H&H Care SA Pty Ltd	Form21. Nursing and Clinical Governance Australian Government Support at Home Program	
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Policy and procedure 21
H&H Care SA Pty Ltd | Support at Home services

This policy establishes H&H Care SA's clinical governance framework for nursing and clinical support in home and community settings. It defines accountability, approved scope, safe clinical processes, delegation, oversight and evidence of quality outcomes.

Document control	Details
Policy number	HH SAH CLINICAL 021
Version and status	1.0 — Draft for Director and Clinical Lead RN approval
Prepared	24 October 2026
Policy owner	Director and appointed Clinical Lead RN
Approved by	Director: Huy Le RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Directors, managers, RNs, ENs, workers and approved contractors involved in clinical service planning, delivery or oversight

1 Purpose and scope

Clinical governance is the system by which leadership, clinicians, workers and clients share responsibility for safe, effective, person-centred clinical care. H&H Care will match clinical services to client needs, professional authority, worker competence, resources and monitoring. A written policy does not itself establish safe practice or approve a new clinical service.

This policy applies to services delivered on behalf of The Fig Trees and other approved registered providers. It supports their applicable clinical governance obligations without replacing their statutory responsibilities. Standard 5 applies according to registration categories and services; H&H Care's associated provider role does not automatically make every registered-provider requirement its own direct duty.

Nursing, medicines, wounds, continence, dysphagia, diabetes, catheters, injections, enteral care and other clinical activities require service-specific approval and procedures. NDIS registration or previous experience does not itself authorise an aged care clinical task. This framework is not a treatment order, prescribing authority or blanket permission to offer all complex care.

2 Governance principles

Partner with the client; use current evidence and lawful clinical directions; provide competent care and safe staffing; recognise and escalate risk; communicate honestly; learn from outcomes. Support clients' independence and informed choices while managing duty of care and worker safety. Do not substitute business convenience or funding assumptions for clinical assessment.

Accountability professional roles and clinical cover

3 Role responsibilities

Role	Accountability and required actions
Director	Approve clinical scope, framework and resources; appoint qualified leadership and backup; review clinical risks, outcomes and corrective actions; ensure safe agreements with providers.
Clinical Lead RN	Maintain clinical systems within competence; assess/coordinate needs, plans, delegation, supervision, referrals, competency and risk review; advise management and escalate beyond expertise.
Registered nurses	Assess, plan, provide and evaluate nursing care within lawful scope; make and review appropriate delegation decisions; monitor outcomes and seek specialist/prescriber support.
Enrolled nurses	Provide nursing care within their education, registration and competence under appropriate RN direction and supervision; retain accountability for their own actions and report changes.
Support workers	Perform only approved tasks within competence and any required lawful delegation; observe, document and escalate; do not independently diagnose, prescribe or alter treatment.
Coordinator	Verify service authorisation, safe roster, equipment, current instructions and actual clinical cover; manage handovers, missed care and follow-up with the registered provider.
The registered provider	Retains responsibility for funded service quality and compliance; agrees care management, authorisations, clinical interfaces, oversight and regulatory reporting arrangements.
Prescribers and allied health	Provide clinical directions, treatment, assessment and specialist input within their professional roles; verify referrals and instructions rather than assuming involvement.

4 Appointments and independence

Appoint the Clinical Lead RN and backup in writing, verifying current Ahpra registration, relevant experience, restrictions and capacity. Record authority, available hours, duties, escalation and performance review. If the Director also holds an operational role, distinguish it from clinical authority; a medical background or management title is not evidence of current Australian registration or authority to direct nursing treatment.

An appointed lead working elsewhere must have genuinely available time and agreed cover. Do not roster services based only on their name or presume a hospital role supplies H&H clinical supervision. Obtain external specialist review when the team lacks expertise or an unconflicted reviewer.

5 Clinical cover and the provider interface

Agree with The Fig Trees who assesses, approves plans, provides RN supervision, contacts prescribers, orders equipment and follows clinical referrals, incidents and after-hours concerns. Identify one accountable role for each action and backup. Verify actual response availability during affected services. Do not describe the business as a 24-hour clinical service unless competent cover and response are in place.

Approved scope and clinical readiness

6 Authorise the service before acceptance

Maintain a clinical scope register identifying each service/task, routes/devices, client limits, required practitioners, competencies, equipment, clinical directions, risk controls, insurance and approval. The Director and Clinical Lead RN approve entry or expansion only after verifying legal, professional and contractual requirements. The supplied Fig Trees scope lists RN and EN services but does not approve every procedure or transfer prescribing authority.

- Confirm client assessment, goals, consent and any verified substitute authority. Identify clinical instability, communication needs, home risks and required specialist input.
- Obtain current, authenticated treatment or medicine directions where required, with clear task instructions and review/stop/escalation criteria. Resolve conflicting records before affected care.
- Verify competent staff, required numbers, practical task sign-off, professional scope and any delegation/supervision. Funding for a worker does not establish clinical competence.
- Confirm suitable equipment, supplies, IPC, waste management, safe environment, monitoring and emergency response. Validate device instructions and maintenance.
- Establish referral, prescriber/pharmacy contact, after-hours cover, continuity and confirmed handover. Do not rely on an unacknowledged referral.
- Record Director/RN readiness, provider service authorisation and client agreement. Pause unsupported tasks and arrange appropriate alternatives for essential care.

7 Nursing assessment and individual clinical plan

The RN or relevant qualified practitioner completes a proportionate assessment within scope, using evidence-based tools where appropriate. Identify baseline function, physical/cognitive/psychological needs, medicines, allergies, nutrition/swallowing, mobility, skin, pain, continence, infection, carer capacity and other relevant risks. Do not use a score as a substitute for judgement or diagnose outside competence.

Translate findings into current clinical instructions and a coordinated care plan under Policies 5 and 6. Include client goals, treatment purpose, procedures, staffing, monitoring, deterioration triggers, referrals and review. Link specialist plans by source/date and make the authoritative version available. Clinical and service authorisation are separate; do not omit assessed unmet needs to fit the budget.

8 Consent communication and client partnership

Explain care, risks, options and service limits accessibly; offer an interpreter, advocate or chosen supporter. Seek ongoing consent and respect refusal, escalating risks without force. Verify legal authority rather than assuming next of kin can decide. Refer advance care and treatment-limit questions to qualified advice; a care plan does not itself establish a valid treatment refusal or resuscitation direction.

Delegation supervision and clinical workforce

9 Delegation decision procedure

Use the current NMBA Decision-making Framework and relevant law. Delegation is a professional decision about a specific activity in the actual circumstances, not an automatic consequence of a job title, roster or training course. The RN retains accountability for the decision to delegate, appropriate supervision and evaluation; the person accepting the activity remains accountable for their own performance.

- Assess the client, task, stability, foreseeable risks and whether the activity may lawfully and appropriately be delegated. Identify clinical judgements that must remain with the qualified practitioner.
- Verify the delegate's registration where relevant, training, demonstrated competence, experience, workload and willingness. Check professional conditions, organisational scope and contract limits.
- Explain the purpose, exact activity, instructions, expected outcomes, limits, required observations, documentation and stop/escalation triggers. Obtain client consent for the care and involvement of the proposed worker.
- Determine and record the supervision needed, including direct or indirect arrangements, named supervising RN, contact/response availability and backup. Indirect supervision is not simply an unanswered phone number.
- Confirm the delegate understands, accepts and can safely undertake the activity. If they decline or identify a gap, reassess without pressure or punishment.
- Record the delegation, competency evidence, start/review dates and conditions. Observe practice and evaluate results; change or withdraw the delegation when needs, risk, competence or cover changes.

10 Limits and EN supervision

Do not delegate where the activity is prohibited, outside the delegate's lawful scope, insufficiently assessed or unsupported by competence, instructions, equipment or supervision. Organisational sign-off cannot create prescribing authority or remove a professional responsibility. A worker may not pass on a clinical delegation to someone else by private roster swap; obtain appropriate RN reassessment and approval.

ENs work with appropriate direct or indirect RN supervision and retain accountability for their own practice. Verify medication education, any notation and actual competence for medicine tasks. Record how RN supervision is available in the home/community arrangement and check NMBA requirements, including employment/interface issues where different organisations are involved. An external provider agreement does not automatically establish suitable professional supervision.

11 Workforce readiness and review

Apply Policy 15 screening, registration and qualification checks and role-specific practical assessment before deployment. Use competent clinical assessors and record limits. Training attendance alone does not establish competency. Reassess after new procedures/devices, changed needs, incidents, absence or observed gaps, with annual review as an internal minimum and more frequent review where indicated. Remove affected tasks when essential authority, competence or cover lapses.

Clinical safety communication and oversight

12 Clinical risk controls

Area	Required system controls
Medicines	Current valid directions, reconciled information, lawful worker tasks, PRN/high-risk safeguards, supply, records and error response under Policy 20.
Deterioration and emergencies	Baseline, clinician-set triggers, prompt direct escalation, 000 for emergencies, cover and verified handover under Policy 12.
Infection and procedures	Standard/additional precautions, aseptic technique, PPE, sharps/waste, device instructions and exposure response under Policy 13.
Falls mobility skin and continence	Assessed movement and pressure/skin plans, equipment, practical competence, timely care and referral under Policies 14 and 19 and relevant clinical procedures.
Nutrition swallowing pain and wellbeing	Relevant assessment, professional instructions, monitoring, treatment review and reporting; do not improvise textures, doses or clinical programmes.
Complex devices and care	Procedure-specific authorisation, prescriptions where required, validated competence, supplies, maintenance, monitoring and rescue/backup arrangements.
Palliative and restrictive practices	Respect current lawful directions, goals and safeguards; obtain specialist support and do not treat consent or family instruction as unrestricted authority.

13 Clinical communication and transitions

Use structured, acknowledged handover for urgent changes, ongoing clinical actions, practitioner transfers and discharge. State the client, situation, relevant background, observations, actions, requested response and timing. Verify identity and a lawful sharing basis. Keep current instructions accessible and preserve audit history; case notes are not a substitute for direct urgent contact.

Track test or assessment referrals, prescriptions, specialist recommendations and care gaps until a named professional accepts responsibility and action is confirmed. Avoid duplicating or missing treatment across family and providers. After hospital discharge, reconcile medicines and clinical plans and confirm readiness before affected tasks resume. Review mismatches promptly rather than assuming old instructions remain current.

14 Clinical review and assurance

As internal controls, review unresolved urgent clinical matters each service day and as often as risk requires. The RN and management review clinical incidents, missed care, medicines/PRN, skin, falls, IPC, transfers, complaints, refusals and outstanding referrals monthly. Audit a risk-based sample of plans, delegation, records and observed practice quarterly. Use counts/rates in context and client goals/experience, not tick-box completion alone.

The Director documents decisions, resources, priorities and follow-up under Policy 18. Investigate incidents and use open disclosure under Policies 9 and 10; assess SIRS or other notifications without assuming every clinical event is reportable. Verify action effectiveness and seek independent review for serious, conflicted or specialised concerns.

Clinical service readiness and review record

CLIN F01 | Client/service: _____ Assessment date: _____
Clinical Lead RN/reviewer and role: _____
Proposed tasks and scope-register reference: _____
Clinical assessment sources and current plan: _____
Client goals consent and communication support: _____

Readiness requirement	Evidence controls and approval
Clinical need stability and risks	_____ _____
Directions prescriptions and plan source	_____ _____
Staff credentials task competence and numbers	_____ _____
Delegation RN/EN cover and backup	_____ _____
Equipment supplies IPC and environment	_____ _____
Monitoring emergency and continuity plans	_____ _____
Provider authorisation and referrals	_____ _____

Unmet needs interim care and escalation: _____
_____
Tasks approved excluded or paused: _____
_____
RN clinical approval/date and conditions: _____
Director resource/scope approval where required: _____
Provider approval reference: _____
Workers notified and acknowledged: _____
Review date/earlier triggers: _____

Review outcome

Client feedback clinical progress and current concerns: _____
_____
Actions owner deadline and confirmation method: _____
Updated instructions and recipients: _____

Delegation and supervision record

CLIN F02 | Complete for the specific activity/client and authorised worker. This record does not replace legal authority, current orders or ongoing professional judgement.

Client identifiers: _____
Delegating RN name registration and contact: _____
Delegate name role and registration if relevant: _____
Task exact scope and exclusions: _____
_____
Client assessment suitability and reasons to delegate: _____
_____
Current clinical directions/procedure version: _____
Competency evidence assessor and date: _____
Client consent and involvement: _____

Instructions and limits

Required preparation equipment and assistance: _____
_____
Expected outcomes and observations: _____
_____
Stop criteria deterioration triggers and required action: _____
_____
Documentation and handover requirements: _____

Supervision and acceptance

Direct/indirect supervision and reasons: _____
Named RN availability/response and coverage hours: _____
Backup RN and action if unavailable: _____
Review/observation schedule and outcome evaluation: _____
Delegation begins: _____ Review/expiry: _____
Triggers for withdrawal or reassessment: _____
Delegate understanding acceptance and limits: _____
Delegating RN authentication/date: _____
Delegate authentication/date: _____

Follow up or withdrawal

Practice observed and clinical outcome: _____
_____
Changed conditions remediation or withdrawal/date: _____
Client/provider/worker notifications: _____
Safe continuity action and accountable person: _____

If required supervision, instructions or competence is unavailable, pause the affected task, obtain help and arrange safe care. Never rely on a form alone when the real circumstances have changed.

Governance review template implementation and references

Clinical governance review record

CLIN F03 | Period/date: _____ Director/RN participants: _____
Services and high-risk clients reviewed: _____
Client feedback outcomes and unmet needs: _____
Incidents medicines falls skin IPC and transfers: _____
Referrals/clinical cover/delegations/competencies outstanding: _____
Data sources sample limitations and external advice: _____

Finding and agreed action	Owner and due date	Effectiveness evidence
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____

Provider communication and decisions: _____
Unresolved risks/resource escalation: _____
Next review and sign-off: _____

15 Implementation and records

Before approval, appoint the RN lead and backup; approve the clinical scope register; agree provider responsibilities; verify supervision, referrals and cover; and establish task-specific procedures and competencies. Review existing clients for unsupported clinical tasks and arrange safe alternatives. Maintain appointment, scope, delegation, plan, review, audit and incident evidence securely under Policy 8. Review the framework annually and after significant events, new services or legal changes.

16 References and related policies

Policies 1 to 20 and relevant task-specific clinical procedures. Aged Care Act 2024 and Rules 2025; National Law and relevant professional standards; South Australian consent, medicines, WHS and privacy requirements; The Fig Trees agreement and current variations.

- Commission — Outcome 5.1 Clinical governance and Standard 5 Clinical care. https://www.agedcarequality.gov.au/strengthened-quality-standards/clinical-care/clinical-governance
- Commission — Application of Standard 5 by registration category. https://www.agedcarequality.gov.au/providers/quality-standards/standard-5-clinical-care
- NMBA — Current Decision-making Framework for nursing and midwifery. https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx
- NMBA — Enrolled nurse standards for practice and Registered nurse standards for practice. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/enrolled-nurse-standards-for-practice
- Ahpra — Current register of practitioners and registration conditions. https://www.ahpra.gov.au/

Official guidance checked 24 October 2026. Apply requirements relevant to services and provider categories; do not infer clinical authority from the policy title or employer approval. Internal review frequencies do not replace shorter professional or clinical requirements.

Director approval: _____ Clinical Lead RN approval: _____
Effective date: _____ Next review: _____
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