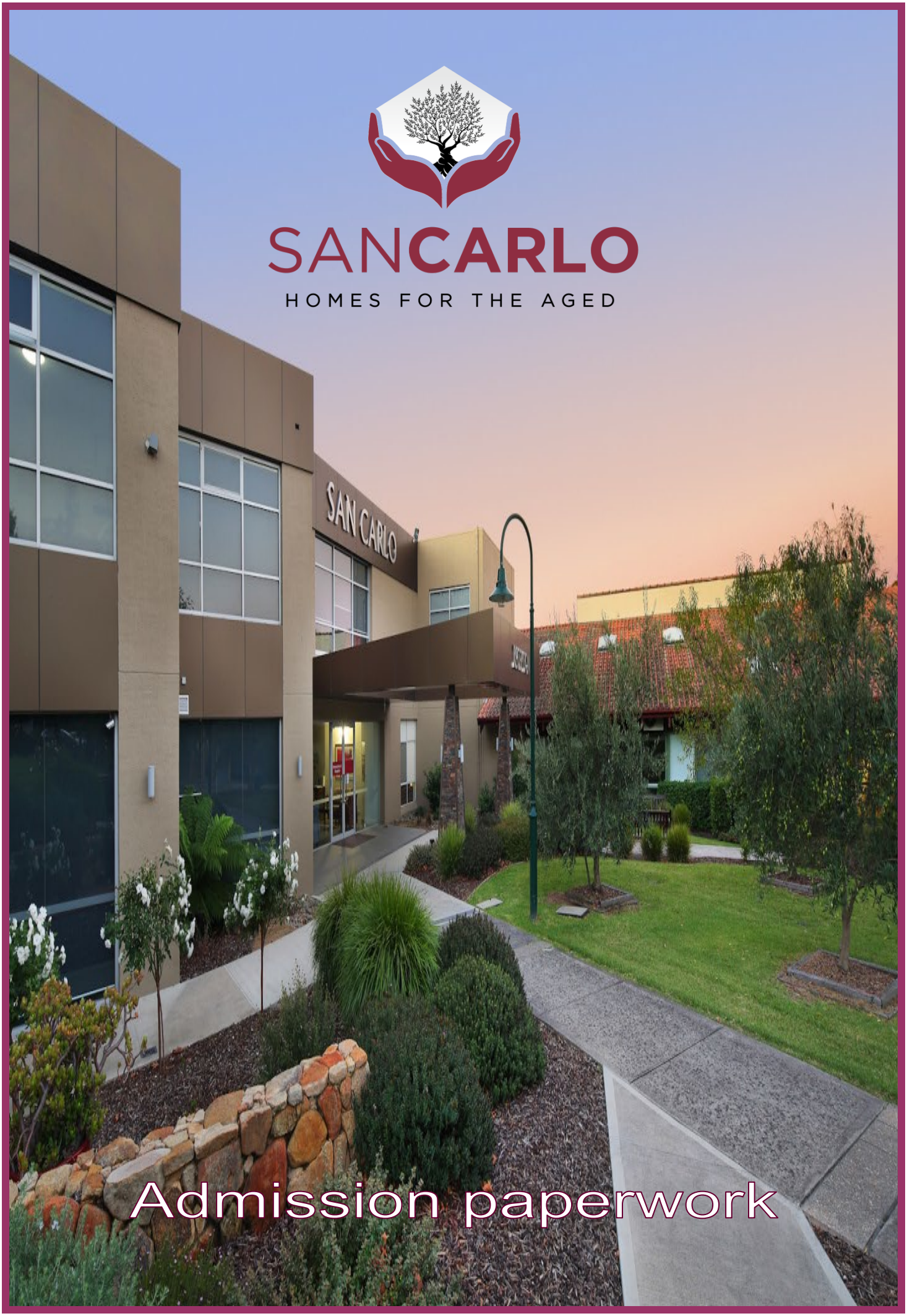

Admission paperwork

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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.

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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
FULL NAME (BLOCK LETTERS) _____ NOME PREFERITO **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
PRESENTADDRESS _____

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

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

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

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

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

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

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FIGLI – **CHILDREN**

NOME E COGNOME **NAME IN FULL**	INDIRIZZO **ADDRESS**	EMAIL **EMAIL**	NUMERO TELEFONICO **PHONE NOS.**
1.			
2.			
3.			
4.			
5.			

I'INDIRIZZO EMAIL:
EMAIL ADDRESS: _____

PER RICEVERE FATTURE / NEWSLETTERE / ALTRE INFORMAZIONI
TO RECEIVE INVOICES / NEWSLETTER / OTHER INFORMATION

PERSONA RESPONSABILE DEGLI AFFARI FINANZIARII 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 FENEBRI 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: _____ /_____/_____

Name: _____ ☐ Resident ☐ POA/NOK (please tick one) Signature: _____	Witness Name: _____ Witness Signature: _____

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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 ☐ I am the applicant
(Please attach a copy of POA/Guardianship)

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

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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_____

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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: _____

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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

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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.

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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	
	Would want Religious care	
If I am critically ill, I want the following directives to be respected	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) / 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: _ / / _

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: 1.4	Date of Issue: 14-06-2024
Authorised by: Chief Executive Officer	Distribution: All visitors	Risk level: High
Date last reviewed: 15.02.2024	Reviewed by: WorkWise Lawyers Michelle Phang Agnes Loffeleya	Date of next review: June 2027

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COMMENCEMENT OF POLICY

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

APPLICATION OF THE POLICY

This policy applies to all visitors. A separate Code of Conduct & Ethics exists for staff (including volunteers and agency personnel).

DEFINITIONS

VISITOR

- In this policy, a visitor refers to any person who interacts with San Carlo's staff, residents, and/or environment. This includes (but is not limited to):Residents' families and friends;
- Contractors;
- Visiting health professionals; and
- Representatives of other organisations.

but does not include San Carlo's employees, volunteers and agency personnel.

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) on our premises in any circumstances.

POLICY AWARENESS

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

VISITOR RESPONSIBILITES

EXPECTED BEHAVIOUR

Whilst on or interacting within the premises, visitors are required 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 -not threatening or using expletives, profanities or swearing in any language.
- Ensure written communication is courteous and polite at all times If visitors are directed to only communicate with certain San Carlo staff members or to only communicate in a certain form at any time, then visitors are required to comply with those directions.
- Avoid gestures that may be considered aggressive (including but not limited to 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).
- Unauthorised confinement: No family member or visitor shall confine or restrict the movement of staff in any room or area. Such actions are strictly prohibited.
- 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 San Carlo's directions regarding visiting arrangements. Limitations San Carlo places on visiting may result from external regulatory requirements or as otherwise determined by San Carlo in its direction taking into consideration the need to ensure resident and staff safety and wellbeing 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) or under the influence of alcohol or other illegal (non-prescribed) drugs.
- 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

The Chief Executive Officer (CEO), Executive Care Manager 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 San Carlo receives a complaint from any other person regarding offensive, harassing or other inappropriate behaviour by a visitor, San Carlo will endeavour to contact the visitor(2) 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 their delegate may be provided. This gesture is made in good faith with the wellbeing of residents, employees and other visitors as the highest priority.

In the event the visitor continues to behave inappropriately and/or in a manner that jeopardises the occupational health and safety of residents, San Carlo staff, or other visitors, serious measures wil be considered. This may include, but is not limited to:

- A direction that visitors only communicate with nominated San Carlo staff members and/or do not communicate with identified staff members.
- A direction that visitors' communication may only be in writing and then, that the communication be directed to nominated San Carlo staff members.
- Limiting access to San Carlo's premises for individual(s) concerned.
- Such other direction as San Carlo considers reasonable and appropriate in its discretion taking into consideration resident and staff safety and wellbeing.

If the behaviour persists despite these directions, involvement of law enforcement and/or other legal avenues of redress may be pursued by San Carlo.

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
- 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	14-02-2024	Dates	San Carlo	Rhonda Joiner	February 2027
1.4	14-06-2024	All	San Carlo	Rhonda Joiner	June 2027

AUTHORITY

This policy is authorised under delegation by:

Rhonda Joiner
Chief Executive Officer

_____POA / NOK agree to abide by the above San Carlo's Visitor Code of Conduct.

(Print Name)

Signature: _____ __ Date:_____/___/_____

UNCONTROLLED DOCUMENT WHEN PRINTED

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LEISURE AND LIFESTYLE RESIDENT CONSENT FORM

Resident Name: _____ D.O.B: _____

Resident and/or POA/NOK permission to...

For staff to lock resident's room on their behalf when resident is not inside? ☐ Yes ☐ No

If no, on a Dementia Unit do you understand that another resident could intrude into your room when unattended and left unlocked. ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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?

Resident Name and Photo Use Permission:

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: _____

Resident consent for bus trips: ☐ Yes ☐ 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. ☐ Yes ☐ 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. ☐ Yes ☐ No Initial: _____

POA/NOK wishes to be contacted before resident goes on an outing ☐ Yes ☐ 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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About me | Snapshot

Name:

Please call me:

I was born in:

I am most proud of: Social & Personal History

A good day for me includes: Likes, dislikes, wishes/ hopes & fears

Please talk or engage with me about: Hobbies,Pastimes & Interest/ Relatives /friends

I feel relaxed and comfortable when: What I expect from aged care & staff

NOTE: as much as possible, this should be written from the individual's perspective.

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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) ....

If debiting from a joint bank account, all signatures may be required

Date

DIRECT DEBIT

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

INFORMATION STATEMENT

The Residential Medication Management Review (RMMR) is a service referred by a Medical Professional who confirms that there is an identifiable clinical need for the Patient to have the service, and it is provided to residents living in approved Australian Government funded Aged Care Facilities. Credentialed pharmacists visit residents in facilities to conduct a comprehensive review of the resident's medication to identify, resolve and prevent medication related problems.

In order to receive the RMMR service you need to be a Medicare and/or Department of Veterans' Affairs (DVA) cardholder, currently experiencing, or at risk of experiencing, medication misadventure, have received a referral from a Medical Professional and:

- a permanent resident of an Australian Government funded Aged Care Facility; or
- a permanent resident in a facility receiving funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care program; or
- a permanent resident of an MPS facility; or
- a resident in an Australian Government-funded Transition Care Facility for more than 14 consecutive days

Under this service, your pharmacist will:

- Assess your eligibility to receive the service and obtain informed consent from you
- Review your prescription medications, over the counter medications, vitamins or supplements
- Talk to you about your medical conditions and any allergies you may have
- Send a written report stating their findings and outline recommendations to relevant members of your healthcare team
- If necessary, conduct any follow up service(s)
- Upload a record of the RMMR service to your My Health Record (if you have one)
- Collect personal and sensitive information from you to enable the pharmacist to claim a payment for delivery of this service.

The Australian Government is paying the Service Provider for the RMMR Service. You will not be charged a fee by the Service Provider, however, if you do not meet the Eligibility Criteria or do not consent to your information being provided to the PPA and Department of Health and Aged Care for the purpose of claiming a funded service, the Service Provider may offer the service at your own cost.

You will still be required to pay the costs of the medicines that will be checked through this RMMR service including the PBS co-payment (if applicable) when medications are dispensed.

This program is funded by the Australian Government.

WHAT YOU NEED TO KNOW BEFORE YOU GIVE CONSENT

This consent form is to allow the pharmacist to provide your personal information to the Pharmacy Programs Administrator (PPA) and the Department of Health and Aged Care to verify your eligibility to receive the RMMR service and to enable the pharmacist to claim a payment for providing this service.

If you choose to provide written consent, the pharmacist will require you to sign the Written Consent form on page 3. If you are unable to provide written consent, your pharmacist will obtain verbal consent and keep a record by filling in the Verbal Consent form on page 4. If you are unable to provide consent the pharmacist will fill out the Unable to Provide Consent form on page 5.

This process is similar to the clinic/GP practice providing your Medicare number to claim for you seeing a Health Worker or General Practitioner (GP). Your personal information is protected by law, including the Privacy Act 1988. The Department is unlikely to disclose your personal information to overseas recipients.

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RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

Your/the patient's personal information that will be collected by the pharmacy include:

- Personal details – Name, Address, Medicare number, Date of Birth
- The names of the medicines you/the patient are taking; and
- Details about the patient's authorised representative, if applicable.

If you do not provide your consent to the collection of information for this purpose, your pharmacist will not be able to assess your eligibility for the service and you will not be able to access a funded RMMR service. In this event, you may be required to pay for the cost of the service to your pharmacist.

The Department has a privacy policy which you can read at: http://www.health.gov.au/privacy. The Department can be contacted by telephone on **(02) 6289 1555** or free call **1800 020 103** or by using the online enquiries form at http://www.health.gov.au.

The Pharmacy Programs Administrator has a Privacy Policy you can read here: https://www.ppaonline.com.au/privacy-policy. The Pharmacy Programs Administrator can be contacted by telephone on **1800 951 285** or email at support@ppaonline.com.au.

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RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

SERVICE DETAILS *Must be filled in by the pharmacist prior to service.

Name of Pharmacist Providing Service	Andriana Vamvakinos	**Date of Service**	
Patient Name (Given name and family name)			

WRITTEN PATIENT CONSENT

Consent provided by the patient:

I acknowledge I have read or had explained to me, and understand, the contents of the RMMR Service Information Statement.

By signing below, I consent to receive the RMMR Service and to the collection of my personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health and Aged Care to enable the pharmacy to claim a payment for delivery of that service and for program monitoring and evaluation purposes.

Patient Signature		**Date of Consent**	

Consent provided by a person authorised to act on behalf of the patient:

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).

If you are signing on behalf of the patient, please indicate your relationship to the patient:

- ☐ Parent or guardian of child
- ☐ Enduring Guardian, recognised by a relevant state or territory law
- ☐ Enduring Power of Attorney, recognised by a relevant state or territory law
- ☐ A person who has been nominated in writing by the patient while the patient was capable of giving consent
- ☐ A person recognised by a relevant state or territory law

By signing below, I consent to the patient receiving the RMMR Service and to the collection of their personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health and Aged Care to enable the pharmacy to claim a payment for delivery of that service and for program monitoring and evaluation purposes.

Authorised Person Signature		**Date of Consent**	
Authorised Person Name			

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RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

SERVICE DETAILS *Must be filled in by the pharmacist prior to service.

Name of Pharmacist Providing Service	Andriana Vamvakinos	**Date of Service**	
Patient Name (Given name and family name)			

VERBAL CONSENT (BY AUTHORISED LEGAL REPRESENTATIVE)

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.

To be completed by the person obtaining verbal consent:

☑ I have explained to the patient's authorised legal representative how the information will be used for the purpose of conducting a RMMR Service as funded by the Australian Government

☑ 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.

***Please indicate who provided the consent*:**

☐ The patient

☐ A person authorised to act on behalf of the patient

Authorised Person Name (Given name and family name)		**Date of verbal consent**	
Authorised Person's Address			

Please indicate the authorised person's relationship with the patient:

☐ Parent or guardian of child

☐ Enduring Guardian, recognised by a relevant state or territory law

☐ Enduring Power of Attorney, recognised by a relevant state or territory law

☐ A person who has been nominated in writing by the patient while the patient was capable of giving consent

☐ A person recognised by a relevant state or territory law

Details of person who obtained the verbal consent:

Name of person who obtained verbal consent		**Name of Service Provider**	
Signature of person who obtained verbal consent			

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

UNABLE TO OBTAIN PATIENT CONSENT

If the patient does not have the capacity to provide their consent, and there is no other suitable person who is able to provide consent on behalf of that patient, such as a guardian or a person appointed under an enduring power of attorney, a service can still be completed, where you consider that without completing a service:

- The patient's physical or mental health or safety may be significantly and detrimentally impacted;
- The patient may be exposed to a potentially life-threatening situation; and/or
- The patient might reasonably be exposed to serious injury or illness.

Your collection, use and disclosure of the patient's information under the RMMR program will be permitted under the *Privacy Act 1988 (Cth).*

If no Patient Consent (or other authorised person consent) is available please complete this section (including tick box):

☑ I, the Credentialed Pharmacist undertaking the service, confirm that the patient does not have the capacity to provide consent for this RMMR service to be undertaken and there is no suitable person to give consent on the patient's behalf. Also in my opinion, without the service, the patient is at risk of experiencing at least one of the three scenarios listed above.

Patient Name (Given name and family name)			
Name of Credentialed Pharmacist undertaking the service	Andriana Vamvakinos	**Date of Service**	
Name of Service Provider	Andriana Vamvakinos		