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1 General information

1.1 Introduction

The Community Health - Policies, Procedures and Guidelines Manual (the Manual) has been developed to assist all health professionals working within community health across Western Australia, and has relevance within WA Country Health Service and Child and Adolescent Community Health. Although the manual is predominantly community health nursing focused, it is hoped that all community health professionals (CHPs), including child development and allied health staff, will use it as a reference point for information pertaining to the delivery of services in a community health setting. The term CHP is inclusive of community health nurses, Aboriginal health workers and allied health professionals.

1.1.1 Aims of the manual

To provide evidence-based policies, procedures, and professional resources for Child and Adolescent Community Health professionals in Western Australia (WA).

To assist in the achievement of an optimum standard of community health care to children, young people, and their families throughout the state of Western Australia.

1.1.2 Organisation of the manual

This manual is separated into the following sections:

- General Information – provides an overview of general information relevant to all health professionals working in community health.
- Maternal and Family – (under development).
- Birth to School Entry – includes policies and guidelines relevant to staff working with families with children under five years.
- School Aged Children - includes policies and guidelines relevant to staff working across the school aged cohort.
- At-risk Youth – includes documents to support staff working with at-risk populations.
- Procedures – includes procedures which are specific to community health service provision.
- Child Development – this will support staff working with children with developmental needs across all age groups (under development).

To facilitate access to this manual and the addition of new items, each policy, procedure and guideline has been numbered using a mixed notation system which denotes:

- The section in which the item appears.
  e.g. Birth to School Entry = 3
- The group to which the item belongs.
  e.g. Guidelines for Universal Meeting Schedule = 3.3
- The number of the specific item in each group.
  e.g. 3-4 Months Meeting = 3.3.4
1.1.2.1. Feedback

Feedback on the content in the manual, including the identification of any gaps that may exist can be emailed to childcommunity@health.wa.gov.au or faxed to (08) 9323 6699.

1.1.3 Key definitions

For the purpose of this manual the following definitions apply.

1.1.3.1 Policy

A policy is a brief statement of position indicating intention and direction, enabling decision making. It defines goals in a given area and provides a framework to guide action to achieve them.

The policy statements are consistent with current legislation and WA Health policies. They form the basis for development of Area Health Services Policies. Compliance with policies is mandatory.

1.1.3.2 Procedure

A procedure lays out a precise and detailed statement, steps, or sequential set of instructions which may be based on policy, clinical, or corporate guidelines to meet the Service’s conditions and constraints.

1.1.3.3 Guidelines

Guidelines represent statements, developed through specific process, that are designed to assist health practitioners and patients in making appropriate health care decisions about a specific condition or treatment. Clinical guidelines are usually developed under the auspices of an association or government agency by a panel of experts and are based on a thorough review of scientific studies on the topic being addressed.

1.1.3.4 Standards of practice

Standards of Practice are authoritative statements that reflect the values held by the profession and the specialised area of practice that set the level of competent care and professional performance for which its practitioners are held accountable.

For more information on the National Safety and Quality Health Service (NSQHS) Standards which aim to improve the quality of health service provision in Australia, visit http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/.

1.1.3.5 Australian Charter of Healthcare Rights

Everyone who is seeking or receiving care in the Australian Health system has certain rights regarding the nature of that care. These are described in the Australian Charter of Healthcare Rights. The rights included in the Charter relate to access, safety, respect, communication, participation, privacy and comment. All CHPs should be aware of each of these seven Charter rights as upholding these rights play a vital role in ensuring that quality care is delivered to patients and consumers and, by their
professionalism and dedication, ensure that the very best outcomes are achieved for everyone in the system.

The rights in the Charter express many of the actions and obligations that healthcare providers already have under existing organisational or professional codes or policies. For more information on the Charter please visit: http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

1.2 Community health

The provision of community health services are grounded in the philosophical beliefs of social justice and empowerment, achieved through participatory, community development processes that address broad social determinants of health. Community health practise looks not just at the individual and their physical health but also the interconnected impact of the environment they live in, the formal and informal support networks, the community’s norms and social nuances as well as its institutions, politics, and belief systems. Community Health Professionals are most effective when they understand and participate in the culture of the community they work within and when they work in partnership with community members on health improvement initiatives.

1.2.1 Community health services

CHPs deliver health care with an understanding of the connection between biology, genetic predisposition, and the psychological, social, cultural, spiritual, and physical environments that surround people (McMurray & Clendon, 2010). The services include a range of non-institutional health services managed and delivered in the community. Core services may be delivered by a range of nursing and allied health practitioners, and are distinguished from other community care services by their focus on promotion, prevention and early intervention.

CHPs focus their work on the underlying causes of disease and ill-health rather than just on the diseases themselves. They work with the community to implement effective interventions, to prevent disease and the associated expense of treating disease, and contribute to the multiplier effect by preventing multiple disease outcomes with one intervention. They also promote the development and maintenance of an integrated approach to service delivery through interagency collaboration and networking with other agencies to ensure a seamless service delivery model is maintained.

The existing scope of community health services is to:

- Promote health and wellbeing through the provision of health education, promotion, and prevention services.
- Provide surveillance and screening services to ensure early identification, detection, and referral of disability and disease.
- Provide treatment of selected conditions and facilitate access to services for people with barriers to access.
• Provide a range of services that support the optimal development of children with or at risk of developmental delay or disorder, in partnership with families and the community.

Community health services are provided in a manner which furthers the principles of providing care close to home and promotes continuity of care through linkages with other health care services both within and outside the area. They are also essential to the effectiveness of many Public Health programs in health promotion, disease prevention, and early detection.

1.2.2 Child and Adolescent Community Health Policy Unit (statewide)

Child and Adolescent Community Health Policy Unit (State wide) provides strategic leadership, policy direction, and support to WA Health in the delivery of high quality, evidence-based child and adolescent community health services in the areas of maternal and child health, school health, Child and Adolescent Mental Health Service (CAMHS), and child development.

The Policy Unit is responsible for the development of policy, guidelines, and professional resources for community health services. The Policy Unit also provides specialist input into strategic policy initiatives in child and adolescent community health across agencies and across various levels of Government, representing WA Health in various forums on early childhood, both state and national.

The functions of the Policy Unit are:

• Developing policy and best practice guidelines to support child and adolescent community health service delivery.
• Monitoring, reviewing and evaluating the operation and effectiveness of policies and programs.
• Providing timely, expert policy advice to government on child and adolescent community health issues.
• Identifying and disseminating research, reports and information resources to relevant health professionals in WA Health, on child and family health issues.
• Represent WA Health on high level interagency and national committees to do with child and adolescent community health.
• Plan, deliver and evaluate Statewide projects.

1.3 Legal and legislative information

1.3.1 Legal and legislative services

Legal and Legislative Services is a Directorate within WA Health’s Health System Support, responsible for providing a broad-based legal service to WA Health on a range of matters relating to operational or service delivery.

Legal services branch

Services include:

• Provide and coordinate legal advice and support to WA Health
• Represent the health system/Department of Health on inter-jurisdictional forums developing legal reform initiatives
• Manage coronal investigations and medical treatment liability claims against non-teaching hospitals
• Develop educational programs for WA Health
• Monitor, review and advise on legal and legislative implications of emerging trends and issues at the State and national level
• Conduct and participate in projects with significant legal implications, including legislation.

**Legislative services branch**

Services include:

• Develop and implement the legislative program to achieve the legislative priorities set by the Minister for Health and Minister for Mental Health and support the attainment of strategic objectives for WA Health.
• Provide legislative and policy advice in relation to health reform issues and Commonwealth legislation impacting on WA Health.
• Interpret current legislation and conduct regulatory reviews.
• Develop primary and subsidiary legislation, including preparation of drafting instructions to Parliamentary Counsel.


**1.3.2 WA Health operational directives and information circulars**

All WA Health documents that require compliance must be incorporated into the new Operational Directive and Information Circular distribution system. Before a document can be issued or published by WA Health, a review will be undertaken by the appropriate WA Health Division or Area Health Service, to determine if the document should be incorporated into the Operational Directive and Information Circular distribution system.

The new system has two document type categories: Operational Directives and Information Circulars.

**Operational directives**

Operational Directives are policy statements that are approved by the Director-General of Health and are mandatory for all WA Health staff to comply with. Information and policies may take many forms and are often termed strategies, plans, frameworks, and guidelines. Documents containing material that is expected to be understood by relevant staff, complied with, and implemented by the WA public health system will be notified to the WA public health system by way of an Operational Directive, in addition to any other methods of distribution used.
Information circulars

InformationCirculars aredocuments that provide advice or guidance within WA’s public health system. They are not policy statements, although they may be used to advise the existence or change in status of a policy statement.

Examples of matters that are required to be issued by Information Circulars are:

- Industrial award variations
- Industrial award variations
- Fee increases (gazetted under legislation)
- Advice regarding introduction of new legislation
- Training courses
- Public holidays

To access Operational Directives and Information Circulars visit:

1.3.3 Confidentiality

Health professionals are under a duty to maintain the confidentiality of all information that comes to them in the course of their relationship with clients. The duty protects information created, disclosed, or acquired (directly or indirectly) in the context of the client and health care provider.

All persons, including administrative staff, who come into contact with the information as part of the health care process, have a duty to maintain the confidentiality of that information.

The general principle is that the duty of confidence prevents the disclosure of the information to individuals and organisations not involved in the particular health care process.

The duty of confidence can arise by statute, under the common law, and in equity. The duty does not end when the professional relationship with the client has ceased, nor does it end with the death of the client.

For more information see Operational Circular OP 2050/06 - Patient Confidentiality and Divulging Patient Information to Third Parties. This circular has been prepared to provide a broad overview to health providers of the:

- Common law duty of confidentiality owed by health professionals to clients.
- General circumstances in which confidential client information may be disclosed to third parties under the common law.

A separate Operational Circular (OP 2102/06) has been issued to cover key provisions under the Children and Community Services Act 2004.

CHPs should also refer to local Area Health Service policy on confidentiality.

1.3.4 Subpoenas

As set out above, community health staff are protected in disclosing confidential client information to a court or tribunal in compliance with a subpoena. A subpoena
issued by a court or tribunal requires the subpoenaed party to be present at court or a tribunal at a time and place for a specified purpose. Subpoenas are sometimes called by other names, frequently "summonses".

Subpoena can be categorised as follows:

- A subpoena to produce documents – this requires the subpoenaed party to attend court or a tribunal and produce certain (existing) documents to the court or tribunal (however the subpoena may offer a choice of sending in the documents to the court or tribunal rather than attending in person). A subpoena to produce documents may be addressed to the organisation or an individual with custody, control or possession of the documents.
- A subpoena to give evidence – this requires the subpoenaed party to attend the court or tribunal as a witness to give oral evidence. A subpoena to give evidence must be addressed to an individual.
- A subpoena to produce and give evidence – this requires the subpoenaed party to do both of the above.


Please refer to your local area health service policy for the processes in place for the receipt and action of subpoenas.

1.3.5 Inquests and coronial investigations

An Inquest is a court hearing in which the Coroner examines the circumstances surrounding a reportable death. The Inquest is an inquisitorial process; its purpose is to establish the facts. The hearing is usually open to members of the public and the press.

In some cases the Coroner may comment and make recommendations about public health or safety to help prevent similar deaths happening in the future. Recommendations relevant to WA Health are considered and where appropriate implemented by WA Health with periodic updates provided to the Coroner. The Coroner may also make referrals to the health professionals’ registration board or the police and the Director of Public Prosecutions should the Coroner consider it warranted in the circumstances.

Community health staff might be called to give evidence at an Inquest if they have been involved in providing health care practice to the deceased and/or the deceased’s family. For example, where they have been involved in providing health care practice to a child who has died unexpectedly or the child’s parent.

After liaising with and attaining the approval of their Manager, it is recommended that community health staff contact Legal and Legislative Services after receiving contact from Coronial Investigators. The Legal and Legislative Services Directorate (LLSD) provide legal advice and assistance at each stage of the coronial process and can advise community health staff of their options in the circumstances. A request for advice form can be submitted to the LLSD via the following link: [http://intranet.health.wa.gov.au/LLSD/home/request.cfm](http://intranet.health.wa.gov.au/LLSD/home/request.cfm)
For more detailed information on coronial matters please see: http://www.coronerscourt.wa.gov.au/#content

1.3.5.1 Role of the community health service staff in legal processes

Being involved in legal processes can be quite daunting for community health staff, in particular because many staff work in isolated conditions and often are contacted directly. It is therefore very important that community health services have a clear procedure in place for receipt and management of legal documents and requests and that all staff are aware of, and follow the procedure put in place.

The community health service should ensure staff are supported through the legal process. Staff should where appropriate be encouraged to access employee assistance support through WA Health Employee Assistance Program and/or to have access to a support person within the community health service who can assist them. In addition the community health service should:

- Ascertain if the circumstances indicate legal advice or assistance is required – Role of line manager/s and/or designated officer;
- Ensure the Executive Director and/or Population Health Director are aware of any subpoena and other legal document received – Role of line manager/s and/or designated officer;
- Ensure that subpoenas and other legal documents received are appropriately actioned;
- Ensure that any community health staff member who has been requested or required to participate in legal processes is offered access to the necessary legal advice and support.

Role of community health staff:

- Ascertain if the circumstances indicate legal advice or assistance is required and liaise with their line manager and/or designated officer in this regard;
- Ensure that they are aware of the professional standards expected of them;
- Ensure that accurate record keeping and documentation is maintained;
- Ensure that client confidentiality is maintained (unless an exception applies);
- If a subpoena or other legal document is received, ensure that they are aware of and follow the process put in place by the health service and that their line manager and/or designated officer is informed. Ensure that the subpoena or other legal document is appropriately actioned;
- Liaise with their manager and Legal and Legislative Services if contact is made by the Coronial Investigators for advice on the coronial process.

1.3.6 Guidelines for mandatory notification

Members of the public may make a notification to AHPRA about the conduct, health or performance of a practitioner or the health of a student.

Practitioners, employers and education providers are all mandated by law to report notifiable conduct relating to a registered practitioner or student.

In relation to a registered health professional, notifiable conduct refers to circumstances where the practitioner has:
• Practiced their profession while intoxicated by alcohol or drugs.
• Engaged in sexual misconduct in connection with the practice of their profession.
• Placed the public at risk of substantial harm in their practice of the profession because they have an impairment.
• Placed the public at risk of harm because they practiced their profession in a way that constitutes a significant departure from accepted professional standards.

Each National Board under AHPRA has issued guidelines on mandatory reporting, which are published on their websites. These guidelines may be accessed through the following link: https://www.ahpra.gov.au/Notifications/Make-a-Notification.aspx

1.3.7 Medication administration

The Poisons Act 1964 and Poisons Regulations 1965 outline the categorisation of different drugs and those health professionals who may manufacture, supply, and administer pharmaceutical drugs to clients. The Vaccine Administration Code should be read in conjunction with the Poisons Act and Regulations. It can be accessed via the following link: http://www.public.health.wa.gov.au/3/469/2/immunisation_homepage.pm

Medications will be administered in a consistent manner which fulfils legislative, professional and organisational requirements and supports safe client care. Child Health Professionals must work within their scope of professional practice, by only undertaking medication management activities for which they are legally entitled to perform, educationally prepared for, competent to undertake and for which they are willing to be accountable.

Prior to administration, CHPs must have adequate knowledge of the medication: its therapeutic purpose, correct dose, frequency, route of administration, specific precautions, contraindications, side effects, adverse reactions. The need for specific monitoring and/or therapeutic drug ranges also needs to be known.

Clients should be monitored following medication administration, both for therapeutic effectiveness, and adverse drug reactions. Deviations from planned care must be documented and actioned appropriately.

To achieve the greatest benefit and best outcomes for the individual taking medications, best practice indicates that policies and protocols should be devised collaboratively by nursing, midwifery, medical, pharmacy, and management staff. Medication management practices should be audited on a regular basis to ensure effective and safe individual care.

Nurses & Midwives Board of Western Australia. Medication Management Guidelines for Nurses and Midwives, 2010 sets out guidelines on medication management and can be viewed at: http://www.palliativecarewa.asn.au/downloads/nwbwa_medication_management_guidelines_jun_10.pdf
Also available via this website are the links that govern the management and administration of medications by a registered nurse or midwife, including:


1.3.8 Working with adolescents

Working with children and young adults raises many legal challenges. The nature of health law often results in judgements having to be made by the health professional. This can be particularly challenging for those working in community settings where collegiate support is not readily accessible.

Working with children and young adults requires careful consideration of the developmental stage of the individual and the legal status of that person. Health concerns which are of most importance to young people often involve sensitive psychosocial issues. Therefore, the development of trusting relationships between health workers and young people is highly important in the provision of effective care. It is imperative that health professionals understand the legal principles which relate to children under the age of 18 years, and are able to communicate information about rights, responsibilities and relevant limitations. Also of importance is the recognition of vulnerability among many who have reached ‘adult’ age in the eyes of the law.

Refer to Working with Youth. A legal resource for community based health workers, for more information about relevant common law and legislation.

1.3.9 Advertising in child and community health centres

There may be instances where staff members working in child health and community health centres receive written information and/or product samples by mail or directly from product suppliers, with a request that it be displayed in the centre.

The display of products in centres could be interpreted by consumers as an endorsement of the product and therefore may mislead the public. Staff members at centres are placed in an unfair situation when marketing pressure is applied by suppliers and workload is increased.

The display of information and/or sample products, in addition to the display of material advertising services provided by private organisations or individuals for profit or not, is not permitted. This includes services offered by private physiotherapists, speech pathologists, and other allied health professionals or midwives.
An Operational Directive (OD 0510/14) has been developed for staff which entails the necessary criteria for brochures, pamphlets, posters etc. that may be displayed.

1.3.9.1 Advertising of breast-milk substitutes


1.3.10 Social media

Social media involves the use of internet based tools, technologies and approaches that are transforming the web into a powerful open platform of collaboration, engagement, co-production and participation between citizens and government. Examples of social media are Facebook, Twitter, Flickr, YouTube and blogs.

It is of paramount importance that CHPs conduct themselves in a way that promotes public confidence and trust in WA Health as an organisation. Therefore, this obligation extends to the manner in which employees conduct themselves when participating in social media forums.

CHPs should not engage in online communication that is disparaging and/or discriminatory towards the WA Health and/or colleagues. Please see Operational Directive (OD 0326/11) which provides guidance for all WA Health employees online conduct requirements.

1.3.11 Child protection

Community health staff members have a responsibility to monitor the care and protection of all their clients and are ideally placed to identify cases of child protection issues.

1.3.11.1 Children and Community Services Act 2004


The Department for Child Protection and Family Support (CPFS) is responsible for the administration of the CCSA and the protection of children at risk of harm and neglect in Western Australia. An operational circular (OP 2102/06) has been prepared for WA Health and WA Health officers responsible for or involved with child protection issues. Its purpose is to outline some of the key provisions and implications of the CCSA in child protection cases and the legal obligations that arise in such matters.

The Act was amended in 2008 to include mandatory reporting of sexual abuse of children under 18 years of age. Medical, midwifery, and nursing staff as well as teachers and police officers are legally obligated to report any belief, formed on reasonable grounds, that child sexual abuse has occurred any time after January 1,
2009. Staff members should refer to Mandatory reporting of sexual abuse of children under 18 years (OD 0344/11).

To download the Act, go to: http://www.austlii.edu.au/cgi-bin/download.cgi/au/legis/wa/consol_act/cacsa2004318

1.3.11.2 Guidelines for protecting children 2009

Guidelines for Protecting Children were released in 2009 and reflect current best practice to identify children at risk of or in need of protection from abuse or neglect. The guidelines recommend the processes to be followed for the identification, assessment, notification of relevant agencies, and management of child abuse and neglect for all WA Health employees. They supersede the *Guidelines for responding to child abuse, neglect and the impact of family and domestic violence, 2004* (refer to OD 0218/09).

The guidelines for protecting children apply to all DOH staff and health professionals. All staff members have an ethical obligation to take action on behalf of a child they believe is being harmed or likely to be harmed.


When DOH becomes aware of children who have been subjected to, or who are at risk of, abuse and/or neglect it has a responsibility to take action that promotes their safety and wellbeing and when necessary, to make reports to the appropriate authorities.

1.3.11.3 Interagency management of children under 14 Years who are diagnosed with a sexually transmitted infection (STI)

As a result of the Gordon Inquiry into sexual abuse in children, interdepartmental protocols have been developed to notify CPFS and WA Police of all positive cases of sexually transmitted infections (STIs) in children under 14 years of age. The primary aim of these protocols is child protection.

It is the responsibility of the diagnosing practitioner to contact the Communicable Disease Control Directorate (CDCD) at the same time as contacting the CPFS Office responsible for the suburb, town, or locality where the child is residing. These two offices will then notify the WA Police to coordinate any necessary action.

In all cases where a doctor, midwife or nurse forms a reasonable belief that sexual abuse has occurred, or is occurring, in a person under 18 years, a mandatory report must be made, regardless of STI status (refer to *Mandatory reporting of sexual abuse of children under 18 years* [OD 0344/11]).

For more information see Operational Directive (OD 0267/10).
1.3.11.4 Guidelines for responding to family and domestic violence 2014

The Guidelines have been developed to provide health professionals with an understanding of Family and Domestic Violence (FDV), the impact it has on members of the family and the wider community, and to assist health professionals to make safe and effective interventions with victims of violence and abuse, their children, and other vulnerable people in the household. It sets out principles of screening for violence and abuse and of intervention and provides standard information applicable to health professionals and clinical settings.

The Guidelines for Responding to Family and Domestic Violence support the development of models of care and provision of services that conform to a state-wide standard of practice and are locally relevant and appropriate to the communities in each Area Health Service.

For more information:

1.4 Professional practice

1.4.1 Roles and responsibilities of WA Health employees

It is the responsibility of all WA Health employees to understand and enact the vision, mission, and values of the Department of Health (DOH) and to act ethically and with integrity in all professional interactions.

1.4.1.1 WA Health vision, mission, and values

It is the responsibility of all WA Health employees to fulfil the DOH’s vision of “Healthier, longer, and better quality lives for all Western Australians”.

This is achieved through supporting the values of the DOH; to work with care, respect, excellence, integrity, teamwork, and leadership. In addition, staff should endeavour to fulfil the mission to improve, promote, and protect the health of Western Australians through caring for individuals, the community and those most in need, using resources wisely, and supporting the DOH team.

These ethical pillars underpin all the work WA Health employees perform in striving to improve the health of families in the community. The DOH vision, mission, and values are supporting in the Code of Ethics and Code of Conduct, and are consistent with the clinical codes of ethics for health professionals.

For further information on implementing the DOH vision, mission, and values, see the Strategic Intent 2010-2015:

1.4.1.2 Code of ethics and code of conduct

All public sector employees are accountable to the Government of the day, the people of Western Australia, and to each other. Although staff members generally act with honesty and integrity, there are times when it is difficult to determine whether an action is appropriate or not.
While the information contained in the website below attempts to outline your obligations and responsibilities as a public sector employee, each individual is responsible and will be held accountable for their own ethical conduct.


See also: Operational Directive Amendment to WA Health Code of Conduct (OD 0383/12)


1.4.2 Roles and responsibilities of community health staff

Community health staff members work within a multidisciplinary team environment. These teams consist of staff from a range of disciplines including: nursing, health promotion, allied health, and Aboriginal health professionals, as well as staff in administrative positions. Their role involves a wide range of activities including health promotion, prevention, early detection, and early intervention as well as healthy public policy, and individual and community empowerment. Community health services are provided in a family-centred approach that is sensitive and responsive to family, cultural, ethnic, and socio-economic diversity.

Community health staff:

- Assess the health needs of the population.
- Plan and implement programs that promote and protect health.
- Provide child health surveillance programs.
- Perform comprehensive assessment and management of children with developmental delay and disability.
- Work with other agencies to address the social determinants of health.
- Work in partnership with local people using a community development approach to help them identify and prioritise their own health needs.

1.4.3 Professional boards, codes, and competency standards

1.4.3.1 Australian Health Practitioner Regulation Agency (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. This scheme streamlined and centralised the registration and accreditation of 14 professions and is updated with other professions as necessary.

AHPRA works with and provides support to the professional boards of each the 14 professional groups in the National Scheme. Each board is responsible for performing the following duties within their profession:

- Registering professionals and students.
- Developing standards, codes, and guidelines.
- Handling notifications, complaints, investigations and disciplinary hearings.
- Approving accreditation standards and accredited courses of study.
• Assessing overseas trained practitioners who wish to practice in Australia (where applicable to the profession).

For more information: http://www.ahpra.gov.au/

1.4.3.1.1 Nursing and Midwifery Board of Australia (NMBA)

The NMBA manages the registration of nurses, midwives, and students and governs the ethical practice, competence standards, professional conduct, and professional boundaries of the nursing and midwifery professions.

All nursing staff members are responsible for understanding and following the standards and codes set by the NMBA:

• Codes of Ethics for Nurses.
• Codes of Professional Conduct for Nurses
• EN Competency Standards August 2002
• RN Competency Standards January 2006
• Decision Making Framework A3 Nursing Flowchart Final 2010
• Decision Making Framework A4 Nursing Summary Guide Final 2010
• National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice
• Professional Boundaries for Nurses – March 2010
• Nursing and Midwifery - Guidelines for Advertising of Regulated Health Services
• Nursing and Midwifery - Guidelines for Mandatory Notifications


1.4.3.1.1.1 Scope of nursing practice decision making framework

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence.

Competence is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability.

Registered Nurses are accountable for making professional judgements about when an activity is beyond their own capacity or scope of practice, considering the following determinants of practice:

• Legislated authority or restrictions on professional practice (legislation and common law).
• Professional standards of practice; compliance with evidence, professional standards, and regulatory standards, policies and guidelines.
• Evidence for practice.
• Individual capability (knowledge, skill and competence) for practice.
• Context of practice and the service provider/employer’s policies and protocols.

If the activity is NOT within the current contemporary scope of nursing practice, the Registered Nurse must refer to the appropriate health professional.

The same principle applies to enrolled nurses and other health professionals where professional standards for nurses, local or organisational policy, guideline or protocol requires a registered nurse to perform the activity.

The Framework was developed to provide a realistic and effective tool for use by individual nurses to make decisions which demonstrate accountability for the standard and scope of their practice. The Framework covers all practice settings and enables the profession to respond to changes in nursing practice and the health care system.

The Framework provides guidelines for decision-making related to:

• Delegation.
• Advancement or expansion of the scope of practice.
• Negotiation of practice issues with colleagues or employers.
• The relationship between registered and enrolled nurses, other health professionals and unregulated care providers.
• The emphasis throughout is on education, experience, and assessed competence appropriate to the context of nursing practice.

The decision making framework can be found at:

1.4.3.1.2 Aboriginal and Torres Strait Islander Health Practice Board of Australia

The Aboriginal and Torres Strait Islander Health Practice Board of Australia (the Board) develops codes or guidelines that are necessary to provide guidance to health practitioners and clarify the Board’s views and expectations on a range of issues. The following guidelines are relevant to Aboriginal and Torres Strait Islander health professionals across Australia:

• Guidelines on grand parenting. (until July 2015)
• Guidelines for recency of practice.
• Guidelines for Continuing Professional Development.
• Code of Conduct for registered health practitioners.
• Guidelines for advertising of regulated health services.
• Guidelines for mandatory notifications.

For more information:
1.4.3.1.3 Medical Board of Australia
The Medical Board of Australia has developed the following codes of practice and guidelines for medical practitioners across Australia:

- Medical Registration – What does it mean? Who should be registered?
- Good Medical Practice.
- Medical - Guidelines for Mandatory Notifications.
- Medical Guidelines for Advertising of Regulated Health Services.
- Guidelines - Supervised Practice for Limited Registration.
- Sexual Boundaries: Guidelines for doctors.
- Guidelines for Technology Based Patient Consultations.

For more information see:

1.4.3.1.4 Occupational Therapy Board of Australia
The Occupational Therapy Board of Australia has developed codes and guidelines to guide the profession.

- Guidelines for advertising regulated health services.
- Guidelines for mandatory notifications.
- Code of conduct.

For more information see:

1.4.3.1.5 Physiotherapy Board of Australia
Physiotherapy staff members are bound by the following codes and guidelines set out by the Physiotherapy Board of Australia:

- Code of Conduct.
- Guidelines for Mandatory Notifications.
- Guidelines for Professional Indemnity Insurance PII.
- Guidelines on Continuing Professional Development.
- Guidelines on Recency of Practice.
- Guidelines on Substantially Equivalent Qualifications.
- Guideline for Supervision.
- Guidelines for Advertising of Regulated Health Services Physiotherapy Orientation Report.

For more information see:
1.4.3.1.6 Podiatry Board of Australia

The Podiatry Board of Australia has developed codes and guidelines to provide guidance to the profession.

- Code of conduct
- Guidelines for advertising regulated health services
- Guidelines for mandatory notifications
- Podiatry guidelines for podiatrists with blood-borne infections
- Podiatry guidelines for podiatrists working with podiatric assistants in podiatry practice
- Podiatry guidelines on clinical records

Further policies which should be read in conjunction with the above codes and guidelines can be found at:

1.4.3.1.7 Psychology Board of Australia

The Psychology Board of Australia has developed the following codes of practice and guidelines for practitioners across Australia:

- Guideline on professional indemnity insurance for psychologists.
- Guidelines for mandatory notifications.
- Guidelines on continuing professional development.
- Guidelines for advertising of regulated health services.
- Guidelines on Psychology area of practice endorsements.
- Guidelines for 4+2 internship program provisional psychologists and supervisors.

Further policies which should be read in conjunction with the above codes and guidelines can be found at:

1.4.3.1.8 Other Professional Bodies

1.4.3.1.8.1 The Australian Association of Social Workers (AASW) is the professional body for social workers. The AASW's Code of Ethics 2010 (the Code) is the core document which informs and guides the ethical practice of social workers. The Code expresses the values and responsibilities which are integral to and characterise the social work profession. It is intended to assist all social workers, collectively and individually, to act in ethically accountable ways in the pursuit of the profession's aims.

Further information can be found at:
http://www.aasw.asn.au/about-aasw/about-aasw
1.4.3.1.8.2 Speech Pathology Australia is the national peak body for the speech pathology profession in Australia. The Code of Ethics contains the standards:

- which reflect the value base of the profession;
- which reinforce the principles for making ethical decisions;
- which assist members adopt legitimate and professionally acceptable behaviour in Speech Pathology practice;
- by which the profession can be evaluated; and
- which form the basis for the decisions of the Association's Ethics Board.

Further information can be found at: http://www.speechpathologyaustralia.org.au/about-spa

1.5 Professional development

1.5.1 Performance development

Performance development is concerned with ensuring that all health professionals deliver services that meet the health needs of the community, as well as professional and ethical standards. Performance development is a system for rewarding, encouraging, supporting, and developing all employees. It includes the following tools and procedures:

1.5.1.1 Professional registration

Health professionals who require registration must have up to date registration with their appropriate professional body and provide evidence of current registration to their appropriate manager. Managers must implement functional systems to monitor the registration status of health professionals, with particular reference to registration expiry dates. Any professional who works without current registration is liable, as is the organisation for every day worked.

1.5.1.2 Performance agreement

The performance development agreement focuses on assessment of an individual’s current performance with the objectives of distinguishing positive performance aspects, future training, and development activities and career prospects. It is achieved by means of consultation between the line manager and the employee. Performance review occurs both informally and systematically and both these styles are encouraged to form part of the overall performance management of staff. Formal reviews occur on a 12 month cycle called the Performance Development Cycle, consisting of three stages that are discussed during a planning, progress, and review meeting.

The appropriate form can be found at: http://cahs.hdwa.health.wa.gov.au/__data/assets/pdf_file/0006/105927/Performance_Development_Pr37_R_endorsed_Aug2013.pdf
1.5.1.3 Reflective practice

Reflective practice is an essential component of the Performance Development Cycle as well as day-to-day professional practice. It can be interpreted as being the health professional’s ability to access, make sense of, and learn through experience, to achieve more desirable, effective, and satisfying work. It involves reviewing past actions, decisions, and comments, and assessing the appropriateness of them against the outcomes. This reflection allows staff members to identify areas of improvement and make plans to develop particular skills as well as providing staff the opportunity to reflect on issues that they handled well.

Reflective practice enables professionals to learn to value themselves as significant people, with values and feelings that are important factors in giving care. In doing so, this process of reflection may create emotional work experiences that need sensitive guidance and support so that the professional can work through them. This is where supervision becomes valuable.

1.5.1.4 Supervision

Supervision assists staff in developing an understanding of organisational objectives and supporting staff to put these into operation. The aim of supervision is to enable the person being supervised to provide the most effective help possible for the recipients of the service. Supervision and appraisal discussions should concentrate on progress against annually set individual objectives, celebrate successes, and review goals that were not reached and make action plans for future development. This is not only to maintain adequate performance but also to continue to become ever more understanding and effective.

Formal supervision refers to the regular, planned supervision sessions between the supervisor and the supervisee. This formalised approach has been developed in response to work complexity, particularly with clients. Formal supervision has been developed in acknowledgement of the effects of constant exposure by health professionals to complex client issues and the line manager’s responsibility to support the overall standard of service delivery.

Supervision of health professionals should be seen as crucial to services in which psychological and social issues are involved. Supervision, encompassing the provision of personal support for professionals, continuous education and development, and management, in terms of monitoring and evaluation, should be provided by people who understand the processes in which they are involved and have the qualities and skills needed.

1.5.2 Preceptorship and mentorship

The terms ‘preceptor’ and ‘mentor’ may be used to describe the same activity. However the roles of preceptor and mentor are very different, though they are both effective means of supporting and encouraging students, graduates, and new staff in their professional development.

It should be noted that it is a fundamental role of all community health nurses to ‘contribute to the learning experiences and professional development of others’ (ANMC, Competency Standard 5.4). Therefore it is essential that staff are
encouraged and supported in this role by adequate training in preceptoring and mentoring. The differences in preceptorship and mentorship are outlined below. Please contact your local Workforce Development Team for further information and/or training offered to staff in your Area Health Service.

1.5.2.1 Preceptorship
A preceptor is an experienced and competent registered nurse who has received formal preceptor training to function in this capacity and who serves as a clinical role model and resource person to a student or newly employed nurse (preceptee). Preceptors work closely with preceptees on an ongoing basis to plan the orientation, clinical practice/learning experiences, monitor preceptee's progress, provide feedback on preceptee's performance, and help the preceptee feel welcome and integrated into the nursing practice setting and nursing team.

1.5.2.2 Mentorship
Graduate nurses and new staff require support to make the transition into a new job and/or workplace. Such transition can be stressful and assistance during this time can reduce the likelihood of staff feeling vulnerable. Providing encouragement, guidance, and support develops a sense of belonging. Mentorship has been identified as a ‘contemporary method of structured support and integration that can assist role transition and reduce anxiety.’

Mentoring involves multiple roles that are available flexibly depending on the needs of the mentee. It is well documented that effective mentorship can assist with retention of staff. The term mentoring is used to describe a wide range of relationships that are both formal/structured and informal where individuals learn or develop personal or professional skills/competencies from informal interaction with a trusted other. A mentor can be self-selected and the focus is on developing a much broader relationship that does not include assessment, and where the learning experiences can be mutually agreed upon by the mentee and the mentor.

1.5.3 Development of workforce
The role of the Strategic Support Unit (SSU) is to provide a framework of support to enable staff to deliver high quality services to consumers. The Unit provides strategic advice and support to the Executive Director, Zone Directors, clinical practitioners, and Western Australian Country Health Services (WACHS) in a range of areas. More information on the SSU can be found at:


Service delivery support is delivered through multidisciplinary teams from a single metro-wide service. A number of these services are provided across the state while others focus primarily on the metropolitan area.

Key functions of the SSU are:
- Data collection/analysis.
- Research and service evaluation.
1.6 Occupational safety and health

1.6.1 Duty of care

The Occupational Safety and Health Act 1984 provides for the promotion, coordination, administration, and enforcement of occupational safety and health in Western Australia. The Act places certain duties on employers, employees, self-employed people, manufacturers, designers, importers, and suppliers. It also places emphasis on the prevention of accidents and injury. In addition to the broad duties established by the Act, the legislation is supported by a further tier of statute, commonly referred to as regulations, together with a lower tier of non-statutory codes of practice and guidance notes. The Act can be viewed via the following link:


Staff members who work in community health face a number of potential risks to health and safety including: travel, home visiting, working in unfamiliar environments that are not under the control of the employer, working in isolation, and not having immediate or direct access to support.

Employers have a legislative responsibility to identify any foreseeable hazards in the workplace and to ensure that, as far as possible, employees who work in community health do so in an environment that is safe and without risks to the employee’s health and wellbeing. Employees have a responsibility to carry out their duties in a manner that does not adversely affect their own health and safety. This responsibility extends to reporting security incidents and notifying their manager of any shortfalls in safety and security arrangements.

For more information, please refer to your local Area Health Service policies and procedures.
1.6.2 Mandatory training

CACH and WACHS are committed to providing a safe environment for both clients and employees and as such provide education and training for specific skills. The mandatory knowledge and skills employees are required to demonstrate are specific to areas and the type of work performed as reflected in their job description. Mandatory training and demonstration of competence is essential to the work of employees and includes professional, organisational and legislative requirements.

For the Mandatory Training and Competencies required for staff, refer to your local health service framework:

CACH
mmunity_health/child__and__adolescent_community_health/training

WACHS

This training should be conducted on commencement of employment and thereafter as mandated.

Further information detailing options to maintain competency can be obtained through your manager, WACHS Staff Development or CACH Workforce Development.

1.7 Information management

1.7.1 Introduction

The medical/health record is, in general, a contemporaneous record of events that have taken place and reflects the facts of treatment, care or education provided. Whilst it primarily serves as a clinical record for the management of clients, it is also a useful tool in court proceedings.

The importance of accurate record keeping cannot be over-emphasised.

Community health records are the property of the health service and must be retained in accordance with Patient Information Retention and Disposal Schedule Version 3, 2008 (OD 0133/08). An updated version (Version 4, 2013) is currently being developed. Please refer to the most up-to-date OD so as to be aware of any significant changes relevant to Child Health and School Health client record keeping and disposal. In the interests of care continuity for a client who has relocated, a health service can transfer most community health records to another health service where the community health services provided are essentially the same and are directly related to the client’s continuity of care. Although there is no legal obligation, it is advisable that the health service in possession of the client record advises the client that records will be transferred to the relevant health service.

The date of last access refers to the last time the record was accessed for purposes directly related to the care of the client. This includes accessing the record for a client admission, a “non-admitted patient” service and the addition of new or amendment of existing documentation in the client record.
1.7.2 Health Care and Related Information Systems (HCARe)

HCARe is a computer-based system to which supports the provision of both hospital and community health based care within some metropolitan community health services, the Western Australian Country Health Service (WACHS), and some ‘Whole of State’ health services such as dental services.

HCARe is a multi-user system and each user requires an individual login-ID and password to access areas of the system which are relative to their position. It is essential that your login-ID and password are kept in strictest confidence to enable a high level of security to be maintained.

There are modules which support both hospitals and community health based care.

**HCARe Community Health Modules:**

- Client Master Index (CMI).
- Occasions of Service Registered Clients (OOS).
- Occasions of Service Non Registered Clients (includes groups).
- Occasions of Service Reports.
- Maternal and Child Health.
- Immunisation.
- Women’s Health.
- Communicable Diseases.

**HCARe Hospital and Patient Modules:**

- Client Master Index
- Admissions, Transfers and Separations
- Emergency Department (ED)
- Patient Accounting
- Ambulatory Other Patient and Domiciliary (AOD)

To support the entering of data into the Community Health Modules, a Clinical Services Data Collection System has evolved as the result of wide consultation with community health staff across the state since its implementation in July 1992. The *Maternal & Child Health v11.09 System Procedure Manual* and an *AOD Data Collection v11.09 System Procedure Manual* are available online at: [http://intranet.health.wa.gov.au/HIN/applications/hcare_manuals.cfm](http://intranet.health.wa.gov.au/HIN/applications/hcare_manuals.cfm)
Community health staff members are encouraged to read the instruction manuals for each relevant module/s that they will be accessing and it is the responsibility of designated staff within each Area Health Service to provide ongoing training and support of the Client Management System.

There are a number of electronic data systems across state. Please refer to your local health service management guidelines for more information.

1.7.3 Child Development Information Systems (CDIS)

CDIS is CACH’s electronic client information system. The system is an integrated client management application where each client has one record that is shared across multiple CACH services.

It is currently used by the Child Development Service, and metropolitan community health nurses providing the Child Health BTSE schedule, as well as School Health services providing the School Entry Health Assessment. CDIS is being progressively implemented across targeted services within metropolitan community health, including enhanced home visiting, lactation consultancy, children in care services and programs supporting the enhanced Aboriginal Child Health Schedule.

CDIS has a range of functions and capabilities as follows:

- Client management including demographic information, client tracking, and service records
- Receipt and distribution of birth notifications
- Recording progress notes and assessments
- Calendar management including scheduling of appointments.
- Caseload and waitlist management.
- Making and managing referrals in and out of the service.
- “Flags” for family / child / environmental clinical risk factors
- Linking of siblings
- Automated production of standard letters and SMS reminders.
- Reporting to support service planning and delivery.

CDIS requires an individual login-ID and password and access to the functions of the system is dependent on a staff member’s role and responsibilities. It is essential that login-ID and password are kept in strictest confidence to enable a high level of security to be maintained.

All new staff members are provided with the opportunity to attend CDIS training coordinated and delivered by the CDIS Team. Line managers are to arrange for all new staff to attend scheduled training as soon as possible after commencement. In the interim, line managers can provide on-site training for their staff in consultation with the CDIS team to arrange the CDIS registration.

Ongoing support in use is also provided by the CDIS Helpdesk on cdis@health.wa.gov.au.

There are a number of electronic data systems across state. Please refer to your local health service management guidelines for more information.
1.8 Delivering community health services

1.8.1 Family-centred practice

A family-centred approach to service provision recognises and respects the integral role of the family in the lives of children and that positive outcomes result from how services are provided as well as what is provided. Family-centred practice involves the family being offered complete and unbiased information about intervention options, sharing decision making, and being directly involved in the decision making process. It includes three key elements: (1) an emphasis on strengths, not deficits, (2) promoting family choice and control over desired resources, and (3) the development of a collaborative relationship between parents and professionals.

It is widely agreed that effective participatory involvement results in parents and patients feeling more in control, and a strengthening of parental competence. Within family-centred practice, families are supported to make informed choices about what services are provided and how they are provided. Families and professionals work together in an equal partnership with the overall aim being to strengthen and maximise the functioning, capabilities, and wellbeing of families.

For more information, see the Australian Institute for Patient and Family Centred Care: [http://www.aipfcc.org.au/](http://www.aipfcc.org.au/)

1.8.2 Family partnership approach

The family partnership approach recognises the integral role of parents and family in the lives of children as being a central tenet on which to build service provision. Through the family partnership approach, service providers engage and relate to parents in a facilitative manner and develop genuine and respectful partnerships with families. This has been shown to lead to more effective support for parents, a greater appreciation of the psychosocial and emotional aspects affecting families and a focus on building strengths, with ongoing benefits for parents and children.

The theoretical framework underlying the family partnership approach emphasises the need for highly skilled professional communication. It also assumes that a respectful partnership between parent and potential helper is a powerful support in its own right and the means by which parents’ self esteem may be increased. Such a relationship is assumed to be the vehicle by which parents may be able to explore the difficulties they face, to clarify their situation and to develop the most helpful and effective strategies for optimising the psychosocial development of their children.

Family partnership training can help community health staff to develop the knowledge, skills and confidence in the processes of engaging and relating to parents and supporting them effectively. These processes involve the development of a genuine and respectful partnership.


1.8.3 Working in teams
Community health staff members often work in a team setting. Teams may consist of community health nurses, Aboriginal health professionals, and number of different allied health staff who belong to a particular Area Health Service. In many cases team members may be from another government or a non-government organisation. In any multi-agency work, different organisations are likely to have a range of potentially competing priorities which need to be taken into account and it will take time for different professionals and clients to get to know each other so they can work in an effective partnership.

Teamwork is a complex process and requires ongoing attention if it is to succeed. The multidisciplinary, interdisciplinary, and trans-disciplinary team models of service delivery have been utilised for a number of years in team programs. Each model differs in relation to parent and family involvement, team interaction, assessment method, and service planning and delivery.

Whichever team model is utilised, a number of qualities are essential to successful teamwork. These include:

- Having clear objectives.
- Assigning different roles and responsibilities.
- Sharing knowledge and expertise.
- Developing networks with other service providers.
- Having clear lines of accountability and.
- Managing change effectively.

Teams that work well have the capacity to share information and knowledge across agencies. In doing so, families can receive continuity of care, reducing confusion and ambiguity for parents. Therefore the wider team context needs to be considered and understood, and interagency collaboration fostered to promote an underlying philosophy of cooperation, partnership and teamwork in the community.

1.8.3.1 Multidisciplinary model

Within a multidisciplinary team model, disciplines work individually and in isolation to provide services to children and their families. Team members recognise the importance of other disciplines, but there is little to no collaboration or exchange of pertinent information. Family members meet individually with different team members and are involved in answering questions from the professionals; however, there is no direct collaboration between professional and family members. Communication lines are informal and assessment is discipline specific with individual reports compiled by each professional. Professionals develop and implement service plans for the child independent of cooperation with families and other team members.

1.8.3.2 Interdisciplinary model

Interdisciplinary teams focus on using a cooperative approach to facilitate sharing of information and responsibility across disciplines. Team members consider the suggestions and information provided by others as integral to their knowledge of a child and their family. Families still meet with professionals individually, but their preferences are respected and invited. Communication between team members is
formalised through regular team meetings and consultations. Through the sharing of information, there is increased cooperation and consensus regarding goals and plans for intervention; however, team members continue to provide services individually.

1.8.3.3 Trans-disciplinary model

The trans-disciplinary model involves team members committing to learning, sharing, and transferring skills across traditional discipline boundaries to implement a cohesive intervention plan for child and family. Family members are viewed as full and active team members who have equal power and value on the team. Communication is provided through regular team meetings where exchange of information and transferring of skills is paramount.

Assessment is jointly planned for and conducted with parents and all team members in order to construct a holistic view of child and family. A service plan is developed with the team and family, based on the family’s chosen priorities, with the selected service provider(s) undertaking intervention. This involves other team members relinquishing their role to the chosen service provider so development of the client’s skills in all domains can be achieved.

1.8.4 Interpreter services

Community health service delivery needs to take into account Western Australia’s diverse population and understand the requirements for interpreter services. Communication problems involving non-English speaking clients, clients with limited English, or those with hearing impairments can have significant health ramifications for clients as well as legal risks for health service staff and service units, therefore the assistance of interpreters is required.

The Western Australian Language Services Policy (2008) states that a client has the right to request a professional interpreter to communicate with any state government agency. Western Australian Health Language Services Policy (2011) reflects this commitment by the DOH. The WA Health policy promotes the universal right to health by facilitating effective communication between government health service providers and people who may need language assistance including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people who are deaf or hearing impaired. The use of professional interpreters ensures quality of communication, impartiality, and confidentiality for all clients requiring interpreter services.

For more information:

1.8.5 Aboriginal cultural learning and respect frameworks

Aboriginal and Torres Strait Islander people comprise about three percent of the Western Australian population, and have the greatest health and welfare needs of any group of Western Australians.

The Aboriginal Cultural Respect – Implementation Framework (2005) aims to ensure that WA Health services incorporate the health needs and interests of Aboriginal
people in the development of new health policies and programs by assisting staff to produce an Aboriginal Health Impact Statement. The Implementation Framework targets achievable goals and sets out a methodology that focuses on strategic partnerships. To assist staff to implement the framework an *Aboriginal Health Impact Statement and Guidelines (2005)* has been developed.

Staff responsible for the development of policies that are particularly relevant to Aboriginal health should give detailed attention to the requirements outlined in the *How to use the checklist (Part 3)* before completing an *Aboriginal Health Impact Statement*.

The *WA Health Aboriginal Cultural Learning Framework (2012)* builds on past efforts and activities of the Implementation Framework and provides direction for the period 2012-2018. It encourage all areas of WA Health to work together to make Aboriginal health everyone’s business. Its framework aims to improve health outcomes of all Aboriginal peoples and is underpinned by the following principles:

- Every person in Western Australia has the right to receive high-quality health care, regardless of their cultural background.
- A workforce that understands and addresses cultural links will provide improved health care for Aboriginal people.
- Embedding cultural learning within WA Health is a practical strategy to close the gap in Aboriginal health outcomes.
- Increased Aboriginal consumer, carer and community involvement will enhance the delivery of health services.


For more information contact Aboriginal Health, Department of Health on:
1.9 Health promotion

1.9.1 Overview of health promotion

Community health practice aims to promote the health and wellbeing of individuals and the community through the promotion of healthy behaviours and environments across the life course; early detection and intervention; and disease management. Health promotion underpins each of these.

Health promotion represents:

“a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to take control over the determinants of their health and thereby improve their health.” (WHO, 1998; WA Health Promotion Strategic Framework 2012-2016, 2012)

Health promotion activities aim to influence both behavioural and socio-environmental factors that affect health. Behavioural factors such as smoking, physical activity, sun exposure, and sexual behaviour can often be modified. However, they are mediated by socio-environmental factors such as education, housing, income, social inclusion, and access to healthy environments and resources. Partnerships between the health sector and other organisations such as transport, urban planning, welfare, and education are essential in promoting good health given the complexity of socio-environmental factors impacting the health of the community.

Health promotion recognises the complexity of changing health related behaviours and the need for a comprehensive approach to the prevention of chronic disease and injury. This includes population based policy and legislative approaches that create environments that support better health; lifestyle and behavioural approaches in community and health care settings that improve health communication, health education and skills development; and community development and engagement. Using a combination of strategies is the most effective health promotion. For more information on these strategies see: [http://www.manaiapho.co.nz/health_promotion](http://www.manaiapho.co.nz/health_promotion)

Health promotion strategies can occur in a range of settings including communities or neighbourhoods, schools, public spaces/playgrounds, workplaces, homes, health centres and services, and local government, and at an individual, group, or population level. Community health practitioners can support clients to exercise control over their health in the course of their practice and can assist clients with referrals to appropriate services.

To ensure health promotion programs address the needs of the local community, and behavioural and socio-environmental changes are sustained, community development and engagement is essential. This may include involving students in a school health setting, or new parents in a child health setting, in the planning and implementation of the health promotion program. Community health professionals
are well placed to access targeted groups to assist in the delivery of health promotion strategies.

As in any field, evaluation of the health promotion program is required to assess its effectiveness, efficiency and appropriateness. Evaluation can assist at each stage of the program’s development; with the evidence and program justification (formative evaluation), the implementation of strategies (process evaluation); and the short and long term effects of the program (impact and outcome evaluations). It is essential to plan evaluation strategies in the initial stages of program planning to improve data quality and program development. Health promotion staffs are a valuable resource and should be consulted when planning an evaluation.

For more information see the *WA Health Promotion Strategic Framework 2012-2016:*
http://www.public.health.wa.gov.au/2/1588/2/the_wa_health_promotion_strategic_framework_.pm

1.9.2 Development of health promotion practice

Health Promotion has evolved over the past thirty years. There have been a number of key documents over this time including the Declaration of Alma-Ata in 1978 which saw the foundation of primary health care, and the development of the Social Determinants of Health by the World Health Organisation (WHO) in 1998.

The first international WHO sponsored conference on Health Promotion was held in 1986 in Ottawa, Canada. From this event emerged the world-renowned cornerstone of Health Promotion practice: The Ottawa Charter for Health Promotion.

The Ottawa Charter has been revisited at subsequent WHO conferences on health promotion resulting in The Jakarta Declaration (1997) and The Bangkok Charter (2005). The Jakarta Declaration on Leading Health Promotion into the Twenty-First Century emphasises the five action areas listed in the Ottawa Charter, and sets five priorities for health promotion:

The Bangkok Charter recognised that health promotion had established a range of evidence-based strategies in the progress towards a healthier world. The Charter committed to making the promotion of health at broad, global and societal levels and that government has a core responsibility to addressing health inequalities.

Further information is available at the following:


1.9.2.1 The social determinants of health

As evidenced in the Ottawa Charter, Jakarta Declaration and Bangkok Charter, the determinants of health extend beyond behavioural factors and include socio-environmental factors.

Many of the underlying causes of poor health derive from the social, environmental, economic and cultural contexts in which people live, work and play. The social determinants of health are increasingly recognised as a priority area for health in their own right, but are also very much embedded in the environments that shape behavioural risk factors and inequalities in health.


1.9.3 Community development and capacity building

Communities need to be at the centre of health promotion action and decision-making processes for the efforts to have sustainable effectiveness. Additionally, health promotion projects must look to the context in which health activities occur so there is an understanding of the impact of the social determinants of health.

1.9.3.1 Community development

Community development is a process of empowering communities to improve their health and wellbeing. It is an effective way of regenerating and empowering communities to influence local health policy and service development. Working alongside local people on issues that they know to be important in their lives can help reduce inequalities in health.

Community development work involves a number of key principles:

- **Participation** - everyone having a say in what is right for them in their community.
- **Collaboration and partnership** - recognising the interdependence of local community structures to improve community health.
- **Equality and equity** - the belief that people have the right to equal access to resources for the maintenance and promotion of health, and where none exist, that they be provided.
- **Collective action** - bringing people together to deal with issues and needs, which they have defined as problematic.
- **Empowerment** - by which people, organisations and communities gain control over their lives.

One of the challenges of community development is to ensure that health professionals do not impose their agenda on the community. The role of the health professional then, is to provide enough information for the community to have sufficient knowledge to plan for improved health outcomes for themselves.
1.9.3.2 Capacity building
Capacity building is sometimes described as the ‘invisible work’ of health promotion. Capacity building has been defined as “an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over” (Hawe, 1999).

Capacity building occurs both within programs and within systems, (e.g. activities may be developed with individuals, groups, teams, organisations, inter-organisational coalitions, or communities).

NSW Health has published a framework for capacity building, which identifies five key components: organisational development, workforce development, resource allocation, leadership, and partnerships.

References

1.9.4 Role of the community health professional in health promotion
Initially the role of a community health professional, in a clinical setting, focused largely on health education and skill development to modify behaviour. The role has now broadened to encompass other aspects of health promotion such as advocacy, policy development, and leadership to modify determinants of health and establish healthy environments.

In general, community health professionals should consider how to address both lifestyle behaviour factors and socio-environmental determinants of health. Health promotion can and should be delivered by the community health professional at both the individual and community level.

Community health professionals should work collaboratively with other community health, public, and/or population health staff (e.g. health promotion officers) as well as the non-health sector. The community health professional’s role might include being a point of reference for advice, a catalyst for action, or a leader of change, depending on capacity and existing expertise within the local community.

Below are some suggestions which may assist community health professionals to identify what their health promotion role within the community may be.

Individual Community Health Professionals:
- Actively seek to be informed about and support health needs in the community.
- Be aware of existing services and other support staff within the wider community.

With Clients:
When seeing clients in a primary care context, enquire about lifestyle (healthy eating, physical activity, tobacco, drug or alcohol use) and mental wellbeing as part of a basic assessment, and offer support as appropriate.

Provide resources and information to assist in improving knowledge, skills and behaviour change for key health issues.

Link individuals and families to appropriate services to assist with health concerns.

In the Community:

- Provide advocacy where there are gaps in awareness of health issues and/or services for particular issues or population groups.
- Promote a coordinated and holistic approach to health related issues.
- Advocate within the community (including schools, local business, local government, community organisations) using an inclusive and consultative approach to develop healthy lifestyle policies, strategies and programs.
- Advocate for health impact assessments where local community planning or policy changes are proposed.
- Advocate for the involvement of parents, young people, health professionals and other members of the wider community in health promotion strategies and programs.
- Work with health promotion staff to advocate and support the creation of healthy environments via policy developments (including local school policies), linking partner agencies, and promoting health lifestyle messages.

Please refer to the School Health Chapter for Health Promotion in the School setting in Section 4.3.

1.9.5 The Health Promoting Schools (HPS) framework and school health services

For many young children, school is the first major transition in life from the family home and into other environments, and therefore can be an important influencing agency in a child’s life. It is a crucial time for learning, social and emotional development and social participation, as well as the acquisition of literacy and numeracy skills. Most importantly, it is a critical time for establishing good health behaviours. To achieve education and health goals, schools must be able to promote health as they do learning.

There are several factors unique to schools that make them an appropriate setting for enhancing the health and wellbeing of children. These are:

1. They have an existing infrastructure incorporating educational opportunities, staff trained in the provision of education, environmental services, various structures and supports that can reinforce health messages, and existing links to community based agencies and support services. Health Promotion can therefore be cost effectively incorporated into this pre-existing structure.

2. Schools have links to several influences on children’s health, including family, peers, and the local community. This access puts schools in an ideal position from which to initiate interaction between key influences on children’s health.
behaviours, to create supportive environments and reinforce messages from outside the school setting.

3. Schools provide an opportunity to reach all children, regardless of socioeconomic background, ethnicity or geography.

The Health Promoting Schools (HPS) Framework was first introduced in WA in the late 1990’s with growing adoption and embracing in varying capacities by most schools since this time.

There are three widely accepted interrelated components to the Health Promoting School Framework including:

- **Curriculum, teaching and learning:** considers the formal content of teaching and learning approaches, key issues, the developmental and sequential nature of the program, and resources.

- **School organisation, ethos and environment:** considers the school policy and philosophical support for the health curriculum, approaches to health and wellbeing, school community relationships and the school’s physical environment e.g. school grounds, canteen amenities.

- **Partnerships and services:** includes the school health service, family consultation and involvement, community based programs and the development of strong community links to the school.

For more information of the HPS framework, visit:


1.10 Disease control

1.10.1 Communicable disease prevention and control (Communicable Disease Control Directorate)

The Communicable Disease Control Directorate (CDCD) sits within WA Health and can be viewed at:


CDCD’s core function is prevention and control of communicable diseases. They do this through the development of policy in consultation with a wide range of public and private agencies to ensure policy is practical and workable in a community setting. To facilitate the effective coordination of disease prevention, CDCD is divided into five key areas:

- Prevention and Control (including immunisation, education, and infection control)
- Blood-borne viruses and sexual health
- Epidemiology and Surveillance (including disease notification and investigating outbreaks)
Many of the strategies to prevent and control communicable diseases involve:

- mandatory reporting of notifiable diseases,
- ongoing surveillance of disease,
- speedy response/intervention to new cases of disease that have public health significance,
- promoting immunisation uptake through the 0-5 year, school-based, and adult immunisation programs,
- alerting public health, GPs, and health care services of occurrence of diseases that have the potential to impact on their services,
- promoting positive health messages to specific target groups e.g. STI-Chlamydia, HPV and measles, mumps, rubella immunisation campaigns, and
- supporting Commonwealth initiatives that aim to protect the public from diseases e.g. pandemic influenza.

1.10.2 Roles and responsibilities of community health professionals

Community Health Professionals (CHPs) have a number of roles and responsibilities in preventing and reporting the spread of communicable diseases. They are responsible for:

- maintaining current information of communicable diseases,
- being informed about which communicable diseases are notifiable, and understanding the notification and outbreak management process, including liaison with CDCD or the regional Public Health Units (PHU)
- being informed about State and Commonwealth Departments of Health policy and guidelines relating to communicable diseases, and
- contributing to the development of communicable disease health promotion resources and materials.

Their role includes:

- Promoting health education and prevention activities, such as hand hygiene practices e.g. with schools, parenting groups and individuals
- Promoting childhood and adult immunisation, including encouraging schools and child care centres to maintain a register of a child’s immunisation status
- Promoting and supporting harm minimisation strategies relating to communicable disease e.g. safer sex practices, and needle and syringe programs
- Identifying people who are at high risk of contracting communicable diseases and promoting early intervention strategies e.g. harm minimisation and referral to appropriate counselling or rehabilitation services

1.10.2.1 Notification of communicable diseases
The purpose of notification of specified communicable diseases is to:

- Ensure timely public health response in management of a sporadic case or an outbreak to prevent or minimise the spread of disease.
- Collect epidemiological data for public health policy and planning.
- Contact a range of community organizations to provide outreach, health promotion, or support services for people who have or are at risk of contracting communicable disease. This includes sexual health and blood-borne viruses, as well as needle and syringe programs.

The Health Act 1911 requires medical officers and other health professionals to notify suspected and specific diseases to the CDCD in the metropolitan area and to the PHU in regional areas. In addition, there is now a requirement under the Health Amendment Act 2006 that laboratories must report confirmed cases of a communicable disease to CDCD.

Diseases requiring urgent reporting are indicated on the notification form with a telephone symbol and are those diseases which require follow up action as they have immediate and serious health risk implications for close contacts and the wider community.

A list of notifiable diseases can be viewed at:

A list of notification forms can be viewed at:

### 1.10.2.2 Reporting of a suspected communicable disease case

Community health professionals should:

- Report the suspected communicable disease case to their line manager.
- Utilise the appropriate notification form and report to their metropolitan or regional PHU that a suspected case of urgent notifiable disease has been reported to them.
- Collaborate with the Public Health Nurse in liaising with the school, child care centre, or workplace to advise staff regarding follow up action which may include exclusion periods.
- Consult with the regional PHN regarding appropriate information for dissemination to contacts, parents, and the public.
- Assist the regional PHN in undertaking contact tracing and provision of prophylaxis as requested.

### 1.10.3 Immunisation

All employees in a health environment are at potential risk of exposure to vaccine-preventable diseases (VPD), as well as at risk of transmitting VPDs to clients and/or other health care workers. It is the responsibility of the Area Health Services to promote CHP immunisation uptake and to ensure that immunisations are made
available to those employees who are at potential risk of exposure to VPDs in the workplace.


This should be read in conjunction with Tuberculosis and Health Care Workers (OP 1828/04).

See local Area Health Service for up to date guidelines and procedures for the provision of immunisations.

1.10.4 Key references for all Community Health Professionals

For more information on the Communicable Disease Control Directorate, see: http://www.public.health.wa.gov.au/2/611/1/communicable_disease_control_directorate__organisa.pm

For Metropolitan and Regional Public Health Unit Phone Numbers, see: http://www.public.health.wa.gov.au/3/280/2/contact_details_for_regional_population__public_he.pm

1.10.4.1 Communicable disease guidelines

All CHPs should be familiar with and have access to the Communicable Disease Guidelines for Teachers, Child Care Workers, Local Government Authorities, and Medical Practitioners 2012. The Guidelines list the common childhood communicable diseases and provides information on transmission, incubation periods, and periods of communicability of these diseases. The Guidelines provide direction for exclusion from school, child care, or work where appropriate and specifies notifiable communicable diseases which must be reported to the Department of Health.


The Staying Healthy in Child Care 2006 manual published by the National Health and Medical Research Council provides information and guidelines for child care providers on infection control, immunisation, notifiable diseases, management of minor childhood illnesses, when to call a parent, and when to refer a child to a doctor. The manual also contains a set of fact sheets on common childhood illnesses.

To view the manual go to: http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ch43.pdf

1.10.4.2 Infectious disease acquired during pregnancy

CHPs should be aware of those communicable diseases which may have adverse foetal or maternal effects if acquired during pregnancy. These include parvovirus, chickenpox, rubella, mumps, Listeria, cytomegalovirus (CMV), and toxoplasmosis.
Further information on the effects of these diseases in pregnancy is available from the A-Z Topics and Diseases list at: 
http://www.public.health.wa.gov.au/1/9/2/az_topics_and_diseases.pm


1.11 Infection control

1.11.1 Introduction

Infection control is a key priority within all Western Australian health settings as health care associated infections remain an ongoing challenge particularly with the increase in multi-resistant bacteria. In support of infection control, the Australian Health Ministers in October 2010 endorsed the National Health and Medical Research Council (2010) Australian Guidelines for the Prevention and Control of Infection in Healthcare.

To view this document, go to the following link: http://www.nhmrc.gov.au/node/30290

Infection control initiatives are promoted by WA Health through:

- Ongoing surveillance of infection in hospitals and the community;
- Developing infection control policy and procedures;
- Having highly skilled infection control staff (nurses, doctors, microbiologists, infectious disease physicians) who work together for a positive outcome;
- Providing ongoing education for clients (fact sheets, pamphlets) and staff (ongoing education); and,
- Ongoing monitoring of staff and client compliance with infection control policy/recommendations.

Infection Control Professionals working across the health care sector work collaboratively together to share knowledge and expertise. This expertise is available to all health care staff working throughout Western Australia.

All staff should refer to their local Health Service Policies for further guidance. In addition to these policies, the following references may provide assistance:

References:

- Health Act 1911
- Health Services (Conciliation and Review) Act 1995
- Health Practitioner Regulation National Law (WA) Act 2010
1.11.2 Standard and additional infection control procedures

Improving the quality of care and providing a safe working environment are fundamental to the provision of health care services. WA Health’s infection control policy includes standard and additional precautions for HCWs, including student HCWs.

Standard Precautions are work practices required to achieve a basic level of infection control and therefore, are the minimum acceptable level of practice in all health-care settings. Standard Precautions are designed to prevent or reduce the transmission of pathogens to and from HCWs and clients and are applied to all clients receiving care regardless of their diagnosis or presumed infection status i.e. recognised and unrecognised sources of infection.

Standard Precautions apply to:

- Blood (including dried blood).
- All other body fluids, secretions, and excretions (excluding sweat), regardless of whether they contain visible blood.
- Mucous membranes.
- Non-intact skin.

Additional Precautions are used in addition to Standard Precautions when extra measures are required to prevent transmission of specific infectious diseases.

Please refer to NHMRC 2010 *Australian Guidelines for the Prevention and Control of Infection in Healthcare* for more information on standard and additional infection control precautions (includes areas such as personal protective equipment [PPE], facial protection, prevention of sharps injuries, blood/body fluid spills).

1.11.3 Hand hygiene

Hand hygiene is recognised as the single most important measure to prevent health care associated infections in both community health staff and clients. With the emerging challenge of community acquired antibiotic resistant bacteria, staff working in community health must be as vigilant as their hospital-based colleagues. All staff must clean their hands in accordance with the “5 Moments of Hand Hygiene” (refer to Hand Hygiene Australia and local policy), and encourage clients, visitors, families, and volunteers to also practice appropriate hand hygiene.

Community health professionals must practice hand hygiene before and after any client contact and after any procedure/body fluid exposure or touching of client surrounds.

All staff should have convenient access to a designated hand basin within their work site. Paper towels, liquid soap, and skin moisturiser should be provided at all hand basins. Alcohol-based hand rub should be accessible to all staff, and gloves available to staff for use as required. Staff involved in mobile services should carry...
disposable hand wipes for removal of residue as well as alcohol-based hand rub for decontamination purposes.

Clients, parents, and visitors should be encouraged to practice hand hygiene after visiting the toilet, after coming into contact with their own or the client’s body excretions and secretions, and before eating or drinking. Hand hygiene facilities must be readily accessible i.e. wall mounted dispenser of hand cleanser near the entrance to clinic or waiting area.

Community health professionals employed to deliver clinical services within child and adolescent community health services state-wide must possess the relevant qualifications applicable to their field. They must also receive hand hygiene education on commencement of employment and at regular intervals, such as via annual competency training.

Please refer to *Hand Hygiene in Western Australian Hospitals* (OD 0429/13) and your local Area Health Service infection control policy.