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PATIENT MATTERS MANUAL

FOR

HEALTH SERVICE AREAS

June 1989

FOREWORD

This is one of a series of Public Hospital Procedure Manuals produced as a joint project by the Department of Health New South Wales and the Australian College of Health Service Administrators (NSW Branch).

Whilst the manual reflects the current Departmental policies contained in the Consolidated Circulars that it supersedes, it must be emphasised that it is a 'live' document to which amendments will be issued on a regular basis. Amendments should be recorded on the amendment sheet.

Suggestions are invited for amendments and should be submitted through the appropriate channels i.e. hospital administration, Area/District Offices.

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1. ANAESTHETICS 1.1

PRINCIPLES OF ANAESTHETIC CARE

- Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia.

- Every patient presenting for anaesthesia should have a pre-anaesthetic consultation by a medical practitioner.

- Modern practice demands certain basic facilities, equipment and staff for safe administration of anaesthesia.

- An operation involving a general anaesthetic is not to be undertaken unless the services are available of a second medical practitioner to act as anaesthetist.

(Faculty of Anaesthetists, Royal Australasian College of Surgeons Documents Nos. P2, P7, T1, T3, T4, T6.)

PRE-ANAESTHETIC CONSULTATION

- The pre-anaesthetic consultation will ensure that the patient is in the optimal state for anaesthesia and surgery. It should be performed by the anaesthetist who is to administer the anaesthetic.

- The pre-anaesthetic consultation should include:

  (a) Identification of the patient
  (b) Confirmation of the nature of the procedures
  (c) A medical history and clinical examination of the patient
  (d) Ordering appropriate pre-medical if necessary
  (e) A written summary, which is part of the medical record

(Faculty of Anaesthetists, Royal Australasian College of Surgeons, Document No. P7.)

ADMINISTRATION OF DRUGS SPECIFICALLY TO PRODUCE COMA

- Every patient who is to be given drugs for the specific purpose of producing coma should have a general medical assessment by a medical practitioner.

- Persons administering drugs which produce coma should have the basic knowledge to be able to:

  - understand and deal with the actions of the drug and a drug being administered;
  - defect and manage appropriately any complications arising from these actions;
  - anticipate and manage appropriately the modifications of these actions by any concurrent therapeutic regime or disease process which may be present.

- The administration of drugs for the specific purpose of producing coma should be directly supervised by a practitioner with appropriate postgraduate training in anaesthetics. This person must not assume the additional role of operator.

- Whenever drugs are used to produce coma, certain basic facilities, equipment and staff should be provided.

(Faculty of Anaesthetists, Royal Australasian College of Surgeons, Documents Nos. P5, P4, P8, T1.)

MAJOR REGIONAL ANAESTHESIA

- Major regional anaesthesia should be undertaken only by persons with adequate experience in the technique to be applied, and the ability to recognise and treat any complications arising from the anaesthetic technique, promptly and competently.

- Management of major regional anaesthesia should include appropriate monitoring and therapy by the anaesthetist, who should be present until the block is complete, the condition of the patient is stable, and any surgical procedure has been completed.

- The placement and subsequent management of an epidural cannula, including top-up doses, remains the responsibility of the anaesthetist inserting the cannula, no matter who performs these later procedures.

- Should the anaesthetist delegate the further management including topping up of the epidural cannula to another person it is the responsibility of the anaesthetist to properly hand over the patient's management to that person and to satisfy himself or herself of the competence of that person to manage the patient and carry out the top-up procedure. Adequate medical records documenting the time, due and subsequent effects must be kept.

- Competence should be established by:

  (a) a form of accreditation which certifies that the procedure has been carried out satisfactorily under supervision, and

  (b) inquiry of the person to establish familiarity with and knowledge of the procedure and subsequent management, including the management of complications.

- No person may be required to carry out the top-up procedure if he or she is uncertain of his or her competence to do so.

- Certain basic facilities, equipment and staff for the safe administration of anaesthesia should be provided.

- The anaesthetist must ensure that he or she is readily contactable, and suitable arrangements must be made for a competent medical officer to be available to see the patient at any time during major regional anaesthesia should the nursing staff consider this necessary.

(Faculty of Anaesthetists, Royal Australasian College of Surgeons Document Nos. P3, T1.)

ANAESTHETIC MACHINES

The Special Committee investigating deaths under anaesthesia received reports of fatalities attributed to accidental jamming of non re-breathing (Ruben type) valves in the inspiratory position. The patients were subjected to excessive intrapulmonary pressures as gases from the anaesthetic machine entering the system were unable to escape therefrom.

This accident is likely to arise in any non re-breathing valve which, like the Ruben, does not include a built-in pressure limiting safety device. Anaesthetists should be aware that any sudden, possibly unnoticed, variation in gas inflow or patient ventilatory pattern may so jam the valve that a disastrous pressure injury results. Examples of the way in which this may occur are:

(a) Major variations in patient minute volume.
(b) Coughing following a period of breath-holding.
(c) Accident operation of the emergency oxygen flow control.

Medical interference with the function of the valve spindle by drapes, when the operative field includes the head and neck area, is another possible cause.

Since no guarantee can be given that one or more of the above circumstances will not happen in any anaesthetic, the Special Committee considers that no system which includes a non re-breathing valve should be set up which does not contain a pressure-relief device, set to operate at a pressure below that which could cause damage to the patient's lungs.

It has been suggested that the simplest way of achieving this is to position a straight Heidbrink-type expiratory valve between the gas supply and the reservoir bag of the system. (If the hospital's machines do not incorporate an appropriate pressure relief device, steps should be taken to see that a Heidbrink-type expiratory valve as recommended is available for the use of anaesthetists.) This valve should be set to 'blow off' at pressure which can be achieved comfortably by a forcible expiration. A characteristic hiss of escaping gas will warn the anaesthetist that the non re-breathing valve has jammed, whilst at the same time ensuring that pressure in the system does not build up to dangerous levels.

Following the issue of Commission Notice 70/20 concerning modifications of Emergency Oxygen Valves to prevent inadvertent operation, several hospitals enquired whether this referred to the valve in the circle absorber or the valve on the frame of the machine. The valve for which modification is recommended is the one situated on the circle absorber (Boyle MK.111).

Hospitals are also reminded of the need for machines to be fitted with an oxygen low level alarm.

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 2 - PAEDIATRICS

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Infants and Children: Acute Management of Community Acquired Pneumonia	GL2018_007
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Minimisation of Neonatal Early Onset of Group Streptococcus GBS Sepsis	GL2017_002
NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements	PD2023_019
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Infants and Children: Acute Management of Bronchiolitis	GL2018_001
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Youth Health and Wellbeing Assessment Guideline	GL2018_003
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Paediatric Procedural Sedation - Guide for Emergency Departments, Wards,	GL2018_011

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Jaundice Identification and Management – Neonates - >32 weeks	GL2016_027
Hypoxic ischaemic encephalopathy in newborns - recognition, monitoring and early management	IB2023_028
Child Wellbeing and Child Protection Policies and Procedures for NSW Health	PD2013_007
Statewide Eyesight Preschooler Screening (StEPS) Program	PD2018_015
Paediatric Procedural Sedation - Guide for Emergency Departments, Wards, Clinics and Imaging	GL2018_011
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Clinical Determination for Boarder Baby Registration	GL2020_020
Syphilis in Pregnancy and Newborns	PD2023_029

NEWBORN BLOODSPOT SCREENING POLICY (PD2016_015)

PD2016_015 rescinds PD2006_099.

PURPOSE

This Policy Directive provides direction to maternity services in NSW regarding the requirements of the Newborn Bloodspot Screening Program. This includes the following information: parents / guardians must be provided with information about conditions that are screened for by the Newborn Bloodspot Screening Program; the consent and documentation that must be obtained and recorded; and the requirements in relation to the privacy, storage and security of the information collected.

MANDATORY REQUIREMENTS

All parents / guardians must be provided with the consumer brochure *Newborn Bloodspot Screening* in the last four to six weeks of pregnancy.

All parents / guardians must be told about:

- What information is collected
- Storage of the blood sample
- The potential uses of the information collected
- The potential future uses of the blood sample
- The privacy and protection processes.

All parents / guardians must be provided an opportunity to ask questions about the Newborn Bloodspot Screening program.

All parents / guardians must sign the written consent component of the newborn screening card prior to the blood sample being collected.

All parents / guardians must be offered Newborn Bloodspot Screening for their baby within 48–72 hours of the baby's birth.

A newborn bloodspot screening card must be sent to the Newborn Bloodspot Screening laboratory for every baby born in NSW, even in the event that the parents/guardians have refused the screening test.

IMPLEMENTATION

The Chief Executives of NSW Local Health Districts are ultimately responsible for the implementation of this Policy Directive within their services / facilities.

1 BACKGROUND

1.1 Introduction

Newborn bloodspot screening (NBS) detects babies at risk of serious disorders including phenylketonuria, primary congenital hypothyroidism, cystic fibrosis, galactosaemia and rare metabolic disorders of amino acids, organic acids and fatty acid oxidation defects. Early diagnosis and treatment by medication or diet can prevent death or serious complications and can lead to significantly improved outcomes. Among the 100,000 babies born each year in NSW and ACT, over 100 babies are diagnosed with one of these conditions.

A checklist (Appendix 1) has been developed for health professionals to ensure that parents have been provided the information at the most appropriate time about the:

- Screening tests and benefits
- Storage and potential uses of bloodspots
- Consent processes
- Legally enforceable privacy safeguards.

1.2 Key definitions

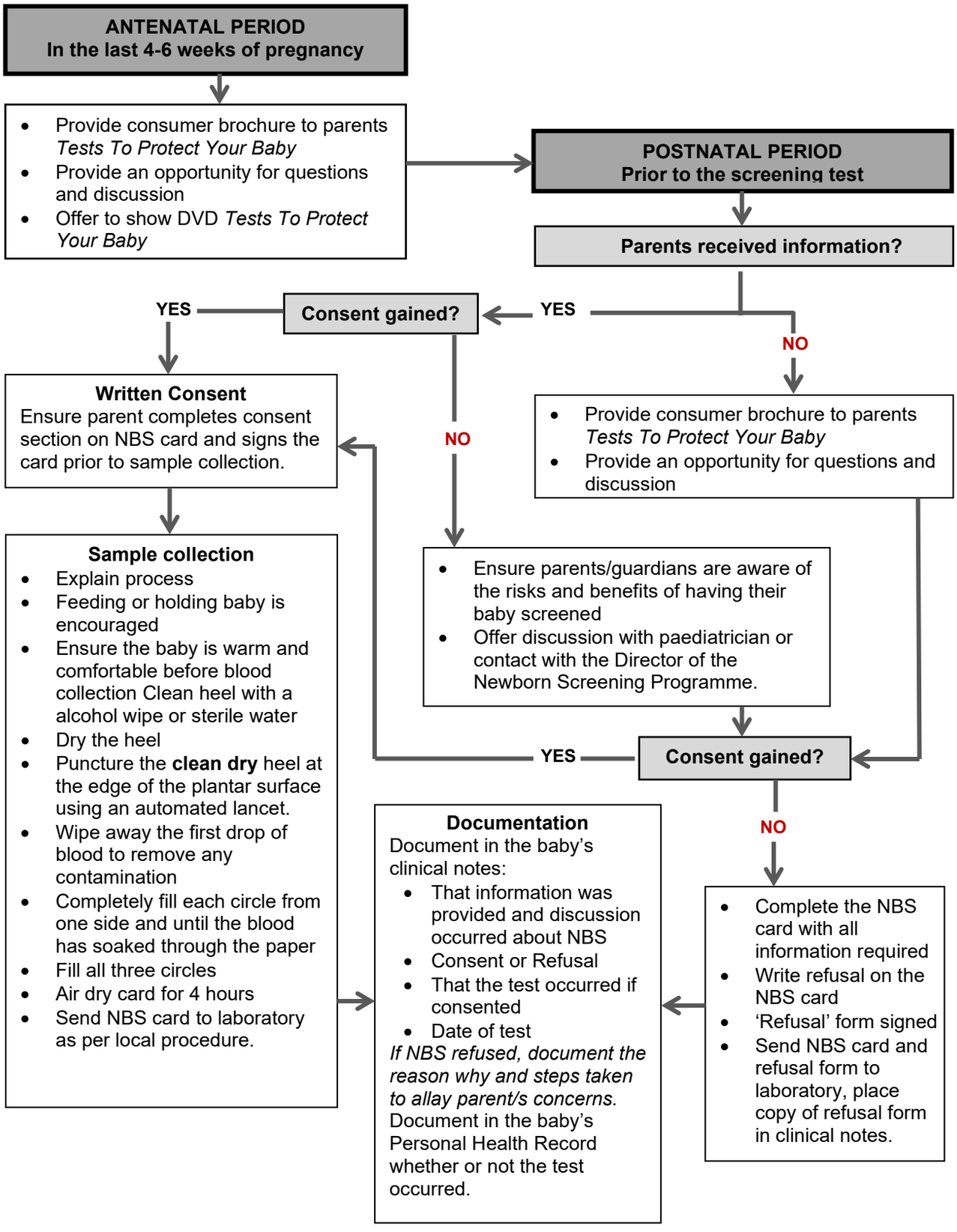
Must - Indicates a mandatory action requiring compliance.

Should - Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

1.3 Abbreviations

CF	Cystic Fibrosis
DNA	Deoxyribonucleic acid
LHD	Local Health District
MCAD	Medium chain acyl coenzyme A dehydrogenase
MOU	Memorandum of Understanding
NBS	Newborn Bloodspot Screening
PHO	Public Health Organisation
PKU	Phenylketonuria
PPM	Privately practising midwife

FLOWCHART: NEWBORN BLOODSPOT SCREENING PROCESS



2 INFORMATION FOR PARENTS / GUARDIANS

All information as outlined below must be provided to parents / guardians prior to the blood sample being collected.

- Parents / guardians:
  - Must be given a copy of the consumer brochure *Newborn Bloodspot Screening* in an appropriate language where possible
  - Should be offered the opportunity to watch the *NSW & ACT Newborn Screening Tests Education Video For Parents*
  - Must be told:
    - What information is collected Section 8.1
    - Storage of the blood sample Section 8.2
    - The potential uses of the health information collected Section 8.3
    - Potential future use of the blood sample Section 8.4
    - The privacy and protection processes Section 8.2
  - Must be provided with the opportunity to ask questions (discussion and questions may occur either in a group situation such as antenatal classes and / or on a one to one basis). An interpreter must be present for this discussion if required.

NOTE: The consumer brochure must not be distributed without discussion.

3 BLOODSPOT SCREENING

Newborn bloodspot screening is highly recommended for all babies. Among the 100,000 babies born each year in NSW and ACT, over 100 babies are diagnosed with one of the conditions tested for. Early diagnosis and immediate treatment by medication or diet can prevent death or serious complications including intellectual disability, and lead to significantly improved outcomes.

Therefore:

- Newborn bloodspot screening must be offered to all babies.
- Parents / guardians should be informed about newborn bloodspot screening during the last four to six weeks of their pregnancy to allow sufficient time for consideration, clarification and informed decision-making
- Prior to the blood sample being collected, the person taking the sample must:
  - Check that parents / guardians have received a copy of the consumer brochure *Newborn Bloodspot Screening*
  - That they have had opportunity for discussion and clarification
  - That they consent to the screening test
  - Cross check patient identification.

4 CONDITIONS SCREENED

The Newborn Bloodspot Screening program screens for approximately 25 medical conditions. Only a small number of babies will be diagnosed with one of the medical conditions of which the following are the more common conditions detected.

Table 2: Conditions screened for

Condition	Incidence	Caused by	If left untreated	Treatment
Primary congenital hypothyroidism:	1 in 2,600 live births (about 40 babies per year).	Absence or abnormal formation or function of the thyroid gland.	Causes growth and intellectual disability if not treated.	Medication with thyroid hormone started early results in normal growth and development.
Cystic Fibrosis (CF):	1 in 3,700 live births (about 30 babies per year).	A dysfunctional gene results in thick mucus in different organs throughout the body in particular the lungs and gastrointestinal tract.	Without treatment severe chest infections occur and often very serious failure to thrive leading to early death.	Early commencement of treatment greatly improves the health of individuals with CF.
	NOTE: Newborn bloodspot screening detects about 95% of babies with CF. Screening will also detect some babies who may only be healthy carriers. For these babies a sweat test at about six weeks of age determines whether the baby has CF or is a healthy carrier.			
Phenylketonuria (PKU):	1 in 10,000 live births (about 10 babies per year).	Inability of the body to break down the essential amino acid phenylalanine.	High blood levels of phenylalanine cause severe intellectual disability if left untreated.	A carefully managed diet low in phenylalanine, started in the first two to three weeks prevents this damage.
Medium chain acyl coenzyme A dehydrogenase (MCAD) deficiency:	1 in 15,000 births (about 6-8 babies a year).	Inability of the body to completely break down fat.	May be life-threatening or cause severe disability during times of common childhood illnesses.	Extra precautions are taken to ensure adequate energy intake during illnesses.
Galactosaemia:	1 in 40,000 births (about 1-3 babies per year).	Inability of the body to process galactose, a component of lactose found in milk and other foods.	Life-threatening liver failure and infections can occur.	A galactose-free diet commenced before 2 weeks of age is lifesaving.
Other rare metabolic disorders:	Rarer disorders that in total affect approximately 20 babies a year.	Some disorders of the metabolism of amino acids, urea cycle, organic acids and fatty acid oxidation can be detected.	Without appropriate management they can have severe disability or death.	Early detection is important as diet and medications can treat most of these disorders.
NOTE: For further information on disorders screened for please see: http://www.schn.health.nsw.gov.au/health-professionals/statewide-laboratory-services/nsw-newborn-screening-programme				

5 OBTAINING AND RECORDING OF CONSENT OR REFUSAL

5.1 Consent

Offering the screening test and obtaining consent should comply with PD2005_406 Consent to Medical Treatment – Patient Information. As the baby is a patient under the age of 14 the consent of a parent or guardian is necessary.

The following are the levels of consent required by NSW Health for the Newborn Bloodspot Screen.

Table 3: Consent

Procedure	Level of consent and documentation
Obtaining newborn blood sample for screening	Verbal consent required and to be documented in the baby's clinical notes. Written consent by parent / guardian is documented on the NBS card at the time of taking the sample.
Storage of the sample for longer than 2 years	Written consent by parent / guardian is documented on the NBS card at the time of taking the sample.
Use of the sample for de-identified research	Parent / guardian indicates yes / no on NBS card at the time of taking the sample. NOTE: *Cards without consent for de-identified research will not be used for de-identified research.*
Use of the sample for identified research	Written consent from either the parent or the child (dependent on the age of the child at the time of the research) will be required prior to the research being commenced.

5.2 Processes for obtaining consent to newborn bloodspot screening

In newborn bloodspot screening, valid consent requires provision of full information about the test including information about what happens to the bloodspot sample after testing as outlined in Section 7. Any NSW Public Health Organisation (PHO) caring for babies must ensure the following:

- Both sections on the newborn bloodspot screening card *Consent for the collection and testing of sample* and *Storage >2 years* must be completed by the parent/guardian
- The newborn bloodspot screening card must be signed by the parent /guardian
- Documentation in the baby's clinical record includes the following:
  - That discussion about the newborn bloodspot screening test has occurred
  - That the parent / guardian has consented
  - That the newborn screening test has occurred. Use of a pre-inked stamp similar to the example below is recommended.
- Documentation in the baby's Personal Health Record (PHR) "Blue Book" whether or not the newborn bloodspot screen occurred.

Baby's name: _____

Signature (Health Professional)

Provision of the NBS pamphlet: _____ Date: _____

Discussion of NBS information: _____ Date: _____

Verbal/written consent: _____ Date: _____

Completion of sample collection: _____ Date: _____

5.3 Refusals

Parents / guardians may refuse the newborn bloodspot screening test on behalf of the baby. In this circumstance, it is suggested that parents/guardians:

- Are provided an opportunity to discuss their concerns with a paediatrician or specified health professional who is aware of all the implications of not screening
- Are offered the option of telephoning the Director of the Newborn Screening Programme to answer any further questions they may have Telephone (02) 9845 3659
- Are advised to notify their health care worker, in the event of the child requiring medical attention, that the child has not been screened.

Clinicians should undertake the following:

- Document the reason for refusal in the baby's medical record
- Complete a newborn bloodspot screening sample card, with all information completed on both sides, and write "refusal" on the card
- Send the card and the completed refusal form to the laboratory
- Retain a copy of the refusal form in the baby's clinical notes.

NOTE: PD2005_406 Consent to Medical Treatment – Patient Information provides guidance concerning refusals and care and protection of minors based on the Children and Young Persons (Care and Protection) Act 19981.

NOTE: A refusal form is available for use by hospitals in the NSW Newborn Screening Programme Sampling Information and Guidelines (see Section 9).

6 COLLECTING THE BLOODSPOT SAMPLE

- The process for collecting the bloodspot must be explained to parents
- A blood sample is obtained by heel prick ideally when the baby is 48 to 72 hours old
- The blood sample is placed on a special pre-printed filter paper card
  - Do not use the card if damaged
  - Do not touch the sample area.
- The heel is the preferred site to obtain the sample. In the event that a sample cannot be obtained at the heel and a venepuncture is being undertaken for other tests, this blood can be used for Newborn Bloodspot Screening. In this case clinicians should ensure that the blood obtained is not mixed with other solutions or taken from a tube containing preservative prior to placing the sample on the card. Any blood sample obtained should be placed directly onto the card before being used for other testing purposes
- Mothers / parents / guardians are encouraged to be present and hold the baby during the procedure
- To relieve discomfort for the baby, breast-feeding is encouraged or alternatively comfort measures should be provided
- Should an adverse reaction or injury occur when obtaining the blood sample, a notification should be made through the NSW Health Incident Information Management System (IIMS).

1 NSW Children and Young Persons (Care and Protection) Act, 1998

Table 4: Sample collection	
Step	**Action**
1	Ensure the baby is warm and comfortable before blood collection
2	Puncture the clean **dry** heel at the edge of the plantar surface using an automated disposable lancet (Point < 2mm)
3	Wipe away first drop of blood
4	Completely fill each circle from one side and until the blood has soaked through the paper Do NOT layer blood
5	Allow spots to dry before mailing (4 hours)
6	Return completed card **without delay** To: NSW Newborn Screening Programme Locked Bag 2012, WENTWORTHVILLE NSW 2145

6.1 Discharge prior to 48 hours of age

Arrangements must be made for the blood sample to be collected between 48 and 72 hours for all babies discharged prior to 48 hours of age.

The bloodspot sample should only be collected prior to 48 hours of age if:

- The baby is being discharged prior to 48 hours of age, and
- Availability for sample collection post discharge is compromised.

7 RESULTS

The receipt of each baby's bloodspot card is confirmed with the hospital of birth. Results are usually available within two working days after receipt of the sample. In most cases the results are normal and no further notification is made. Hospitals are only advised of individual results when retesting is necessary.

7.1 Repeat blood test

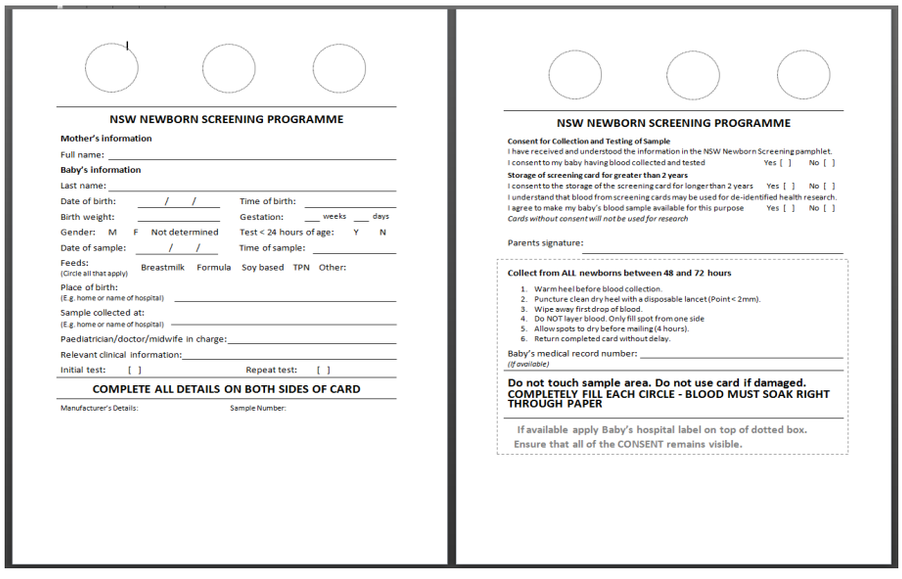
A few babies will need to have a second blood test usually because the first test did not give a clear result or the sample was unsuitable for testing. The reason for retesting should be explained to parents / guardians and most second tests will give normal results.

Routine repeat tests are required for babies with special circumstances such as those with very low birth weight and those who have received blood products as specified in the NSW and ACT Newborn Screening Programme: Sampling Information and Guideline (section 10).

7.2 Abnormal results

The paediatrician / doctor / privately practising midwife (PPM) identified on the newborn bloodspot screening card is notified of test results which are abnormal, the disorder being considered and any appropriate further samples required. It is the responsibility of this person to ensure that the baby is promptly referred for further investigation and treatment. The name of the person responsible must be filled in on the test card. Where there is uncertainty regarding whose name is to be written, it is recommended that the name be that of the paediatrician of the day.

8 NEWBORN BLOODSPOT SCREENING CARD



NSW NEWBORN SCREENING PROGRAMME

Mother's information

Full name: _____

Baby's information

Last name: _____

Date of birth: ___/___/___ Time of birth: _____

Birth weight: _____ Gestation: ___ weeks ___ days

Gender: M F Not determined Test < 24 hours of age: Y N

Date of sample: ___/___/___ Time of sample: _____

Feeds: (Circle all that apply) Breastmilk Formula Soy based TPN Other:

Place of birth: (E.g. home or name of hospital) _____

Sample collected at: (E.g. home or name of hospital) _____

Paediatrician/doctor/midwife in charge: _____

Relevant clinical information: _____

Initial test: [ ] Repeat test: [ ]

COMPLETE ALL DETAILS ON BOTH SIDES OF CARD

Manufacturer's Details: Sample Number:

NSW NEWBORN SCREENING PROGRAMME

Consent for Collection and Testing of Sample

I have received and understood the information in the NSW Newborn Screening pamphlet.

I consent to my baby having blood collected and tested Yes [ ] No [ ]

Storage of screening card for greater than 2 years

I consent to the storage of the screening card for longer than 2 years Yes [ ] No [ ]

I understand that blood from screening cards may be used for de-identified health research.

I agree to make my baby's blood sample available for this purpose Yes [ ] No [ ]

Cards without consent will not be used for research

Parents signature: _____

Collect from ALL newborns between 48 and 72 hours

1. Warm heel before blood collection.
2. Puncture clean dry heel with a disposable lancet (Point < 2mm).
3. Wipe away first drop of blood.
4. Do NOT layer blood. Only fill spot from one side
5. Allow spots to dry before mailing (4 hours).
6. Return completed card without delay.

Baby's medical record number: _____ *(If available)*

Do not touch sample area. Do not use card if damaged.
COMPLETELY FILL EACH CIRCLE - BLOOD MUST SOAK RIGHT THROUGH PAPER

If available apply Baby's hospital label on top of dotted box.
Ensure that all of the CONSENT remains visible.

Newborn bloodspot screening cards are provided by the NSW Newborn Screening Programme, and used in accordance with the NSW Newborn Screening Programme Sampling Information and Guidelines. Contact details are provided in Section 9.

8.1 Information collection and process

The newborn bloodspot screening card collects written information and three bloodspots.
ALL INFORMATION must be completed on the card as each field has been included for a specific purpose.
Once the heel prick process has occurred the newborn bloodspot screening card is sent to the laboratory at the NSW Newborn Screening Programme at The Children's Hospital at Westmead. The laboratory:

- Transfers the written information to an electronic record
- Tests the blood
- Retains the card containing the unused portion of the three bloodspots for a minimum of two years.

NOTE: All results are recorded in the electronic record, not on the card.

8.2 Privacy, storage, security and retention periods

8.2.1 Privacy, storage and security

The NSW Newborn Screening Programme as a NSW Health facility, is the custodian of the bloodspot cards and records. Both the electronic record and the bloodspot card are subject to the privacy protection requirements of NSW privacy legislation[2,3,4]. The bloodspot cards are stored in a secured locked area with appropriate safeguards to prevent unauthorised use, disclosure, loss or other misuse.

2 NSW Health Privacy Manual for Health Information as at March 2015: http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf

3 Privacy and Personal Information Protection Act, 1998

4 Health Records and Information Privacy Act, 2002

8.2.2 Retention of cards and data

Cards

- In accordance with National Pathology Accreditation Advisory Council requirements the laboratory must retain the cards for a minimum of 2 years for quality assurance and audit purposes
- In general the cards are retained for 18 years (age a child can legally consent for themselves)
- After this time the cards are destroyed.

Data

- In accordance with National Pathology Accreditation Advisory Council requirements the data is stored for 100 years.

8.2.3 Deoxyribonucleic acid (DNA) testing and data

Newborn bloodspot screening involves biochemical testing. Approximately 1% of the samples show an increased risk for cystic fibrosis and MCAD deficiency (a fatty acid oxidation disorder) from the biochemical testing. As part of routine testing these samples are then retested for the most common mutations in the DNA associated with each disorder. No DNA tests are done on any other samples and no other DNA records are held.

8.3 Potential uses of bloodspots

Stored bloodspots have a number of potential uses (Table 5). Any further use must be in compliance with privacy law, NSW Human Tissue Act5 and the NSW Human Tissue Legislation Amendment Act 20126. Potential benefits from stored bloodspots include obtaining clinical information for the child and/or the family. Whilst requests for use for this purpose are rare, the information potentially available to families is extremely valuable. Bloodspots may also be used for research to improve newborn screening techniques or develop new tests. Individual consent will be sought before research on any identified sample. However, de-identified samples may be used for ethics committee approved research with the approval of the NSW Newborn Screening Advisory Committee.

8.3.1 Table 5: Potential uses of bloodspot samples

Table 5: Potential uses of bloodspot samples

Consent given on the card covers the following:	**SEPARATE consent other than on the card is required for the following:**
Directly related clinical purposes • Retesting to confirm result • Provide information to a person or organisation providing ongoing care to the baby.	***Clinical use for the individual and family*** • Further testing at the request of the parents or guardians that may provide medical information for the benefit of the child or family e.g. was an infection present at birth such as cytomegalovirus • Diagnostic information for future reproductive decisions.
Research using non-identifiable bloodspot samples • Samples may be released only with approval by the appropriate health research ethics committee and the NSW Newborn Screening Advisory Committee	***Research using identified bloodspot samples*** • Research requires approval from the parent/guardian, the appropriate health research ethics committee and the NSW Newborn Screening Advisory Committee.

5 NSW Human Tissue Act, 1983
6 NSW Human Tissue Amendment Act, 2012

Table 5: Potential uses of bloodspot samples	
Consent given on the card covers the following:	**SEPARATE consent other than on the card is required for the following:**
Laboratory quality control	***Third party access*** • Access to stored samples or information by employers, insurers, police, legal representatives, other relatives or medical practitioners requires written consent of the parent/guardian (or child if of age of consent) or by court order.
Patient access • Parents/guardians on behalf of the child or the patient at adulthood have the right to access personal information held about them	***Coronial purposes*** • A memorandum of understanding (MOU) between NSW Health and NSW police 2002[14] sets out parameters and processes for requests for access to newborn bloodspot screening cards.
	Access for law enforcement purposes and access and disclosure authorised by law • It is possible that access to samples and disclosure of information may be required by court order.

8.4 Transfer of cards to parents / guardians

The laboratory must retain the bloodspot cards for a minimum of 2 years for quality assurance and audit purposes in accordance with National Pathology Accreditation Advisory Council requirements. Any requests from parents/guardians for the destruction or transfer of the screening cards must be made in writing and must be supported with identification.
NOTE: Destruction or transfer of a screening card can only occur after the 2 year retention period is complete.
NOTE: For further information on sample storage and laboratory practice, please see:
http://www.schn.health.nsw.gov.au/health-professionals/statewide-laboratory-services/nsw-newborn-screening-programme

9 SAMPLING INFORMATION AND GUIDELINES

The NSW and ACT Newborn Screening Programme provide a guideline: *Sampling Information and Guidelines* which details procedures for:

- Storage of blank NBS cards
- Refusal of screening tests
- Collection of the blood sample for NBS
- Drying and storage of NBS cards prior to sending to laboratory
  - Hospital
  - Community
- Sending of NBS cards to laboratory
- When to take the sample if the baby needs a blood transfusion
- Low birth weight babies
- Stillbirths and neonatal deaths.

These are updated as required to incorporate new information and procedures and are supplied to hospitals / maternity units and privately practising midwives.
The Guideline is available either online at
http://www.schn.health.nsw.gov.au/files/attachments/newborn_screening_guidlines_2015.pdf or from: The NSW Newborn Screening Programme
Locked Bag 2012, WENTWORTHVILLE NSW 2145
Telephone: (02) 9845 3255 / 3659, Facsimile: (02) 9845 3800,Email: newborns@chw.edu.au

10 QUALITY ASSURANCE AND MONITORING

10.1 Role of the hospital/Local Health District (LHD)

The hospital of birth is responsible for ensuring all babies are offered the newborn screening test and arranging for any repeat samples, including those babies who have been transferred to another hospital and require a repeat sample.

Hospitals with maternity units and those who care for babies must nominate a liaison person (e.g. community liaison midwife or midwifery unit manager) to be responsible for newborn bloodspot screening. The name and position of the nominated (and relief person) should be notified in writing to *The NSW Newborn Screening Programme* (see Section 9). Responsibilities of the nominated newborn screening liaison person are detailed in The NSW and ACT Newborn Screening Programme Sampling Information and Guidelines and include the following:

- Ensuring that all parents / guardians are provided information on newborn bloodspot
- Ensuring that all babies have newborn bloodspot screening cards sent to the laboratory irrespective of whether the sample has been collected (Section 5.3)
- Ensuring that when a repeat or extra sample is requested by the laboratory that it happens in a timely manner
- Ensuring that staff are kept up to date with changes to the NSW Newborn Screening Programme Sampling Information and Guidelines.

Reports from the NSW Newborn Screening Programme are regularly provided to hospitals regarding screening samples and quality issues related to screening activities. LHDs are encouraged to ensure these reports are monitored locally to identify trends in relation to quality and compliance with this policy. Timely action must be taken when issues are identified that may adversely affect the efficacy of the screening test.

The Implementation Checklist for LHDs in relation to Newborn Bloodspot Screening is at Section 15

11 CONSUMER INFORMATION

Newborn Bloodspot Screening Consumer Brochure

A printable version of the consumer brochure *Newborn Bloodspot Screening* is provided at Attachment 1.For information on ordering hard copies of the consumer brochure (English only) please visit http://www.kidsfamilies.health.nsw.gov.au/publications/

The consumer brochure can also be downloaded from the Office of Kids and Families website http://www.kidsfamilies.health.nsw.gov.au/publications/tests-to-protect-your-baby-newborn-bloodspot-screening/

The consumer brochure is also available for download in Arabic, Traditional Chinese, Indonesian, Japanese, Khmer, Korean, Serbian, Turkish and Vietnamese, Thai, Bengali, Nepali, Tamil and Hindi at http://www.kidsfamilies.health.nsw.gov.au/publications/tests-to-protect-your-baby-newborn-bloodspot-screening/

NSW & ACT Newborn Screening Tests Education Video for Parents
Available to view online at http://www.schn.health.nsw.gov.au/health-professionals/statewide-laboratory-services/nsw-newborn-screening-programme

12 APPENDIX 1: CHECKLIST FOR HEALTH PROFESSIONALS

Table 3 Checklist for health professionals

During pregnancy	Provide the consumer brochure *Newborn Bloodspot Screening* to parents preferably in the last four to six weeks of pregnancy. Provide an opportunity for discussion and questions and offer to show the DVD *NSW & ACT Newborn Screening Tests Education Video for Parents*.
After birth	Make sure that parents / guardians have been provided the consumer brochure *Tests to protect your baby.* Make sure that parents/guardians have been provided with an opportunity for discussion and questions.
Inform parents/ guardians about:	1. Conditions tested – phenylketonuria, galactosaemia, hypothyroidism, cystic fibrosis and rare metabolic disorders. 2. Benefits of testing - diagnosis and treatment can prevent death or serious disability. 3. Collection of blood sample – encourage mothers to be present and breastfeed or offer alternative comfort measures. 4. Information collected – name, date of birth, hospital, etc. 5. Bloodspot storage - minimum of 2 years and in general are stored for up to 18 years – written consent on the back of the card. 6. Bloodspots and record security – governed by privacy and human tissue legislation and Health Department policy. 7. Potential uses of, access to, and storage of bloodspot cards: • Identified cards may be used for family benefit or research and only with separate consent obtained before testing • Non-identifiable cards, i.e. with identifiers permanently removed may be used for research approved by a health research ethics committee and with the approval of the NSW Newborn Screening Advisory Committee – consent on the back of the card • Parents have a right to access their child's information. Other access requires parental consent except where there is a court order. 8. Inform the parents about how results are conveyed • Normal results • Retesting • Abnormal results.
After all the above information has been provided and discussed:	1. Record in the mother's / baby's medical record that information has been provided and discussed. 2. Obtain and document parent / guardian consent in the baby's clinical record. 3. Hospital staff are required to complete the relevant section of the baby's Personal Health Record (Blue Book). 4. If parents refuse testing, see Section 5.3 of this Policy for further guidance 5. Conduct the test following sampling guidelines provided by the NSW Newborn Screening Programme.

13 APPENDIX 2: RELEVANT DOCUMENTS

Type	Published by	Publication
Policy Directive	NSW Health	PD2005_406 Consent to Medical Treatment – Patient Information
Policy Directive	NSW Health	NSW Health Privacy Manual for Health Information as at March 2015: http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf
Information Bulletin	NSW Health	General Retention and Disposal Authority – Public Health Services: Patient/ Client Records (GDA 17), NSW Department of Health Information Bulletin No 2004/20, http://www.health.nsw.gov.au/archive/cib/information-bulletins/2004/ib2004-20.pdf
Policy Directive	NSW Health	Health Care Records - Documentation and Management http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_069.pdf
Legislation	NSW Act	Human Tissue ACT 1983
Legislation	NSW Act	Health Records and Information Privacy Act, 2002
Legislation	NSW Act	NSW State Records Act, 1998
Legislation	NSW Act	Privacy and Personal Information Protection Act, 1998
Legislation	NSW Act	NSW Children and Young Persons (Care and Protection) Act, 1998
Resource	Office of Kids and Families	Consumer brochure: Newborn Bloodspot Screening
Resource	Sydney Children's Hospital Network	Consumer video: NSW & ACT Newborn Screening Tests Education Video for Parents
Other Guidelines	National Health and Medical Research Council	National Statement on Ethical Conduct in Research Involving Humans, 2007 http://www.nhmrc.gov.au/guidelines/publications/e72
Other Guidelines	Australian Government, Department of Health	National Pathology Accreditation Advisory Council, Retention of laboratory records and diagnostic material.

14 IMPLEMENTATION CHECKLIST

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Ensure all clinical staff working in maternity services are updated on the changes to the policy	❑	❑	❑
	Notes:		
2. Ensure all women are provided with the Consumer Brochure *Newborn Bloodspot Screening*	❑	❑	❑
	Notes:		
3. Ensure that written consent is provided by a parent/guardian prior to collection of the blood sample	❑	❑	❑
	Notes:		
4. Ensure that the name and position of the hospital-nominated newborn screening liaison person is notified in writing to the NSW Newborn Screening Programme	❑	❑	❑
	Notes:		
5. Ensure that Executive oversight for newborn screening activites occurs at facility level to ensure regular monitoring of the NSW Newborn Screening Programme reports	❑	❑	❑
	Notes:		

15 ATTACHMENT 1: CONSUMER BROCHURE

Consumer Brochure – Newborn Bloodspot Screening. Available on health.nsw.gov.au/policies/PD2016_015.pdf is a printable version of the Consumer Brochure

BREASTFEEDING IN NSW: PROMOTION PROTECTION AND SUPPORT
(PD2018_034)

PD2018_034 rescinds PD2011_042.

PURPOSE

The policy supports NSW Health's commitment to best practice in the promotion, protection and support of breastfeeding; to increase the initiation and duration rates of breastfeeding and to ensure the Health workforce have the knowledge and skills to implement this policy.

MANDATORY REQUIREMENTS

NSW Health organisations must implement the strategies, appropriate to their organisation, identified in Section 4, The Practice Guide.

NSW Health organisations are required to comply with responsibilities under the WHO International Code of Marketing of Breastmilk Substitutes and the Marketing in Australia of Infant Formula: Manufacturers and Importers Agreement (MAIF).

NSW Health organisations must ensure midwives, child and family health and paediatric nurses complete the HETI eLearning module Breastfeeding Promotion, Protection and Support (course code 45338916) at commencement of employment and every 5 years.
The module is highly recommended, based on location and role, for Registered Nurses (RN) (Community Health), RN Mental Health and other RNs, Enrolled Nurses and Aboriginal and Torres Strait Islander Health Workers in contact with breastfeeding mothers.

IMPLEMENTATION

The Chief Executives or delegated officers of all NSW Health organisations must ensure the following actions are undertaken to implement the revised Policy Directive:

- All staff are made aware of the revised Policy Directive.
- Key personnel are made aware of their responsibilities in the revised Policy Directive.
- Designated lead is identified to develop local policies/guidelines/procedures to support the implementation of the revised Policy Directive.

Breastfeeding in NSW: Promotion Protection and Support Procedures

1 BACKGROUND

1.1 Introduction

NSW Health recognises and supports the importance of creating and providing environments in its services and facilities, where breastfeeding is promoted, protected and supported by all staff.

This Policy Directive, Breastfeeding in NSW – Promotion, Protection and Support (policy) supports and encourages breastfeeding as the optimal way for a woman to feed her infant. The policy also recognises that all women and their families have the right to clear, impartial and evidence based information to enable them to make an informed choice as to how they feed and care for their infants.

The policy is designed to contribute to the following goals:

- increase the number of infants exclusively fed with breast milk on discharge from the birth admission
- increase the number of infants exclusively fed with breast milk to around six months of age
- increase the number of infants continued to be fed with breast milk, to 12 months and beyond, after the introduction of family foods at around six months of age.

1.2 Key definitions

Health workforce	Refers to medical officers, nurses, midwives, Aboriginal health workers, allied health workers caring for pregnant and breastfeeding women, their families and infants
Maternity continuum	Refers to the antenatal, intrapartum and postnatal periods
NSW Health organisations	Refers to districts, networks, services, pillars, facilities, hospitals, community based health services
Women and their families	Refers to pregnant women, mothers, fathers, partners, family and is inclusive of the LGBTIQ community

See glossary for further definitions.

2 THE EVIDENCE

Breastfeeding is important for optimal infant nutrition, growth and healthy development, protection against infection and chronic disease, and benefits the mother's health. Breastfeeding provides short-term and long-term health, economic and environmental advantages to children, women, families and society.

The provision of evidence based quality care is integral to promoting, protecting and supporting breastfeeding in all NSW Health facilities and services. A literature review was conducted to inform the revision of the policy. For evidence from the recent literature review see Attachment 2.

3 THE POLICY CONTEXT

This policy has been reviewed within the context of the following state, national and international policies, frameworks, and services. The most relevant are listed below with a more extensive list at Attachment 3.

NSW State Health Plan Towards 2021

This plan provides the strategic framework for NSW Health and sets priorities across the system for the delivery of 'the right care, in the right place, at the right time' for everyone. Direction One: Keeping People Healthy supports a healthy start to life through breastfeeding, good nutrition and a healthy weight gain in pregnancy. This direction is also in line with one of the 12 Premier's priorities, reduce overweight and obesity rates of children by 5% over 10 years.

Healthy, Safe and Well a Strategic Health Plan for Children, Young People and Families 2014-2024 NSW Kids and Families

Healthy, Safe and Well is a 10-year strategic health plan focusing on preconception to 24 years of age. This plan's agenda is to renew efforts to promote health, prevent illness, embed early intervention and deliver integrated, connected care for all NSW children and families no matter where they live. The promotion of breastfeeding, in accordance with World Health Organisation (WHO) Standards and the Baby Friendly Health Initiative (BFHI), is a strategy under the plan.

NSW Healthy Eating Active Living Strategy

This strategy provides a whole of government framework to promote and support healthy eating and active living in NSW and to reduce the impact of lifestyle-related chronic disease. This strategy aims to ensure that everyone has opportunities to be healthy through the delivery of evidence-based, interactive and relevant programs. One of the strategy's actions is to promote the initiation and duration of breastfeeding as a way to provide good infant nutrition and reduce the risk of overweight and obesity in childhood, adolescence and early adulthood.

Australian National Breastfeeding Strategy

The Australian Government and jurisdictions are developing an enduring national breastfeeding strategy to replace the 2010-2015 strategy. This strategy encourages all public and private health

facilities/services to implement the BFHI steps to successful breastfeeding and to work towards or maintain BFHI accreditation. This policy will be reviewed, if required, once the national strategy has been released.

Australian Dietary Guidelines

The early nutrition and growth of infants has an important effect on early morbidity and mortality. There is increasing evidence of the medium and long-term effects of nutrition on health. Infant growth is now recognised as one of the influences on health and longevity of life and breastfeeding is the foundation of early nutrition. NSW Health supports the use of the National Health and Medical Research Council Australian Dietary Guidelines (2013) and the Infant Feeding Guidelines (2012).

WHO 2006 growth charts

In 2012, all Australian states and territories agreed to adopt the WHO 2006 growth charts as the standard for Australian children aged 0–2 years. The WHO 2006 charts reflect growth patterns among children who are predominantly breastfed for at least 4 months and are still breastfeeding at 12 months.

Baby Friendly Health Initiative

The role of the BFHI is to protect, promote and support breastfeeding by providing frameworks for:

- maternity services - Ten Steps to Successful Breastfeeding (Attachment 4)
- community facilities - 7 Point Plan (Attachment 5)
- neonatal services - The Neo-BFHI: The Baby-friendly Hospital Initiative (Attachment 6).

These three frameworks promote the importance of all women and families receiving appropriate support and consistent up-to-date information about infant feeding. While breastfeeding is promoted, every woman and family is supported to care for their infant in the best and safest way possible regardless of feeding choices and circumstances.

4 THE PRACTICE GUIDE

There has been significant work by health professionals and service managers to promote, protect and support breastfeeding in NSW. While Australia has a high rate of breastfeeding initiation, in NSW there is considerable scope to increase the rates of initiation, full breastfeeding on discharge from birth admission and breastfeeding duration.

Breastfeeding initiation and duration are influenced by many factors. For this reason a multifaceted approach targeting change at an organisation, service delivery, community and individual level is recommended.

Implementing the following strategies will assist NSW Health organisations to increase the rates of initiation and duration of breastfeeding:

i. Support infants being fed with breast milk
ii. Provide additional support to Aboriginal women, their partners, families and communities
iii. Provide additional support to women, their partners and families at risk of lower rates of breastfeeding initiation and duration
iv. Strengthen continuity of care, referral pathways and support networks
v. Support health professionals' education and professional development
vi. Provide breastfeeding friendly environments
vii. Ensure monitoring and surveillance
viii. Support Australia's response to the Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement 1992.

i. Support infants being fed with breast milk

Best Practice

NSW Health organisations providing maternity, neonatal and community child and family health services use the relevant BFHI frameworks to improve breastfeeding practices.

All women and their families receive consistent, evidence based information, education and support during the maternity continuum and early childhood periods regarding infant feeding.
NSW Health staff inform women and their families of accessible breastfeeding information, support and advice from evidence based sources such as the Australian Breastfeeding Association, Pregnancy Birth and Baby Helpline, or the Raising Children Network.
NSW Health organisations ensure all breastfed infants in their care receive breast milk from their birth mother except where there is access to a milk bank approved by the Chief Executive. Local arrangements should be made for special circumstances, including but not limited to, adoption, same sex couples, foster carers and surrogacy.
NSW Health organisations ensure that infants are not separated from their mothers for any length of time, unless clinically indicated, to support bonding and successful breastfeeding.
NSW Health organisations support women to continue breastfeeding when they or their infant are admitted, or present to, inpatient, emergency, outpatients or paediatric services.
Breastfeeding should be encouraged, welcomed and supported in all NSW Health organisations. It is important that there is a designated space with appropriate signage and facilities available for staff or visitors who need to breastfeed.
NSW Health organisations, caring for women and their families, implement/maintain or link with a breastfeeding reference group to facilitate policy implementation to protect, promote and support breastfeeding.
NSW Health organisations implement and evaluate evidence-based interventions that promote and support breastfeeding.

Health professionals should support women and their families to recognise the importance of breastfeeding for the health and wellbeing of their infants. NSW Health professionals are to fully support women and their families in their choice of infant feeding.

Evidence demonstrates that compliance with BFHI has a positive impact on short-term, medium-term and long-term breastfeeding outcomes. Education and support from professionals and/or peers, which is both timely and person-centred, is crucial to improving breastfeeding practices. Health professionals play a key role in providing education and support spanning the maternity continuum and early childhood periods.

Evidence also suggests that effective social support, peer support and influence from fathers/partners/families combined with reassurance and guidance from skilled practitioners can help women to overcome difficulties and find confidence in their own abilities to achieve their feeding goals.

Any breastfeeding promotion efforts and support should aim to enhance a mother's self-efficacy and confidence with respect to breastfeeding.

ii. Provide additional support to Aboriginal women, their partners, families and communities

Best Practice
NSW Health organisations work in partnership with mothers of Aboriginal infants, their families and communities to promote, protect and support breastfeeding.
NSW Health organisations implement culturally appropriate evidence-based interventions that promote and support breastfeeding.
NSW Health organisations collaborate with other relevant government, non-government and community organisations to promote, protect and support breastfeeding.

Aboriginal infants are less likely to be breastfed than non-Aboriginal infants. It is suggested that promoting breastfeeding to the wider Aboriginal community would assist to create a stronger breastfeeding culture, and would support Aboriginal women to breastfeed.

iii. Provide additional support to women and families at risk of lower rates of breastfeeding initiation and duration

Best Practice
NSW Health organisations provide additional breastfeeding support to these women and their families in the maternity continuum and early childhood periods.
NSW Health staff offer referral for women, to evidence based services/programs such as Australian Breastfeeding Association, Get Healthy in Pregnancy (GHiP), Quitline and Quit for new life.

Women at risk of lower initiation and duration of breastfeeding include:

- women who are less than 25 years of age
- obese women
- mothers of preterm and low birth weight infants
- women who smoke.

Mothers practicing early skin-to-skin contact with their newborns and kangaroo care, for infants in neonatal intensive care units, are more likely to breastfeed in the first one to four months of their child's life and continue for longer durations. Initiation of milk expression within one hour following birth increases milk volume in mothers of low birth weight infants.

Evidence highlights the effectiveness of parent groups, where peers are breastfeeding infants of a similar age, in improving breastfeeding rates/duration. Targeted peer counselling and social support, combined with professional support, is particularly important for younger mothers.

iv. Strengthen continuity of care, referral pathways and support networks

Best Practice
NSW Health organisations maintain an effective and timely referral system from maternity, neonatal and paediatric units to community based child and family health services.
NSW Health organisations collaborate with relevant local government, non-government and community organisations to support women and their families to breastfeed.

Continuity of care enables women to develop a relationship with the same caregiver(s) throughout the maternity continuum and early childhood. There is strong evidence demonstrating that continuity of care models support initiation and duration of breastfeeding.

Support in any form has been identified as a core component of programs to ensure good breastfeeding outcomes. Support provided for infant feeding may be from various sources including professionals, peer support and informal social networks. There is good evidence that a mixture of professional and peer support, for example as provided by the Australian Breastfeeding Association, is likely to be most effective in improving breastfeeding outcomes, particularly support around the perinatal period.

v. Support health professionals' education and professional development

Best Practice
NSW Health organisations ensure that the health workforce, caring for women and their families, complete the HETI My Health Learning Course Code: 45338916 *Breastfeeding Promotion, Protection and Support*
NSW Health organisations provide and support access to education and continuing professional development, based on the BFHI frameworks, to the health workforce caring for women and their families.

NSW Health organisations provide access to evidence based breastfeeding guidelines/resources for the health workforce caring for women and their families.

All health professionals play a key role in promoting, protecting and supporting breastfeeding. Breastfeeding education which increases the knowledge and confidence of medical officers, nurses, midwives, Aboriginal health workers and other health professionals can lead to success in improving breastfeeding outcomes.

Access to consistent evidence based information and empathic communication skills are essential to professional development. The WHO/UNICEF BFHI training package is an effective health professional education package. Continuing professional development will enhance the knowledge, attitude and skills of the health workforce, enabling identification of predictors and barriers to breastfeeding.

Information to support health workers to protect, promote and support breastfeeding can be accessed via both the NSW Health and the Australian Department of Health websites.

vi. Provide breastfeeding friendly workplaces

Best Practice
NSW Health employees are encouraged and supported to combine breastfeeding and work.
NSW Health organisations work towards achieving the Australian Breastfeeding Association Breastfeeding Friendly Workplace Accreditation.

Providing support for breastfeeding is crucial to fostering a workplace that is free of discrimination, offers equal employment opportunity and is family friendly while improving the health outcomes of children. Support for breastfeeding in the workplace aids in the retention of the workforce, helps to maintain the workforce skill base, lowers staff turnover and assists in increasing morale.

NSW Health is committed to fostering a supportive work environment for breastfeeding employees. NSW Health staff should refer to their relevant Awards and Determinations regarding provisions around breastfeeding and working.

NSW Health supports action at a state level by encouraging early childhood education and care environments to support breastfeeding through the NSW Health Healthy Eating Active Living Strategy.

vii. Ensure monitoring and surveillance

Best Practice
NSW Health seeks opportunities to develop a breastfeeding dashboard indicator linking it to relevant performance measurement tools at the national, state and local level.
NSW Health organisations monitor initiation and where able duration of breastfeeding rates.

Monitoring, research and evaluation are important to provide further insight into breastfeeding initiation and duration rates, as well as a better understanding of ways in which breastfeeding can be protected, promoted and supported. To date, all monitoring of breastfeeding in Australia has been completed by cross-sectional, retrospective or small regional cohort studies. While useful data are available, many studies use different definitions and sampling methods that make comparisons difficult.

In NSW, 'breastfeeding on discharge from hospital' is routinely collected via the Perinatal Data Collection.

viii. Support Australia's response to the Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement 1992 (MAIF)

Best Practice
NSW Health organisations inform employees of their responsibilities under the MAIF Agreement and support them in meeting these responsibilities.

NSW Health staff comply with all relevant polices, such as PD2005_415 *Sponsorships Policy - NSW Health*, PD2009_067 *Fundraising Policy,* PD2015_045 *Conflicts of Interest and Gifts and Benefits*

NSW Health is required to comply with responsibilities under the MAIF Agreement in particular the following clauses:

- Clause 4: Information and education
- Clause 5: The general public and mothers
- Clause 6: Health care system
- Clause 7: Health care professionals.

This document sets out the obligations of manufacturers and importers of infant formula and gives effect to the principles of the WHO Code in an Australian context.

NSW Health recognises the need to support staff to notify the Australian Government Department of Health of potential breaches to the MAIF Agreement. Additional information on the MAIF Agreement including Information for Lodging Complaints regarding breaches can be found at the Australian Government Department of Health MAIF Agreement webpage.

5 LIST OF ATTACHMENTS

1. Implementation checklist
2. The evidence
3. International, national and state policy, services and frameworks
4. Baby Friendly Health Initiative Ten Steps to Successful Breastfeeding
5. The 7 Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services
6. Neo-BFHI - The Baby-friendly Hospital Initiative for Neonatal Wards

Attachments are available in the policy document at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2018_034

321(21/09/18)

BREASTMILK: SAFE MANAGEMENT (GL2023_021)

GL2023_021 replaced PD2010_019

GUIDELINE SUMMARY

NSW Health is committed to supporting the safe management of breastmilk in all NSW Health facilities to reduce the risk of misadministration of breastmilk and to manage any adverse incidents.

KEY PRINCIPLES

NSW Health facilities are required to reduce the risk of the misadministration of breastmilk. This includes ensuring that all babies have secure identification in place and babies are not separated from their mothers without a compelling reason.

All expressed breastmilk is required to be safely managed and education is to be provided to parents and carers about this management.

If a baby is exposed to the wrong breastmilk, the relevant health professionals must conduct risk assessments, order and interpret screening, and initiate treatment as required.

All screening, management plans, results and counselling must be documented in the relevant health care record.

Local health districts and specialty health networks must ensure relevant staff:

- receive education and training to support the safe management of breastmilk, to identify risks and to manage adverse incidents
- implement strategies to reduce risk of the misadministration of breastmilk
- implement appropriate management if a baby receives the wrong breastmilk
- develop local policy and guidelines to support families who choose to intentionally feed their baby unpasteurised breastmilk from a nominated non-birth mother
- develop local policy, guidelines and procedures to:
    - implement this Guideline
    - monitor practice
    - document appropriately.

The Breastmilk: Safe Management guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2023_021

APNOEA MONITORS (GL2012_002)

GL2012_002 rescinds GL2005_069.

This Guideline replaces GL2005_069 Apnoea Monitors. It provides advice to clinicians that there is no objective scientific evidence that home apnoea monitoring devices are of any value in preventing Sudden Infant Death Syndrome (SIDS).

There is no objective scientific evidence that home apnoea monitoring devices are of any value in preventing Sudden Infant Death Syndrome. However, it is acknowledged that there is considerable community anxiety about Sudden Infant Death Syndrome and that home monitoring devices are available to the general public. It should be noted that there is no indication for apnoea monitoring for the general population.

It is recommended that only infants deemed to have had serious apnoea by a specialist paediatrician should be placed on apnoea monitoring and this should be accompanied by appropriate advice, training and support for parents. It is recommended that apnoea monitoring devices are only used in the following context:

a) Adequate counselling before and during home monitoring by appropriately trained personnel;
b) Adequate training in the use of monitor and resuscitation techniques;
c) Continuous availability of medical, technical and emotional support services.

These aims may be most readily achieved if the management of an infant undergoing home monitoring is supervised by a hospital or other facility with appropriate specialised staff, including paediatricians and social workers.

GROWTH ASSESSMENT IN CHILDREN AND WEIGHT STATUS ASSESSMENT IN ADULTS

(GL2017_021 issued 17/11/2017)

PURPOSE

To support core patient care, this document describes the following:

- A standardised approach to measuring weight and height in children and adults, and to measuring length and head circumference in younger children.
- Interpreting and recording these measurements as part of determining weight status.
- Key equipment and patient considerations around taking these measurements.

KEY PRINCIPLES

Weight and height measurement of children and adults – or weight, length and head circumference measurement of younger children – should be performed on a regular basis as part of providing good clinical care. For example, it is necessary to measure weight, height and head circumference in order to monitor children's growth. It is also necessary to measure weight and height (or length) to determine weight status in children and adults.

Standardised measurement and interpretation of weight, height, length and weight status, will improve the accuracy and usefulness of measurements over time and across facilities, and support clinical decision making.

USE OF THE GUIDELINE

This guideline helps clinicians perform weight, height, length, or head circumference measurements of their patients, and to use these measurements to assess their patients' weight status.

This guideline also helps managers design and establish workflow practices that enable routine measurements.

To download the guideline go to
Growth Assessment in Children and Weight Status Assessment in Adults

296(17/11/17)

CIRCUMCISION OF NORMAL MALE INFANTS (PD2020_035)

PD2020_035 rescinds PD2012_009

POLICY STATEMENT

Routine circumcision of normal infant males is **not** performed in public hospitals in NSWHealth. This **does not** apply to cases where there is a clear clinical need forintervention, nor directly to adult male circumcision.

Parents who request routine circumcision must be provided with accurate informationon the risks and benefits of circumcision.

SUMMARY OF POLICY REQUIREMENTS

Parents who request circumcision for their infant son must be provided with accurate,unbiased and up to date information about the risks and benefits of the procedure.

Two resources that are recommended for staff:

- The Royal Australasian College of Physicians (RACP) guide for parents RACP -circumcision a guide for parents.
- The Sydney Children's Hospital's Network Fact Sheet: SCHN factsheet - maleinfant circumcision.

Parents must also be referred to RACP statement on circumcision, RACP Statement -Circumcision.

THIS POLICY DIRECTIVE MUST BE READ IN CONJUNCTION WITH:

NSW Health Policy Directive *Waiting Time and Elective Surgery Policy* (PD2012_011) (**Section 2.3**: Circumcision is listed as a discretionary procedure "*that should not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient's physical health")*

NSW Health Information Bulletin *Advice for referring and Treating Doctors – Waiting Time and Elective Surgery Policy* (IB2012_004).

332(07/10/20)

TIERED NETWORKING ARRANGEMENTS FOR PERINATAL CARE IN NSW

(PD2023_035)

PD2023_035 rescinded PD2020_014 and IB2022_026

POLICY STATEMENT

The tiered perinatal networks provide a structure to support pregnancy and birth care through the appropriate use of maternity and neonatal services (capability); access to care appropriate to the level of assessed patient need (patient flow); and a 'whole of health' approach to the management of demand (capacity).

This Policy Directive provides guidance for NSW local health districts, and services in the ACT on the structure, functioning and governance of tiered perinatal networks.

SUMMARY OF POLICY REQUIREMENTS

The Policy Directive refers to the care of women with high-risk pregnancy requiring referral and/or transfer of care to a higher-level facility. It describes maternal and neonatal services in NSW, their tiered perinatal network arrangements; the default protocol; the requirement for local health district operational plans and escalation pathways. Reference is made to unwell neonates who require higher level care at birth but does not include advice on the referral or movement of these patients.

Each tiered perinatal network is responsible for managing the service demands of its population. Higher level facilities are responsible for providing support, advice and management of the women who may require transfer within and across tiered perinatal networks.

Level 6 maternity facilities operate as a part of a statewide system of care and are required to support other tiered perinatal networks. Whenever a maternal transfer is needed the following principles apply:

- No woman is to be moved out of her tiered perinatal network without the advice of the tiered perinatal network Level 6 obstetric consultant.
- Women and their families are provided with timely and accessible information on the transfer process and offered support through Aboriginal Health Liaison Officers, Aboriginal Maternal and Infant Health Service staff, interpreters and/or other support services as required.
- The decision to transfer and determination of the urgency of transfer (medically agreed timeframe) must be made through discussion between the obstetric consultants at the referring and accepting facilities.
- Management of urgency and risk is aligned to the Maternal Transfers Decision Making Tool.
- Access to appropriate care must not be delayed due to maternal or neonatal bed finding. .
- The neonatal team is closely involved in the decision making/ care planning for planned high risk births or involved in the care of urgent transfers. However, where birth is not planned or anticipated within the next 12 hours, a neonatal bed is not required and obstetric decision making takes precedence.
- Obstetric consultant roster must be made available with contact numbers provided.
- No Level 6 to Level 6 maternal transfers should occur from 32 weeks. An exception could be where specific Level 6 neonatal services are required (such as surgical or cardiac).
- If during a transfer, there is deterioration in maternal condition the Aeromedical Control Centre must contact the obstetric consultant at the receiving facility for advice and transfer logistics.

- Higher level facilities are responsible for supporting the woman until transfer is complete, and for notifying the referring hospital if the destination changes.
- All facilities are responsible to accept return transfers from higher level facilities.

The view the entire Tiered Networking Arrangements for Perinatal Care in NSW policy go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_035

347(19/10/22)

NSW PAEDIATRIC SERVICE CAPABILITY FRAMEWORK
(GL2017_010 issued 1/6/2017)

PURPOSE

Service capability describes the planned activity and clinical complexity that a facility is capable of safely providing. The NSW Paediatric Service Capability Framework (the 'Framework') identifies the scope of planned activity for each paediatric service capability level and provides a mechanism for Local Health Districts to assess the planned service capability of their facilities.

Facilities must be capable of providing, at a minimum, all the planned clinical services described for their level. The Framework supports the provision of high quality, safe and timely care for infants, children and adolescents as close to home as possible.

KEY PRINCIPLES

Paediatric medicine service levels range from no planned service to Level 6 in the major children's hospitals.

Surgery for Children service levels range from no planned service to Level 6. Level 6 paediatric surgery is provided in specialist children's hospitals where paediatric surgery and complex genetic and metabolic services are located. There is no level 5 Surgery for Children Service.

This Framework does not cover Level 6 services.

USE OF THE GUIDELINE

Local Health Districts are responsible for determining the paediatric service capability level of their facilities, taking into account the clinical support services available (e.g. pathology, diagnostic imaging).

The Framework also includes the Paediatric Service Capability and Surgery for Children self-assessment checklists for assessing the planned service capability of a facility and a methodology to assist in service planning and risk management for paediatric medicine and surgery for children.

The Framework is supported by the NSW Paediatric Service Capability Framework Companion Toolkit.

To download the guideline go to
NSW Paediatric Service Capability Framework

296(01/06/17)

MATERNITY AND NEONATAL SERVICE CAPABILITY (GL2022_002)

GL2022_002 replaced GL2016_018

GUIDELINE SUMMARY

This document guides NSW Health service executives, managers, clinicians, and health service planners in planning and delivering maternity and neonatal services. The guideline describes the planned activity and clinical complexity that a facility is capable of safely providing, and outlines the processes for assessment, notification and reporting.

KEY PRINCIPLES

Local health districts (districts) and specialty health networks (networks) are responsible for assessing, maintaining and reassessing the service capability level of their maternity and neonatal services. District/networks are responsible for annual reporting of maternity and neonatal service capability levels.

The Secretary of NSW Health must be notified in advance of any planned commencement of a new maternity or neonatal service and/or closure or restriction of the range of maternity or neonatal services.

District/networks are responsible for conducting relevant risk assessments for any planned or unplanned change to services to support safety and quality practices, or at the request of the Ministry of Health. Local processes must be in place to manage any identified risks to operating at a designated service capability level.

Maternity and neonatal managers and clinicians must deliver services in line with the designated service capability level of their facilities and partner with other services within tiered perinatal network arrangements so women and newborns can receive the right care in the right place at the right time.

Accessible information must be provided to women and their families in the antenatal period about the capability of their local service. This will help them understand the care that can be provided locally and what to expect if transfer for higher-level care is required.

Care at all levels of service capability needs to be woman/person-centred (maternity), familycentred (neonatal), culturally safe and appropriate and respond to the diverse needs of women and families including health, mental health, disability, psychosocial and safety needs (including child protection and domestic and family violence).

Maternity and neonatal services implement value-based health care to improve outcomes and experiences for patients, the population, clinicians and service providers, and ensure value for the system.

To download the guideline go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_002

HUMIDIFIED HIGH FLOW NASAL CANNULA OXYGEN GUIDELINE FOR METROPOLITAN PAEDIATRIC WARDS AND EDs – 1ST EDITION (GL2016_004)

PURPOSE

The *Humidified High Flow Nasal Cannula Oxygen Guideline for Metropolitan Paediatric Wards and ED's, 1st edition* has been developed to inform practice for clinicians caring for infants and children. This guideline was developed by a representative group of NSW Clinicians with expertise in acute paediatric care, paediatric intensive care, and paediatric respiratory care as part of a joint project between The Office of Kids and Families and MP4 (Metropolitan Paediatric Level 4 Units Sydney) and is aimed at achieving the best possible care in NSW.

KEY PRINCIPLES

The guideline applies only to Metropolitan Paediatric Level 4 Units and Metropolitan Emergency Departments where paediatric patients are managed. It requires Chief Executives of Metropolitan Local Health Districts to determine where local adaptations are required or whether the guideline can be adopted in the current format.

The guideline reflects what is currently regarded as a safe and appropriate approach to commencement of Humidified High Flow Nasal Cannula Oxygen (HHFNC) and the care of infants while on HHFNC. The document should not be seen as a stringent set of rules to be applied without the clinical input and discretion of the managing professionals. Each patient should be individually evaluated and a decision made as to appropriate management in order to achieve the best clinical outcome.

USE OF THE GUIDELINE

Chief Executives of Metropolitan LHD's must ensure:

- Hospitals and facilities either adopt this protocol or adapt local protocols to comply with the *Humidified High Flow Nasal Cannula Oxygen Guideline for Metropolitan Paediatric Wards and EDs*
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this new guideline.

ATTACHMENTS

1. Humidified High Flow Nasal Cannula Oxygen Guideline for Metropolitan Paediatric Wards and EDs, 1st Edition: Guideline

INFANTS AND CHILDREN INSERTION AND CONFIRMATION OF PLACEMENT OF NASOGASTRIC AND OROGASTRIC TUBES (GL2016_006)

GL2016_006 rescinds GL2016_003

PURPOSE

The *Infants and Children Insertion and Confirmation of Placement of Nasogastric and Orogastric Tubes 1st edition* Guideline provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Procedural Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of The Office of Kids and Families.

KEY PRINCIPLES

This Guideline applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and specialty health networks to determine where local adaptations are required or whether it can be adopted in its current Clinical Practice Guideline format in all hospitals and facilities required to manage insertion and confirmation of nasogastric and orogastric tube placement in infants and children.

The Clinical Practice Guideline reflects what is currently regarded as a safe and appropriate approach to insertion and confirmation of nasogastric and orogastric tube placement in infants and children. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

USE OF THE GUIDELINE

Chief Executives must ensure:

- This Guideline is adopted or local protocols are developed based on the *Infants and Children Insertion and Confirmation of Placement of Nasogastric and Orogastric Tubes 1st edition* Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to insert a nasogastric or orogastric tube in a paediatric patient
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this revised guideline.

ATTACHMENT

2. Infants and Children Insertion and Confirmation of Placement of Nasogastric and Orogastric Tubes 1st Edition: Guideline.

MANAGEMENT OF SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI) (PD2019_035)

PD2019_035 rescinds PD2008_070

PURPOSE

This Policy Directive outlines the mandatory requirements for management of Sudden Unexpected Death in Infancy (SUDI) in NSW Health facilities. It also outlines the role of NSW Health in the context of the NSW Government response to SUDI which includes the NSW Coroner and Police.

MANDATORY REQUIREMENTS

SUDI is a reportable death under the Coroners Act 2009.[1] Most SUDI deaths occur in the community and are brought to their local emergency department, however SUDI can also occur in hospital. NSW Health's role in management of SUDI includes that local health districts and specialty health networks must:

- Ensure that local policies that guide management of SUDI are easily accessible for staff. This includes emergency departments as well as other areas that SUDI may occur such as maternity, paediatrics and intensive care. Information for staff on how to access locally networked paediatric services should be included.
- Ensure that adequate resources and education are provided so that staff can meet the needs of the infant and the parents/carers, and that parents/carers have access to expert medical advice, nursing care and social work. If necessary, these can be accessed via locally networked paediatric services. In some instances the situation may warrant transfer of the infant to a higher level facility.
- Nominate a hospital contact who will coordinate the SUDI response for example a social worker or nurse. This health professional will provide support to the parents/carers and coordinate completion of documentation required by NSW Health. A list of roles and responsibilities of agencies and staff involved in the SUDI response is at Section 6.1 Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities.
- Ensure that the infant's medical history is completed by a senior medical staff member and documented in the health care record. A checklist to support this is at Section 6.2 Medical History Guide – Sudden Unexpected Death in Infancy. A copy of the infant's health care record must be forwarded to Forensic Medicine (NSW Health Pathology) within 24 hours of the infant's death.
- Ensure that support is available for staff who provide care to infants and parents/carers who have experienced SUDI. If necessary, this can be accessed via locally networked paediatric services.

Ensure there are processes to maintain the quality of care and patient experience of SUDI cases. This includes incident notification, documentation, case discussion that includes the perspective of parents/carers and staff and implementation of any identified improvement opportunities.

IMPLEMENTATION

Local health district chief executives are responsible for:

- Assigning responsibility, personnel and resources to implement this policy.
- Establishing mechanisms to ensure the mandatory requirements are applied, achieved and sustained as usual processes in the instance of a SUDI. This should include nomination of an executive sponsor.
- Ensuring that any local policy reflects the requirements of this policy and is written in consultation with the hospital executive, clinical governance unit and clinical staff.

Management of Sudden Unexpected Death in Infancy (SUDI): Procedure.

1 INTRODUCTION

1.2 About This Document

Every year in NSW between 40 and 50 infants under the age of 12 months die suddenly and unexpectedly, with a cause unable to be determined immediately.[1] This procedure document explains and outlines NSW Health's role in the management of Sudden Unexpected Death in Infancy (SUDI) and should be used:

- When an infant is brought to a NSW Health facility, following a sudden, unexpected death
- When an infant is brought to a NSW Health facility after a 'near SUDI' and dies in hospital
- When there is a sudden, unexpected infant death during a hospital admission.

NSW Health's role in the management of SUDI includes:

- Care of the infant and the parents/carers
- Completion of the infant's medical history, with a copy of the infant's health care record forwarded to Forensic Medicine (NSW Health Pathology) within 24 hours of the infant's death
- Completion of the post mortem examination and liaison with other agencies involved in the Coronial process
- Participation in the NSW Government response to SUDI. A flowchart that outlines NSW Health's role in the SUDI response can be found at Section 6.1 Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities.

The SUDI response outlined in this document aims to:

- Establish where possible, the cause of death and assist parents/carers and their families to understand how and why the death may have occurred
- Provide parents/carers with information about any potential health risks for surviving family members
- Ensure timely completion of the infant's medical history. A checklist to support completion of the infant's medical history is attached at Section 6.2 Medical History Guide – Sudden Unexpected Death in Infancy
- Support Forensic Medicine (NSW Health Pathology) to complete the post mortem examination, establish the cause of death and provide information for future SUDI prevention activities of NSW Health and other agencies
- Ensure that statutory obligations are met.2 This includes assisting the NSW Coroner and Police in their role of investigating the infant's death.

1.2 Changes From the Previous Policy

1. This Policy Directive emphasises the need to provide parents/carers with any support they may need, including medical and nursing care, social work and referral to other services such as Red Nose Grief and Loss
2. All episodes of SUDI are to be accepted and managed in hospital, regardless of whether the infant's death occurred in hospital or prior to presentation. Facilities without an onsite paediatrician, paediatric nurse or social worker and can access support via their locally networked paediatric services. For more information about locally networked paediatric services see GL2017_010 NSW Paediatric Service Capability Framework
3. Local Health Districts/Specialty Health Networks (LHDs/SHNs) are not required to have facilities designated to respond to SUDI. It is expected that all facilities are able to initiate a SUDI response
4. The SUDI Medical History Protocol has been revised. For more information see Section 6.2 Medical History Guide – Sudden Unexpected Death in Infancy (SUDI)
5. Information about requirements of a post mortem examination relates to Forensic Medicine and is therefore out of the scope for this policy.

1.3 Definitions

Sudden Unexpected Death in Infancy (SUDI):

The sudden, unexpected death of an infant:

- Less than 12 months of age
- And where the cause was not immediately apparent at the time of death.

This definition excludes infants who die unexpectedly in misadventures due to external injury (such as transport incidents) and accidental drowning.[3]

Sudden Infant Death Syndrome (SIDS):

The sudden, unexpected death of an infant:

- Less than 12 months of age
- With onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, review of the circumstances of the death and the clinical history.[4]

2 CLINICAL GOVERNANCE

2.1 Incident Notification

Where a sudden, unexpected death of an infant death occurs in the community and the infant is brought to a NSW Health facility, notification in the Incident Information Management System (IIMS) is not required and the presentation is to be managed as a SUDI, as outlined in this Policy.

As per NSW Health PD2014_004 Incident Management Policy all deaths in hospital that are unrelated to the natural course of illness must be reported promptly in the IIMS. The Ministry of Health must be notified of the incident via a Reportable Incident Brief (RIB) within 24 hours.

2.2 Health Care Record

Where a post mortem is to be conducted under the direction of the Coroner, the forensic pathologist (NSW Health Pathology) must have access to a copy of the infant's health care record. The health care record should be forwarded within 24 hours. For more information see 4.8 Management of the Infant's Health Care Record.

2.3 Case Review

Following an episode of SUDI, by the next business day, the senior medical officer overseeing the case should review the infant's health care record and address any outstanding issues, including any referrals or follow-up for the parents/carers have been arranged.

LHDs/SHNs should also review all SUDI cases, this may be as part of a mortality and morbidity meeting. Where possible, other agencies involved in management of the case should be invited such as Forensic Medicine (NSW Health Pathology), Ambulance and Police.

Forensic Medicine (NSW Health Pathology) may also invite clinical staff to participate in a multi-disciplinary review.

2.4 Staff Debrief

All staff involved in an episode of SUDI should be offered the opportunity to debrief, both with other staff and individually, if preferred, and be assisted in accessing other support services where required.

3 GENERAL PRINCIPLES

SUDI is a tragic event likely to create an intense response from the parents/carers and their families as well as health professionals. As there is no 'appropriate' response to an overwhelming experience such as SUDI, behaviour of the parents/carers and their families may seem unusual. The immediate care and support provided by health professionals can make a significant difference to parents/carers and their family's grief.

Regardless of the NSW Health facility that the SUDI case presents to, appropriate physical space that allows for privacy should be accessible so that discussions between the infant's parents/carers and staff can occur and that the SUDI response can be managed.

As with all episodes of patient care, where a SUDI case is managed in a NSW Health facility, accurate documentation in the health care record is required. For more information see NSW Health PD2012_069 Health Care Records – Documentation and Management.

4 PROCEDURE FOR MANAGEMENT OF SUDI

SUDI cases will present in various ways, all of which require initiation of the SUDI response outlined in this document. This includes unresponsive or deceased infants brought by their parents/carers or by Ambulance, with or without Police involvement. Infants may be pronounced deceased prior to arrival, on arrival to the Emergency Department (ED), or after admission. Each of these presentations is considered a SUDI case and should be managed as outlined below.

The roles and responsibilities of each agency (Health, Police, Ambulance, Forensic Medicine and the Coroner) has been summarised at Section 6.1 Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities.

4.1 Sudden Unexpected Infant Death in the Community

- Any infant that dies suddenly and unexpectedly in the community is to be taken to their nearest ED
- On arrival, any immediate care should be provided as per usual ED practice and the ED senior medical officer and nurse in charge notified

- The ED senior medical officer is to verify the infant's death (extinction of life) and let the parents/carers know. The infant should be registered as a patient and admitted
- A decision is to be made as to who will coordinate immediate care of the infant and the parents/carers, this may be a senior nurse or social worker
- The infant's medical history must be completed by a senior medical officer, using the Medical History Guide – Sudden Unexpected Death in Infancy (SUDI) (Section 6.2). This should be the on-call paediatrician. If a paediatrician is not available, the locally networked paediatric service should be contacted to determine who will complete the infant's medical history
- Where the infant's death occurs outside of business hours, and social work is not available, clinical staff should provide a handover to social work by the next business day.

4.2 Sudden Unexpected Infant Death in Hospital

- Where a SUDI death occurs in a NSW Health facility, the Admitting Medical Officer (AMO) and nurse in charge of the shift are to nominate a staff member to coordinate care of the infant and the parents/carers, this may be a senior nurse or social worker
- The infant's death (extinction of life) is to be verified and the parents/carers informed
- The infant's medical history must be completed by a senior medical officer, using the Medical History Guide – Sudden Unexpected Death in Infancy (SUDI) (Section 6.2). This should be the AMO or on-call paediatrician. If a paediatrician is not available, the locally networked paediatric service should be contacted to determine who will complete the infant's medical history
- Where the infant's death occurs outside of business hours, and social work is not available, a handover from clinical staff to social work should be provided by the next business day.

4.3 Reporting a Death to the Coroner

As per NSW Health PD2010_054 Coroner's Cases and the Coroner's Act 2009 and IB2010_058 Coronial Checklist sudden and unexpected deaths are reportable to the Coroner.
Where any doubt exists as to whether a death should be reported, call the duty forensic pathologist or the clinical nurse consultant at the relevant Forensic Medicine (NSW Health Pathology) facility:

Business hours (8am - 4:30pm):

- Sydney (Lidcombe): 02 9563 9000
- Wollongong: 02 4222 5466
- Newcastle: 02 4935 9700

After hours calls should be directed to the Lidcombe Forensic Medicine facility. The relevant duty pathologist will be notified by the Lidcombe Forensic Medicine staff.

The State Coroner's Court may also be contacted for advice on 02 8584 7777.

Where a death is reportable to the Coroner, a death certificate must not be issued. Verification of death (extinction of life) is to be documented in the Report of a Death of a Patient to the Coroner (Form A) (State Form SMR010.510). For more information see NSW Health PD2015_040 Death – Verification of Death and Medical Certificate Cause of Death.

4.3.1 Police

Where an infant is brought to a NSW Health facility without any contact with Police, Police should be notified of the death via the Police Area Command so that Police can notify the Coroner. Police will liaise with Family and Community Services where required.

If the infant is brought to a NSW Health facility by Police, the senior medical officer in charge of the shift or their delegate should take a handover, including whether the death has been reported to the Coroner and whether the parents/carers have any objections to a post mortem examination.

Once the infant's death has been confirmed, Police, in their role representing the Coroner, are responsible for the care of the infant's body, timely transfer of the infant to the appropriate Forensic Medicine (NSW Health Pathology) facility and investigation of the infant's death. Police will organise formal identification of the infant, this is to occur before the infant's body leaves the hospital.

Where there is uncertainty or concerns about the roles and expectations of Police in a NSW Health facility, the senior medical officer and nurse in charge should discuss their concerns with the most senior attending Police officer. Any ongoing concerns should be escalated via the Hospital Executive and the Police Area Command.

4.3.2 **Notifying Forensic Medicine (NSW Health Pathology)**

Once Police have been notified, the senior medical officer must inform the duty forensic pathologist or clinical nurse consultant at the relevant Forensic Medicine of the SUDI death as soon as possible. Ideally this should be the senior medical officer who completes the infant's medical history.

Forensic Medicine should also be informed of any existing pathology samples taken prior to death, such as blood and urine, as these samples may be required for further testing as part of the Coronial investigation process. Contact details for Forensic Medicine are in Section 4.3.

4.4 Care of the Infant's Body

As per NSW Health PD2010_054 Coroner's Cases and the Coroner's Act 2009 the hospital in whose care the infant's body is in, is responsible for the safe custody of the body until it is removed by Police. This implies that the infant's body will be in the same condition as when the death occurred and includes no interference with cannulas, incisions or dressings.

All contact with the infant's body must be supervised by Police or a health professional. From arrival to hospital and/or the time of death, no evidence relating to the possible cause of the infant's death is to be altered. However parents/carers may stay with their infant, under supervision, and with support of the hospital contact person. The parents/carers may hold their swaddled infant, however handling of the infant's body should be limited. The parents/carers will be able to see their infant again after the post-mortem examination has taken place.
Hand/foot prints and locks of hair must not be taken until after the post mortem. Parents/carers can request that hand/foot prints and locks of hair are taken after the post mortem by the Forensic Medicine social worker.

4.5 Initial Care of the Parents/Carers

The hospital contact person is to coordinate care of the parents/carers, including organising a private space for discussions, access to toilets and refreshments, introductions to staff members, contacting of family/friends and access to any services they may need such as interpreter services, Aboriginal Liaison Services and religious/cultural organisations. Where parents/carers require medical review such as lactation advice or referral to mental health services, this should be discussed with the senior medical officer overseeing the SUDI response. See also Section 6.3 Factsheet - Breast care after the death of an infant.

On arrival to hospital parents/carers are to be informed of each step in the process, using terminology they can understand, and be given the opportunity to ask questions, including that:

- The circumstances of the infant's death means that the death is reportable under the Coroners Act.[5] Therefore any contact with the infant must be supervised by a health professional (or Police) at all times
- A comprehensive medical history of the infant and family members will be taken by a senior medical officer, while the infant's body is in hospital, to assist with establishing the cause of death
- The Police, in their role representing the Coroner, will likely ask questions about the circumstances of the infant's death and request that a next of kin formally identifies the infant's body
- The Police will explain the coronial process and provide them with a copy of the Initial steps after a death is reported to the Coroner brochure. Information provided should include:
    - That the purpose of the post mortem examination is to establish the cause of death
    - That the results of the post mortem may benefit surviving family members including siblings, for example by identifying any genetic diseases
    - Details of where the post mortem will occur
- The Coroner must be notified of objections to the post mortem. If the parents/carers decide to object to the post mortem:
    - The Coroner must be made aware of objections to the post mortem. If health staff become aware of objections to the post mortem, Police should be informed. Objections to the post mortem should be recorded in the infant's health care record
    - Assistance in exploring the objection should be offered, further information can be sourced from the social worker at the appropriate Forensic Medicine facility
    - If the parents/carers object to a post mortem, they will be contacted by a representative from the Coronial Information and Support Program to discuss the objection and post mortem
- The Forensic Medicine social worker will contact the parents/carers by the next business day after the infant's body is admitted to the Forensic Medicine facility. Information and support about the coronial process and viewing of the infant's body can then be discussed
- A representative from the Coronial Information and Support Program may contact the parents/carers following the post mortem to discuss any organ retention
- A Forensic Medicine social worker will contact the parents/carers to provide interim results of the post mortem.

4.5.1 Initial Care of Siblings

SUDI presentations are particularly difficult when siblings of the infant have witnessed the death, discovery or resuscitation attempts of the infant. The assessment and care of surviving siblings, who may also present to hospital, is an important part of care. LHD/SHN social work should be able to provide resources and referrals to services that can provide support for siblings experiencing grief and loss, such as Red Nose Grief and Loss.

4.6 Completion of the Infant's Medical History

The Medical History Guide - Sudden Unexpected Death in Infancy (SUDI) (Section 6.2) is to be completed by a senior medical officer, as soon as possible after the infant's death. This should be the on-call paediatrician. If the paediatrician is not available, the senior medical officer should contact the locally networked paediatric service to determine who will complete the infant's medical history.

The Medical History Guide - Sudden Unexpected Death in Infancy (Section 6.2) includes details about the infant's health, parents/carers and events in the hours leading up to the infant's death, including the exact position the infant was found and the response of the parents/carers. Some questions may seem intrusive however they relate to known risks for infant mortality and may assist with establishing the cause of death. Where possible, information provided by the parents/carers should be recorded verbatim. Parents/carers should be given the opportunity to ask questions and discuss any concerns that they have.

It is recommended that a second staff member, ideally the hospital contact person, is present throughout the discussion with the parents/carers, about their infant's medical history. If you choose to include Police as observers during the medical history discussion, it is recommended that roles are agreed on before the discussion starts. Parents/carers should be reassured that Police presence does not indicate an assumption of implication of the death of the infant.

Details of those present during the discussion should be documented in the health care record.

4.6.1 Child Protection and Wellbeing

There are cases of SUDI that are the result of a non-accidental injury or neglect, therefore the safety and care of any children the parents/carers are responsible for must be considered. Care should be provided as per NSW Health's PD2012_007 Child Wellbeing and Child Protection Policy.

Where there are concerns for the safety of any children the parents/carers are responsible for see:

- NSW Mandatory Reporter Guide
- Child Protection Helpline 132 111 (Family and Community Services).

NSW Health Child Wellbeing Units 1300 480 420 (Mon - Fri 8:30am - 5pm) can also be contacted for advice.

4.6.2 Screening for Metabolic and Genetic Diseases

In all SUDI cases, the senior medical officer should refer the infant's parents and siblings to their local GP for an ECG. More information can be found in NSW Health's Management of the Death of a Child in Hospital Resource.

The senior medical officer is to consider any conditions that may have implications for surviving family members for example metabolic disease or cardiac dysrhythmia. Features of possible genetic problems include a history of sudden, unexpected death in family members, recurrent syncope, epilepsy and drowning. If there are concerns, the medical officer should contact the relevant medical specialist about possible investigations of the infant and/or family members.

As the infant's death is reportable to the Coroner, no samples of any kind can be taken after death without the permission of the Coroner. If there is a request for peri-mortem specimen collection, call the forensic pathologist at the relevant Forensic Medicine facility. For contact details see Section 4.3.

4.7 Role of the GP

The paediatrician or senior medical officer is to contact the local GP to:

- Inform them of the infant's death
- Discuss any relevant information about the infant and the parents/carers
- Discuss investigations required, for example an ECG on the infant's parents and siblings
- Discuss advice provided about lactation
- Offer assistance with support and referral for the infant's parents/carers

4.8 Management of the Infant's Health Care Record

As per PD2010 054 Coroner's Cases and the Coroner's Act where a post mortem is to be conducted under the direction of the Coroner, the forensic pathologist must have access to a copy of the health care record as soon as possible.

The hospital is responsible for providing a copy of the health care record to the Coroner. Release of copies of health care records should be handled by the medical records department or their delegate. The health care record may be sent with the infant's body but should be collated, packaged and forwarded in a sealed envelope. Records should be sent to Forensic Medicine within 24 hours of the infant's death.

Admission documentation, the infant's medical history, the Ambulance clinical record, records of any medications given and the infant's growth charts should be sent to Forensic Medicine as part of the infant's health care record.

4.8.1 Following Transfer to Forensic Medicine (NSW Health Pathology)

Agencies that request a copy of the infant's health care record, including Forensic Medicine and Police, after the infant's body has been transferred to Forensic Medicine, should be referred to the hospital's medical records department.

If the infant's health care record is not received by Forensic Medicine within 24 hours of the infant's death, Forensic Medicine are to contact the hospital's medical record department.

Where a copy of the infant's medical history has not been received or further information is required, Forensic Medicine is to contact the senior medical officer who completed the infant's medical history. If the senior medical officer is not able to be contacted, the Director of Medical Services/Administration of the hospital or facility should be contacted.

4.9 Departure From the Hospital or Health Care Facility

Before parents/carers leave the hospital or health care facility, the hospital contact person should confirm any appointments made and discuss with the parents/carers notification of other health professionals previously involved in the infant's care.

Parents/carers may want to nominate a family member to act as a contact to assist with decision making on their behalf. Information, both written and verbal, about how to access further support and advice should also be provided such as:

- Child and Family Health Services
- Their local GP
- A medical specialist
- Mental Health Services
- Other health services such as the Aboriginal Maternal and Infant Health Service or NSW Refugee Health Service
- Red Nose Grief and Loss.

Practical assistance and advice should be offered to parents/carers including arranging transport home, care of siblings and funeral arrangements. Note parents/carers should not set a date for their infant's funeral until they have made contact with the Forensic Medicine social worker.

A representative from the hospital or health care facility overseeing care of the infant and the parents/carers should contact the parents/carers within a week of the infant's death, to offer support and confirm any referrals have been organised. This may be the social worker, the hospital contact person or the senior medical officer.

4.10 Forensic Medicine (NSW Health Pathology)

Once parents/carers have had the opportunity to spend time with their infant and the infant's medical history is complete, Police will arrange for the infant's body to be transferred to the appropriate Forensic Medicine facility. This should occur as soon as possible as extended delays can impact the post mortem examination and therefore timing of the report. Police arrange transfer of the infant's body via a government contractor, there is no cost for the transfer.
The hospital contact person should provide a handover to the Forensic Medicine social worker where the post mortem will occur. Contact details of the Forensic Medicine (NSW Health Pathology) social worker should be given to the parents/carers prior to transfer of the infant's body.

The Forensic Medicine social worker will:

- Accept a handover from the hospital contact person (usually by email)
- Contact the parents/carers to confirm that the infant's body has been admitted to the facility (by the next business day).

Forensic Medicine social work is available during office hours (8:00am to 4:30pm) at all sites. After hours social work service is available as follows:

- Sydney: 6pm - 10pm on weekdays, 8am - 8pm on Saturdays and Sundays
- Newcastle: 1pm - 5pm on Saturdays and Sundays
- Wollongong: no after-hours social work support is available however the Wollongong Hospital social work team may accommodate requests for viewings after hours.

While the Coronial process is ongoing, up until after the final post mortem report has been discussed, parents/carers who have experienced the sudden unexpected death of an infant can access support, advice and referral to other services from Forensic Medicine social work.

4.11 The Post Mortem Examination

A post mortem (or autopsy) is a detailed examination of a body by a doctor who has training in this field. A post mortem is requested by the Coroner to inform a balanced, accurate finding regarding the cause of death. In NSW, all post mortem examinations after a SUDI death are undertaken at one of the three Forensic Medicine facilities, in Sydney, Wollongong or Newcastle.

As per Section 4.5 Initial Care of the Parents/Carers the Forensic Medicine social worker will contact the parents/carers to provide interim results of the post mortem. The Forensic Medicine social worker will also:

- If requested, arrange for hand/foot prints and locks of hair to be taken
- Facilitate viewings of the infant's body after the post mortem
- Ask if the parents/carers would like to be contacted by a Forensic Medicine social worker when the final post mortem report is available
- Confirm that the infant's body can be released to the funeral director.

If organ retention occurred as part of the post mortem, the parents/carers will be contacted by a representative from the Coronial Information and Support Program (CISP) to discuss approval by the Coroner, release, retention timeframes and options for disposal or return of organs.

4.12 Final Post Mortem Examination Report

Once the final post mortem report is complete, the Coroner will notify the parents/carers via a letter. Parents/carers can request a copy of the final post mortem report, requests by the parents/carers must be made to the Coroner in writing, this may be via email. There is no charge to parents/carers for a copy of the report. Some of the tests undertaken are complex so it may take months for the post mortem report to be available. It is not uncommon for the post mortem report to be inconclusive.
Note that requests for a copy of the post mortem report from NSW Health to the Coroner, must be made in writing from the hospital's Director of Medical Services (DMS) or Director of Clinical Governance (DCG) directly to the relevant Coroner. If the senior medical officer or paediatrician overseeing care of the infant and the parents/carers would like a copy of the post mortem report they should contact their DMS or DCG.

Once the final post mortem report is available, if parents/carers agreed to be contacted, the Forensic Medicine social worker will contact the parents/carers and offer to discuss the report. The Forensic Medicine social worker can also assist parents/carers with requesting a copy of the post mortem report from the Coroner.

Parents/carers can discuss the post mortem report with the Forensic Medicine social worker and the forensic pathologist. Parents/carers can also discuss the report with the hospital contact person, social worker, senior medical officer, paediatrician or general practitioner involved in their care.

Where there are unanswered questions about the post mortem report, parents/carers or clinical staff can contact Forensic Medicine social work at the relevant Forensic Medicine (NSW Health Pathology) facility for further discussion. Forensic Medicine social work will facilitate any discussion with the forensic pathologist that is required.

During discussions about the final post mortem report, any referrals or further support required by parents/carers are to be provided.

5 RELATED DOCUMENTS

NSW Child Death Review Team. NSW Child Death Review Team Annual Report 2017-18. Sydney: NSW Ombudsman; 2018.

NSW Child Death Review Team. Child Death Review Report 2015. NSW Government Publication: NSW Ombudsman; 2016.

NSW Health PD2013_007Child Wellbeing and Child Protection Policies and Procedures for NSW Health

NSW Health PD 2010_054 Coroner's Cases and the Coroners Act 2009

NSW Health IB2010_058 Coronial Checklist Summary

NSW Health PD2015_040 Death - Verification of Death and Medical Certificate of Cause of Death

NSW Health PD2014_004 Health Incident Management Policy

NSW Health Management of the Death of a Child in Hospital Resource (Office of Kids and Families, 2015)

NSW Health GL GL2005_063 Sudden Infant Death Syndrome (SIDS) and Safe Sleeping For Infants

NSW Health GL2017_010 NSW Paediatric Service Capability Framework

The Royal College of Pathologists Sudden unexpected death in infancy and childhood. Multiagency guidelines for care and investigation 2016. The Royal College of Pathologists, London.

6 ATTACHMENTS

Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities

Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities	
Role	**Responsibilities**
Ambulance	Ambulance to attend, assess, attempt resuscitation (if indicated) and transport infant to hospital Complete an Ambulance Clinical Record and handover
Police	Attend scene Explain Coronial process, provide Initial steps after a death is reported to the Coroner brochure Interview parents/carers and complete Police P79A form Ensure any objection to the post mortem is documented Liaise with Family and Community Services (FACS) Complete formal identification of the infant's body Coordinate transfer of the infant's body to Forensic Medicine (NSW Health Pathology) Preserve and examine scene (Forensic Services, Police)
Senior ED MO or AMO	Manage medical care, including verification of life extinction Coordinate completion of the infant's medical history (by the on-call paediatrician) Coordinate ongoing medical care of parents/carers, including documentation and referrals Coordinate staff debrief
Paediatrician	Complete infant's medical history and documentation Consider medical cause or non-accidental injury Contact GP and relevant medical specialists Participate in Forensic Medicine (NSW Health Pathology) multi-disciplinary meeting if required
Nurse in charge	Coordinate nursing care Liaise with hospital contact person about care of parents/carers Coordinate staff debrief
Hospital contact person (social work/nurse)	Inform parents/carers of SUDI process Support parents/carers in spending time with infant (under clinician supervision with minimal handling) Organise practical support including private space, refreshments, support such as extended family, religious, cultural and Aboriginal Offer contact with Red Nose Grief and Loss Coordinate lactation support and/or referral, where required Provide handover to Forensic Medicine social work Provide handover to hospital social work (if not already aware)
Forensic Medicine (NSW Health Pathology)	Pathologist completes post mortem examination Social work offers parents/carers support, advice and referral Social work and pathologist offer to discuss post mortem results with parents/carers Coordinates multi-disciplinary case review
General practitioner	Provide information about the infant and parents/carers where required Organise ECG for parents and siblings Provide ongoing support and referral for parents/carers
Medical records/clerical	Forward copy of infant's health care record to Forensic Medicine (NSW Health Pathology) within 24 hours of infant's death
Coroner	Determine manner and cause of death and need for inquest based on post mortem report and police investigation Consider requests for release of post mortem report
Clinical governance/ director medical services	Manage requests for post mortem report Distribute post mortem report to relevant clinician
NSW Health PD2019_035 Management of Sudden Unexpected Death in Infancy	

6.2 Medical History Guide – Sudden Unexpected Death in Infancy (SUDI)

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

The unexpected death of an infant is a tragedy for the parents/carers. Investigating infant deaths can be difficult as the situation is highly charged and emotional, and so it requires a unique and sensitive approach.

This guide includes high level of detail about the infant's health, the infant's family and events in the hours before the infant's death, including the infant's exact position and the parent/carer behaviour and use of alcohol or drugs. While these questions may feel intrusive, they relate to known risks for infant mortality, help determine why the infant died and can be asked in a sensitive way.

A detailed medical history will help the forensic pathologist determine a cause of death, including whether the infant may have suffocated, or died from an undiagnosed medical problem. The history is also important in determining the presence of risk factors for Sudden Infant Death Syndrome (SIDS) and any potential child protection concerns.

The following points may assist you with the discussion:

- Where possible, have another clinician, such as a social worker or nurse, with you during the discussion with the family to provide support. If you choose to include the Police as observers while you take the history, agree on roles before starting.
- To build trust with the parents/carers start with less sensitive questions including contact information, general family history, the mother's pregnancy and health, psychosocial aspects and the infant's health, before moving onto the events leading up to the infant's death.
- Use the infant's name whenever possible. The Medical History Guide – Sudden Unexpected Death in Infancy (Section 6.1) uses [infant's name] as a prompt.
- A suggested introduction is:

  'I am so sorry about your loss. Some people describe feeling that it is not quite real, like a nightmare. I would like to help make sense of what has happened. I would like to find out why [infant's name] died and help you understand why. To do that I would like to find out as much as possible about your pregnancy, [infant's name] general health and sleeping and feeding patterns. I also need to ask some questions about you and your health as it will help us understand why some young babies die suddenly. Please let me know if you are uncomfortable with any of these questions.'

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

1. Identification

Infant's name
Date of birth
Date of death
Sex M/F
Ethnicity/Aboriginal/Torres Strait Islander
Address
Postcode

Personal information

Name of mother (and address if different from infant)
Date of birth
Name of father (and address if different from infant)
Date of birth
Consanguinity (degree of relatives)

Healthcare providers

Name of doctor completing the medical history
Social worker
Hospital contact person
Other professionals
Interpreter present
GP name and address

Information retrieved from medical record

As relevant, hospital, GP, midwife, infant's personal health record ('Blue Book')
Ambulance staff
Include growth chart in copy of medical record

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

2. Details of transport of infant to hospital

Place of death, home address as above/another location (specify)
Time found
Time arrived in emergency department (triage time)
Resuscitation carried out
At scene of death – police/ambulance/emergency department/hospital
By who? Parents/carers/GP/ambulance paramedic/hospital staff/other (specify)
Confirmation of death
By who
Time and date
Location

3. Medical history

Taken to emergency department/hospital by
History given by
Relationship to infant

Family history

Details of family and household members, including names, dates of birth, health, any previous or current illnesses including mental health, medications, occupation
Maternal parity and obstetric history
Parental relationships
Children, including children by previous partner
Household composition
Any previous childhood deaths in the family

Social history

Type and nature of housing Major life events Wider family support networks History of family involvement with Family and Community Services Domestic and family violence Smoking, alcohol use
Infant's medical history Pregnancy and delivery, perinatal history, feeding, growth, behaviour and development Health and any previous or current illnesses, hospital admissions, medications Routine checks and immunisations Body systems review
Detailed narrative account of last 24 – 48 hours (To include details of all activities and carers during the last 24-48 hours) Any alcohol, medication consumed by parents/carers Any medication given to infant Details of infant's last sleep, including where and how placed to sleep Details of feeding and care given Further details of previous 2-4 weeks, including infant's health, any changes to routine, when infant last seen by a health professional
NSW Health PD2019_035 Management of Sudden Unexpected Death in Infancy Page 3
Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)
Events surrounding death When infant was last seen alive and by who Who found the infant, where and when, appearance when the infant found Details of sleep environment, type of surface, mattress, bedding, objects, overwrapping or over-heating. Face or head covered. Co-sleeping. Alcohol or drugs consumed by carers. Who called emergency services Details of any resuscitation at home, by ambulance and in hospital For accidental/traumatic deaths, details of circumstances around the death, witnesses
Any other relevant history May vary according to the age of the infant, nature of the infant's death
Genetic or metabolic disease For concerns about genetic or metabolic disease, contact the paediatric metabolic specialist for advice about investigations required For concerns about a condition that may have implications for other family members, for example cardiac dysrhythmia, contact the relevant specialist for advice about investigations required
Child protection and wellbeing If you have any concerns about non-accidental injury or neglect, follow usual child protection procedures
4. Conclusion Cause of death From this history do you have an impression of the possible cause of death?
NSW Health PD2019_035 Management of Sudden Unexpected Death in Infancy Page 4

SCHN Factsheet - Breast Care After the Death of an Infant

Copies of this brochure can be accessed via the Sydney Children's Hospitals Network website:

Factsheet: Breast care for breastfeeding mothers after the death of a child

FACTSHEET

This fact sheet is for education purposes only. Please consult with your doctor or other health professionals to make sure this information is right for your child. If you would like to provide feedback on this fact sheet, please visit: www.schn.health.nsw.gov.au/parents-and-carers/fact-sheets/feedback-form.

Breast care for breastfeeding mothers after the death of a child

Time after the death of your infant can be physically and emotionally exhausting. It is important that you have support during this time. When milk is not regularly removed from the breast, milk production eventually stops of its own accord. Some women experience breast engorgement, leakage of milk, discomfort and some pain during this time.

Often the only treatment needed to stop making milk, is limiting milk removal. To give your body the message to stop making milk, it is best to express only enough to keep your breasts comfortable, unless you need to clear a blockage to prevent mastitis. Caring for your breasts at this difficult time is important, as it will help make them more comfortable and reduce the risk of a blocked duct or mastitis. The following suggestions may provide some relief during this time.

Suggestions as breasts become uncomfortable:

- Wear a well-fitting bra to provide firm breast support, rather than a tight breast binder.
- Breast pads will help absorb leaking milk. These can be the disposable or the reusable type. Change them as they become wet.
- Avoid excessive stimulation of the breast.
- Regularly applying cold compresses may provide pain relief e.g. chilled washers, cool gel packs or washed cabbage leaves can also help.
- Avoid excessive heat on your breasts.
- Consider taking analgesia as required to relieve pain and discomfort (for example paracetamol).
- Breasts should be handled gently during this time as they can bruise easily when engorged.
- Express a little milk to relieve fullness and make the breasts more comfortable. This won't interfere with the progress of suppression, as you are not emptying the breast. Hand expressing in a warm shower or bath can be effective as warmth and relaxation will encourage milk ejection without added nipple and breast stimulation.
- Maintain a normal fluid intake.

Things to watch out for:

- Engorgement- breasts become swollen, hard and painful. If this occurs it is recommended that you express your breasts completely once to relieve the pain. Then over the next few days express enough milk to keep your breasts comfortable. Applying cool packs, avoiding excessive heat and taking analgesia as needed to increase comfort may also help.
- Mastitis –lumps, red areas on the breast. Temperatures or flu like symptoms may indicate you have mastitis and medical assessment should be sought promptly.

How long will I have milk for?

It may take weeks or months for your milk to disappear completely. Leakage may occur for some time after discomfort has settled.

the children's hospital at Westmead
The Sydney Children's Hospitals Network

SYDNEY CHILDREN'S HOSPITAL
The Sydney Children's Hospitals Network

Kaleidoscope

This document was last reviewed on 30 August 2016

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The day of the funeral:

This will be a difficult and emotional day. The following hints may be helpful to consider:

- Express milk for comfort before the funeral and during the day as required.
- Wear a bra which is comfortable and well supported. Your bra should not be too tight.
- There may be some leakage of milk, so be prepared with some extra breast pads.
- Patterned and dark coloured tops are often less likely to show wet patches.
- Jackets or cardigans may help cover up wet spots.
- Use analgesia as required, to help relieve breast pain.

It is important you are well supported during this difficult time.

Helpful organisations you may wish to contact for support include:

- SIDS and KIDS – phone 1300308307
  (24 hour bereavement support, counselling, support groups and workshops)
  www.sidsandkids.org
- Your local General Practitioner
- SANDS - phone 1300 0 sands (1300 072 637)
  (Still born and Neonatal Death support
  24/7 volunteer supporters are on call)
  www.sands.org.au
- Australian breastfeeding Association helpline - phone 18006862686
  www.breastfeeding.asn.au
- Grief line – phone 1300 845 745
  (Confidential and anonymous telephone support, including counselling in diverse languages)

6.4 Implementation Checklist

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Local policies that guide management of SUDI are easily accesible for staff. This includes that all facilities are able to initiate a SUDI response.	❑	❑	❑
	Notes:		
2. Information about how to access locally networked paediatrics services is easily accessible for staff.	❑	❑	❑
	Notes:		
3. Adequate resources and education are provided so that staff can meet the needs of the infant and parents/carers, including providing parents/carers with support and relevant referrals.	❑	❑	❑
	Notes:		
4. Local guidance on allocation of the hospital contact person role is provided.	❑	❑	❑
	Notes:		
5. Local processes support transfer of the infant's health care record to Forensic Medicine (NSW Health Pathology) within 24 hours of the infant's death, and include a copy of the infant's medical history.	❑	❑	❑
	Notes:		
6. That support is available for staff who provide care to infant's and their parents/carers who have experienced SUDI.	❑	❑	❑
	Notes:		
7. Local processes maintain the quality of care and patient experience of SUDI cases.	❑	❑	❑
	Notes:		

RECOMMENDED SAFE SLEEPING PRACTICES FOR BABIES
(GL2021_013)

GL2021_013 resinds PD2019_038

GUIDELINE SUMMARY

The Guideline recommends safe sleeping practices to reduce the risk of Sudden Unexpected Death in Infancy (SUDI) and Sudden Infant Death Syndrome (SIDS).

KEY PRINCIPLES

Health professionals use a partnership approach to engage and work with families in a culturally sensitive manner to build relationships and find ways to support families to keep their babies safe.

Carers receive consistent, clear information about the recommended safe sleeping practices routinely and opportunistically in antenatal, postnatal, newborn care and community settings until the baby is 12 months of age.

Risk assessments are conducted at specified points in care for factors that may indicate a higher risk of SUDI.

All care and care planning, including risk assessments, must be documented in the health record.

USE OF THIS GUIDELINE

Local Health Districts and Specialty Health Networks must ensure relevant staff:

- receive education and training to provide safe sleeping information
- are aware of the evidence supporting the safe sleeping practices
- model safe sleeping practices
- are aware of the risk factors for SUDI and identify families who may require additional information, education and support
- develop local procedures and strategies to:
    - to implement this Guideline
    - monitor practice.

The Recommended Safe Sleeping Practices for Babies guideline is avaialbe at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_013

MANAGEMENT OF CEREBRAL PALSY IN CHILDREN - A GUIDE FOR ALLIED HEALTH PROFESSIONALS

(GL2018_006 issued 14/3/2018)

PURPOSE

Management of Cerebral Palsy in Children - A Guide for Allied Health Professionals provides recommendations, information and guidance to support the clinical decision making of allied health professionals regarding the management of children with cerebral palsy. The guideline was prepared for the NSW Ministry of Health by an expert clinical reference group and is aimed at achieving the best possible paediatric care in all parts of the state.

KEY PRINCIPLES

The guideline reflects what is currently regarded as a safe and appropriate approach to the management of children with cerebral palsy. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

As in any clinical situation and due to the heterogeneous nature of cerebral palsy, there are factors that cannot be covered by a single guide. Clinicians and clients need to develop individual treatment plans that are tailored to the specific needs and circumstances of the client. This guideline should be read in conjunction with other relevant guidelines, position papers, codes of conduct, and policies and procedures, at professional, organisational and Local Health District levels.

USE OF THE GUIDELINE

Chief Executives must ensure:

- This guideline is adopted or local protocols are developed based on *Management of Cerebral Palsy in Children - A Guide for Allied Health Professionals*
- Local protocols are in place in all hospitals and facilities likely to be required to care for children with cerebral palsy
- Ensure that all staff treating paediatric patients are educated and supported in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this revised guideline.

To download this guideline go to
Management Of Cerebral Palsy In Children: A Guide For Allied Health Professionals

FEEDING DIFFICULTIES IN CHILDREN - A GUIDE FOR ALLIED HEALTH PROFESSIONALS

(GL2016_007 issued 18/2/2016)

PURPOSE

Feeding Difficulties in Children - A Guide for Allied Health Professionals provides recommendations, information and guidance to support the clinical decision making of allied health professionals regarding the management of children with feeding difficulties. The guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of The Office of Kids and Families and is aimed at achieving the best possible paediatric care in all parts of the state.

KEY PRINCIPLES

The guideline reflects what is currently regarded as a safe and appropriate approach to the management of children with feeding difficulties. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

As in any clinical situation and due to the heterogeneous nature of feeding difficulties, there are factors that cannot be covered by a single guide. Clinicians and clients need to develop individual treatment plans that are tailored to the specific needs and circumstances of the client. This guideline should be read in conjunction with other relevant guidelines, position papers, codes of conduct, and policies and procedures, at professional, organisational and Local Health District levels.

USE OF THE GUIDE

Chief Executives must ensure:

- This guideline is adopted or local protocols are developed based on *Feeding Difficulties in Children - A Guide for Allied Health Professionals*
- Local protocols are in place in all hospitals and facilities likely to be required to care for children experiencing difficulties with feeding
- Ensure that all staff treating paediatric patients are educated and supported in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this revised guideline.

To download this guideline go to

Feeding Difficulties in Children - A Guide for Allied Health Professionals

296(18/2/16)

SUSPECTED CHILD ABUSE AND NEGLECT (SCAN) MEDICAL PROTOCOL
(GL2014_012)

PURPOSE

This protocol provides medical staff with a standard template and clinical guidance to record a forensically orientated medical assessment of a child or young person. A forensically oriented medical assessment is conducted to enable an opinion to be formed as to the probability that injuries have been caused intentionally or that neglect is present.

KEY PRINCIPLES

Medical staff are required under the *Children and Young Persons (Care and Protection) Act 1998* to provide medical examinations of children and young people in need of care and protection when requested by Community Services or the NSW Police Force, s173; or upon order of the Children's Court, s53. The SCAN Medical Protocol should be used to document these examinations. As a minimum this protocol should be used to document findings in all s173 examinations. An examining doctor is required to provide a written report to the Director General Community Services following completion of a s173 medical examination. The NSW Police Force, the Joint Investigation Response Team (JIRT) and Community Services are required to serve the hospital with a notice requesting s173 medical assessment.

USE OF THE GUIDELINE

The Protocol should be used in conjunction with NSW Health Policy Directive *PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health* which provides information to assist health workers to recognise and respond to child wellbeing and child protection concerns by setting out the legislation; the interagency and NSW Health policies that empower health workers; child abuse and neglect risk indicators; the mandatory reporting requirements and the tools and response mechanisms to children and young people suspected at risk of significant harm.

The NSW Health State Forms Management Committee has endorsed the SCAN Medical Protocol as a form for State-wide use. The Protocol can be accessed as a downloadable self-print document from the NSW Health print portal https://eprintondemand.salmat.com.au

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_012.html

NEONATAL ABSTINENCE SYNDROME GUIDELINES (GL2013_008)

GL2013_008 rescinds PD2005_494.

PURPOSE

These Guidelines specifically address the management of newborns to mothers with a history of opioid use or opioid dependence, including women currently receiving opioid substitution treatment (methadone or buprenorphine) or using prescription pharmaceutical opioids (such as oxycodone, morphine, pethidine or tramadol).

While Neonatal Abstinence Syndrome (NAS) is more common in infants born to opioid dependent women than in infants born to women dependent on other drugs, the effect of polydrug use on NAS is not clearly established and is most likely dependent upon the specific combination and quantities of drugs used by the mother.

Provided that neonatal abstinence syndrome is appropriately managed, it is not currently known to be associated with long-term health problems.

KEY PRINCIPLES

The Guidelines concentrate on two main aspects of care:

1. The care of the opioid-dependent pregnant woman from a drug and alcohol perspective based on "Harm Minimisation" principles, and;
2. The care of the newborn from a child protection perspective.

These guidelines should be used to guide clinical management; however clinicians must always consider the pregnant woman they are managing as an individual, and apply the guidelines appropriately.

Opioid dependent pregnant women have an increased risk of experiencing complications during pregnancy and of their infants experiencing adverse outcomes. The association is complex and may be affected by a range of factors including: poly substance use; inadequate antenatal care; poor nutrition; blood borne virus exposure; mental health problems; housing; and domestic violence. Births in mothers with opioid, stimulant or cannabis use diagnoses are associated with a number of negative neonatal outcomes. Babies are more likely to be born before the gestational age of 37 weeks, to be of low birth weight, and to be admitted to neonatal intensive care units or to special care nurseries than babies born to mothers without such a diagnosis.

Many women are more motivated during pregnancy to make important health and lifestyle changes. This is an ideal time to engage, or more fully engage, a woman in care for her drug use and other problems. A range of services are required to work collaboratively in order to ensure optimal outcomes for both the mother and newborn. The aim is to minimise the likelihood of complications and to provide comprehensive antenatal and postnatal care in a non judgemental, non-threatening environment.

USE OF THE GUIDELINE

While the focus of these Guidelines is opioid dependent women it is recognised that other illicit drugs such as stimulants, sedatives, alcohol and some psychotropic medications may also be associated with NAS and these women and newborns may have similar care needs. Therefore, the care elements of the Guidelines (which exclude elements specifically relating to opioid pharmacology as found in parts of Sections 8.1, 8.2 and 9.5) also apply to this group of women and their infants.

The Guidelines outline minimum standards for the management of NAS. Local Health Districts are responsible for ensuring that maternity services develop clear clinical protocols relevant to each maternity health care facility, based on these Guidelines.

Local policies and guidelines need to be formalised to ensure that the roles and responsibilities of the multidisciplinary team are clear. The guidelines provide advice on a continuum of care (Diagram 1), that includes care of the mother and infant from antenatal care through discharge and follow up.

A number of key priorities are identified in the NAS Guidelines and should be included in any local clinical guidelines or business rule: the early recognition and engagement of the opioid dependent pregnant woman and new mothers into multi-disciplinary team care (Section 6); the care of the newborn child Section 7); the postnatal care of both the mother and child (Sections 8, 9, 10); and the care and protection responsibilities of health workers clinically involved in the care of the newborn (Section 3).

Severe neonatal withdrawal is an indication for pharmacological management of NAS. The Neonatal Abstinence Score (or Finnegan Score – Refer Appendix 3) was developed to monitor the progress of infants experiencing neonatal abstinence due to opioid exposure in utero. It can be used as a trigger for pharmacological treatment of neonatal abstinence (Refer Section 8.2). Provided that neonatal abstinence is appropriately managed, it is not currently known to be associated with long-term health problems.

Section 5 deals with care of the mother's drug dependence during pregnancy and provides advice regarding withdrawal from heroin and assistance in determining a suitable Opioid Substitution Therapy, if required.

Section 6.6 provides advice regarding appropriate assessment and identification of risk for mother and foetus. This section outlines the process for prenatal reporting, including when reporting should be undertaken and the criteria used in assessing a need to report.

Section 8.2 outlines postnatal care of the infant. All infants born to drug dependent mothers should receive routine postnatal monitoring, along with specific assessment for the signs and symptoms of NAS using the Finnegan Neonatal Abstinence Severity Score (NASS) or modified Finnegan scale (See Appendix 3). Monitoring should commence within 2 hours after birth and be conducted 30 - 60 minutes after a feed. The score is an important guide for the appropriate pharmacologic treatment of NAS and health-care providers involved in the care of opioid-exposed infants must be educated in the appropriate application of these scores.

The issue of breastfeeding is complex because of the range of drugs used, their half-life and their interactions. Section 8.4 provides advice for breastfeeding based on the premise that breast milk is the most complete form of nutrition for infants, with a range of benefits for health, growth, immunity, and development. There are times however when the breast milk should be expressed and discarded, particularly following psychostimulant use.

To download the Guideline go to http://www.health.nsw.gov.au/policies/gl/2013/GL2013_008.html

RURAL PAEDIATRIC EMERGENCY CLINICAL GUIDELINES, THIRD EDITION

(GL2021_011)

GL2021_011 rescinded GL2020_016

GUIDELINE SUMMARY

The Guideline provides First Line Emergency Care Course (FLECC) trained nurses with best practice guidance for early management of acute and life-threatening conditions. It is relevant to rural and remote paediatric inpatient areas.

The Guideline aligns with the NSW "Between the Flags" program and facilitates management in the absence of immediate access to a medical officer. It improves overall care and outcomes for infants and children in rural and remote hospitals by allowing treatment to be commenced immediately.

KEY PRINCIPLES

The Guideline is designed to:

- improve emergency care and outcomes for patients in the rural and remote health care settings of NSW
- assist rural and remote Emergency Departments (EDs) in NSW achieve benchmarking targets and best practice standards for patients presenting to emergency
- provide best practice guidance, and to support the role that many Registered Nurses currently perform in rural and remote settings.

In circumstances where a patient meets more than one guideline, the most lifethreatening condition should take priority and the most appropriate corresponding guideline commenced.

USE OF THE GUIDELINE

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of the revised Guideline. Implementation should occur in conjunction with the local Clinical Emergency Response System (CERS) and continuing professional development.

Chief Executives must ensure that:

- the Guideline is adopted or that local protocols are in place in all hospitals and facilities likely to be required to provide emergency treatment to infants and children
- emergency nurses have the opportunity to access the First Line Emergency Care Course (FLECC).

FLECC-trained nurses must ensure that:

- a designated medical officer is notified as soon as practicable

FLECC-trained nurses and medical officers must ensure that:

- medication standing orders contained and used in the Guideline are reviewed and authorised by the designated medical officer as soon as possible (within 24 hours) and;
- the medical officer countersigns the record of administration on the patients' medication chart

Enrolled nurses and registered nurses who are not FLECC credentialed using the guideline to inform assessment and management, are not to undertake shaded interventions that require FLECC credentialing unless previous recognition of prior learning has been granted.

The Guidelines can be downloaded at Rural Paediatric Emergency Clinical Guidelines, Third Edition

STANDARDS FOR PAEDIATRIC INTRAVENOUS FLUIDS: NSW HEALTH (SECOND EDITION) (GL2015_008)

GL2015_008 rescinds GL2014_009.

PURPOSE

Intravenous fluids are important components of appropriate care for hospitalised children. Reports in the medical literature and warnings issued in other countries have highlighted the risks associated with use of low sodium content fluids. The importance of appropriate glucose content has also been identified.

The NSW Chief Paediatrician was tasked to engage clinical experts, Healthshare and a range of other partners in the development of state wide standards across all NSW facilities. The resulting *Standards for Paediatric IV Fluids: NSW Health* addresses fluid content, bag size, labelling, administration, procurement and storage.

Emerging new evidence and clinical experience motivated an early revision of the Standards, resulting in this second edition.

KEY PRINCIPLES

The intended outcomes of the first edition of the standards regarding the content of IV fluids in children and neonates included:

- Reducing the risk of hyponatremia through increased sodium content and limiting the use of low sodium containing fluids.
- Addressing glucose requirements of children and neonates through increased glucose content.
- Consistent inclusion of potassium chloride as early as considered safe and appropriate.

The key changes in the second edition of the Standards regarding the content of IV fluids for children and neonates include:

- Incorporating further evidence supporting the use of isotonic saline solutions in IV maintenance therapy.
- Standardising the use of 1000mL bags in the care of children beyond the specialist children's hospitals.
- Incorporating Special Care Nursery practice and clarification around IV fluids for neonates.

The Statement of the *Standards for Paediatric Intravenous Fluids: NSW Health* (page 8) provides a summary of the recommended standards.

USE OF THE GUIDELINE

The following priorities have been identified to facilitate the implementation of *Standards for Paediatric Intravenous Fluids: NSW Health* (second edition) into all relevant clinical areas; Communication, Education and Raising Awareness, Integration into Practice, Procurement and Monitoring.

To download the Guideline please go to
Standards for Paediatric Intravenous Fluids: NSW Health (second edition)

STANDARDS FOR PAEDIATRIC INTRAVENOUS FLUIDS (IB2014_066)

PURPOSE

To advise clinicians and managers about the products recommended in the Standards for Paediatric IV fluids (GL2015_005) published in August 2015. The Standards address the appropriate choice of IV fluids and measures related to their procurement, storage and safe administration.

Chief Executives are to ensure that the requirements of this information bulletin are communicated to all appropriate staff.

KEY INFORMATION

All fluids recommended in the Standards are available for order from Baxter Healthcare. Some products are compounded and some products are manufactured in the Baxter Toongabbie facility.

Compounded IV Products

Products that are compounded in the Baxter Pharmacy need to be ordered taking into consideration the appropriate lead time (please see the ordering document below).

As they are compounded these products are generally more expensive. If there is sufficient high demand for a compounded product then it may become a custom manufactured product (also known as Therapeutic Goods Administration or TGA Schedule 5A) with storage and cost benefits to healthcare facilities.

The only way to reduce the price of these products is to consistently order according to the Standards.

Schedule 5A Solutions (AHK codes) are made in the Baxter Toongabbie facility and are ordered through Baxter Customer Service. For your first order only a Pharmacist will have to sign a TGA Schedule 5A form. This does not mean these IV fluids will always have to be ordered by your pharmacy department. All subsequent orders will be covered by the initial TGA form. You are not able to receive your order until this form has been completed and returned to Baxter Healthcare. Each individual AHK code must have a signed TGA form. Therefore, your Pharmacist may need to complete several forms for your institution.

IV Bag Sizes

500mL and 1000mL bags will be available to NSW facilities for an initial two years and usage monitored. As the Children's Hospitals only use the 1000ml bags, that price will be lower due to the higher demand. Fluids for neonates will continue to be supplied only in 500mL bags (or less).

Potassium Chloride Products

All products containing potassium chloride (including compounded products) will now be supplied with a pink over-pouch.

Pre-Packaged Bags

The practice of adding potassium chloride or glucose to paediatric IV fluids should be discouraged. If this practice is because of the cost of specific fluid bags, then the use of less expensive 1000mL bag versions should be considered in the interest of patient safety in paediatric areas (not for neonates).

It is strongly recommended that, wherever possible, pre-packaged bags of appropriate IV fluids are available and used with the correct concentrations of sodium, glucose and potassium, across all NSW facilities. The use of premade/pre-packaged IV Fluid bags in paediatrics is also encouraged by:

- Sydney Children's Hospitals Network - Intravenous Fluid and Electrolyte Therapy – Practice Guideline 2013 (page 5)
- Royal Children's Hospital, Melbourne - Intravenous Fluids Clinical Practice Guideline.

Paediatric Infusion Sets

As per NSW Health policy directive PD2010_034, Section 3.3.10 – *"Paediatric infusion sets with inline burette must be used for all children requiring intravenous therapy. An infusion pump should be used in all children".*

Ordering enquiries

For AHK and AHB Baxter IV fluid codes

Baxter Customer Service – Telephone - 1300 789646

For the compounded IVS.1000-5000 products Baxter
Pharmacy Services:
Telephone: 1800 227 487 or (02) 9848 1395

Fax: 1800 025 887 or (02) 9848 1155.

To avoid waste and reduce costs we encourage coordinated ordering across LHDs for the purchasing of less frequently used IV fluids.

Baxter – 2014 – Paediatric IV Fluids Order Form NSW

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF ALTERED CONSCIOUSNESS IN EMERGENCY DEPARTMENTS (GL2014_019)

PURPOSE

The *Infants and Children: Acute Management of Altered Consciousness in Emergency Departments: first edition* Clinical Practice Guideline has been developed to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

KEY PRINCIPLES

This guideline applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts to have local guidelines/protocols based on the attached Clinical Practice Guideline in place in all hospitals and facilities required to assess or manage children with altered consciousness.

The clinical practice guideline reflects what is currently regarded as a safe and appropriate approach to the acute management of altered consciousness in infants and children. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

USE OF THE GUIDELINE

Chief Executives must ensure:

- Local protocols are developed based on the *Infants and Children: Acute Management of Altered Consciousness in Emergency Departments: first edition* Clinical Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with altered consciousness.
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this new guideline.

To download the Guideline please go to
Infants and Children: Acute Management of Altered Consciousness in Emergency Departments

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF COMMUNITY ACQUIRED PNEUMONIA (GL2018_007)

GL2018_007 issued 16/03/2018 rescinds GL2015_005.

PURPOSE

This Clinical Practice Guideline provides evidence based direction to clinicians in the acute management of community acquired pneumonia. It is aimed at achieving the best paediatric clinical care in the assessment and management of acute community acquired pneumonia and appropriate escalation responses across New South Wales.

KEY PRINCIPLES

This Guideline applies to all facilities where paediatric patients are managed. It requires Chief Executives of all Local Health Districts and specialty health networks to determine where local adaptations are required or whether it can be adopted in its current format in all hospitals and facilities required to manage children with community acquired pneumonia.

The Clinical Practice Guideline reflects what is currently regarded as a safe and appropriate approach to the acute management of community acquired pneumonia in infants and children. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation**.

USE OF THE GUIDELINE

Chief Executives must ensure:

- This Guideline is adopted or local protocols are developed based on the Infants and Children: Acute Management of Community Acquired Pneumonia, March 2018 Clinical Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with community acquired pneumonia.
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric guidelines.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this new guideline.

To download the Guideline please go to
Infants and Children: Acute Management of Community Acquired Pneumonia

STATEWIDE INFANT SCREENING – HEARING (SWISH) PROGRAM (GL2010_002)

PURPOSE

This document sets out guidelines for the SWISH program including screening protocols and referral pathways. In doing so, the guidelines describe roles and responsibilities of staff; equipment and protocols for screening, coordination, audiological assessment and paediatric medical assessment.

Technology is available to diagnose hearing problems in the neonatal period. Early identification and intervention are important, with research suggesting that intervention commencing by 6 months of age may result in optimal speech and language development and minimise the need for ongoing special education.

KEY PRINCIPLES

The Guidelines outline the responsibilities each stage has in the hearing screening pathway.
Each Area Health Service (Area or AHS) has a SWISH Coordinator responsible for implementing and managing the screening program across all facilities in their Area. This model allows SWISH Coordinators flexibility to meet unique needs in their Area Health Service. SWISH Coordinators have adopted innovative approaches to ensure maximum screening capture such as service agreements with private hospitals and employing dedicated screeners to meet local needs (eg. Indigenous and Culturally and Linguistically Diverse (CALD) populations). (Chapter 2 & 3)

SWISH diagnostic audiology services are provided through the three tertiary paediatric hospitals which are the acute care hubs of the three paediatric services networks which cover the state (Greater Western, Northern and Greater Eastern and Southern). These hospitals are:

- The Children's Hospital at Westmead;
- John Hunter Children's Hospital, Newcastle; and
- Sydney Children's Hospital, Randwick.

Jim Patrick Audiology Centre is used as an overflow site for unilateral referrals in the Greater Western service network. Jim Patrick Audiology Centre is part of the Royal Institute of Deaf and Blind Children. (Chapter 4)

All referred newborns receive an audiological assessment. If a hearing loss is detected medical assessment and family support is available. A child who is diagnosed with hearing loss in the program could be referral to *Australian Hearing,* SWISH Hearing Support Services and other medical specialists. (Chapter 5)

If diagnosed as having hearing impairment, newborns are provided with options available for intervention services appropriate to the degree of hearing loss and specific diagnosis. Support is provided by the diagnosing Audiologist and SWISH Parent Support (Social Worker) in assisting parents to make the decisions. Parents are also consulted about early intervention, eg. hearing aids, cochlear implant and educational programs. (Chapter 6)

USE OF THE GUIDELINE

The Guidelines of the Statewide Infant Screening - Hearing (SWISH) program are to be used by staff working specifically within the following roles of the NSW Statewide Infant Screening - Hearing program both in public and private sectors.

- Screening Staff (Chapters 2 and 3)
- Area Health Service SWISH Coordinators (Chapters 2 and 3)
- SWISH Diagnostic Audiologists (Chapter 4)
- SWISH Paediatricians (Chapter 5)
- SWISH Parent Support (Social Workers) (Chapter 6)

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2010/GL2010_002.html

SAFETY AND WELLBEING OF CHILDREN AND ADOLESCENTS IN NSW ACUTE HEALTH FACILITIES (PD2022_053)

PD2022_053 rescinds PD2010_032, PD2010_033, PD2010_034

POLICY STATEMENT

NSW Health recognises that the physical, developmental, social and emotional needs of children and adolescents change over time, are unique and are different to the needs of adults. Children and adolescents are among the most vulnerable groups in healthcare settings.

NSW acute health facilities must provide care in line with children and adolescent's individual needs, capabilities, maturity and independence; consider the different risks of harm and have strategies in place to mitigate them.

SUMMARY OF POLICY REQUIREMENTS

The promotion of safe, reliable, and effective patient centred care for children and adolescents is underpinned by the following principles as described in the Charter on the Rights of Child and Young People in Healthcare Services in Australia.

Children and adolescents being cared for in NSW Hospitals can expect:

- the highest attainable standard of healthcare
- equity of access and care for vulnerable population groups including Aboriginal peoples, people who live in rural and remote areas, culturally and linguistically diverse (CALD) communities, people with mental illness, children with intellectual or physical disability and those from socio-economically disadvantaged areas
- their best interests are the primary concern of all involved in their care care provided in line with their developmental stage and ability
- to be kept safe from all forms of harm
- care that supports their gender identity and expression trauma-informed care
- to be able to express their views, and to be heard and taken seriously
- respect for Aboriginal cultures, including recognition that health refers to social, emotional and cultural wellbeing
- respect for themselves as a whole person, as well as respect for their family and the family's individual characteristics, beliefs, culture and context
- to have their family relationships supported by the service providing care information to be provided in a form than is understandable to them
- to participate in decision-making and, as appropriate to their capabilities, to make decisions about their care
- to have their privacy respected
- to participate in education, play, creative activities and recreation
- continuity of healthcare, including well-planned care that takes them beyond the paediatric context.

Local Health Districts and Speciality Health Networks must communicate the information contained within this Policy to relevant facilities and staff; and ensure that consistent local policies are developed and distributed to relevant clinical areas.

Local Health District Chief Executives are responsible for assigning responsibility, personnel and resources to implement this Policy; establishing mechanisms to ensure the mandatory requirements are applied, achieved and sustained. Chief Executives are also responsible for ensuring that any local policy reflects the requirements of this policy and is written in consultation with the hospital executive, clinical governance unit and clinical staff.

1. BACKGROUND

This document was written in consultation with a reference group of clinical experts. Extensive statewide consultation informed further changes to the document.

This document includes:

- principles underpinning the care, safety and wellbeing of children and adolescents
- standards for the provision of clinical care
- standards for safety.

These principles and standards are essential components that enable NSW hospitals to provide care in the right place, at the right time, as close to home as possible.

1.1 About this document

The purpose of this Policy is to promote the safety and wellbeing of children and adolescents in NSW hospitals and acute health services.

This Policy applies to all acute health facilities where paediatric and adolescent patients are cared for. It mandates standards to ensure children and adolescents receive safe and appropriate care whilst in acute facilities.

This Policy must be followed by all organisations delivering acute health services. It is the responsibility of Local Health Districts / Speciality Health Networks to:

- communicate the information contained within this Policy to relevant facilities and staff; and
- adhere to and implement this Policy.

1.2 Key definitions

Admitted patient	An admitted patient is a person: (i) whom a clinician with admitting rights to the facility has determined meets the admission criteria (ii) has undergone the admission process (iii) has not been separated by the facility. A patient treated solely within the ED is not an admitted patient.
Child and Adolescent under Assumption of Care Order	A child or adolescent who has been removed from the care of their parents/carers and their care has been assumed by Department of Communities and Justice.
Child and adolescent	For the purpose of this Policy, a child and adolescent is defined as aged up to their 16th birthday. This Policy recognises that the needs of children and adolescents change with their age and developmental stage.
Paediatrics	The branch of medicine centred on the health and medical care of children and adolescents until transition to adult health services.
Parents/carers	Parents and carers is a broad term including those who are closest to the patient in knowledge, care and affection, for example parents, siblings, grandparents, aunts, uncles, cousins, friends, kin and carers. It also includes guardianship arrangements and extended familial relationships and kinship relationships for Aboriginal communities.

NSW Hospitals and Acute Health Services	This Policy covers health facilities and services where children and adolescents are treated and where the primary clinical purpose or treatment goal is to: • cure illness or provide definitive treatment of injury • perform surgery (other than when the exceptions documented in the included guidelines apply) • relieve symptoms of illness or injury • reduce severity of an illness or injury • perform diagnostic or therapeutic procedures, and/or • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function. This policy includes Children's wards or units in NSW Hospitals and other areas in NSW Hospitals and outpatient services that treat children and adolescents. It does not include community health services.
Mature Minor	A minor who has a sufficient level of understanding and intelligence to enable them to understand fully what medical or healthcare treatment is proposed. Mature Minors may independently consent to or refuse medical or healthcare treatment (see the NSW Health Consent to Medical and Healthcare Treatment Manual). There is no set age at which a child or young person is capable of giving consent. It depends upon the treatment being proposed and the minor's ability to fully understand the implications of that treatment. The term Mature Minor is interchangeable with the term Gillick Competent. A court may still override a Mature Minor's consent to or refusal of treatment in the Mature Minor's best interests.
Paediatric admission	A paediatric admission refers to children and adolescents under 16 years of age. Adolescents aged 16 years and older will usually be admitted to an adult ward or hospital. By exception, some 16 and 17 year olds may be admitted to a children's ward/hospital following negotiation, including older adolescents who have not completed transition to adult health services for chronic or complex care.
Paediatric safe bed or environment	A safe bed or space is an environment which meets the physical, developmental, social and emotional needs of children and adolescents.
Safety	Avoidance of harm to patients from the care that is intended to help them, this includes consideration of harms in regard to: • cultural safety • medication safety • mental health safety • emotional safety • sexual safety • online safety • physical safety • infection prevention and control.
Transition	The purposeful planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult oriented health care systems.
Trauma informed care	Trauma-informed care recognises the impact that traumatic events have on a child or adolescent's wellbeing. Trauma informed care involves: • understanding the impact of trauma on children and the family • providing care in a place that is physically and emotionally safe

	• ensuring the workforce is culturally competent and can implement practices that are respectful of cultural backgrounds • helping children and adolescents who have been victims of trauma regain control of their day-to-day lives. • including communities in governance processes and decision-making about the design of services.
Zero tolerance	A zero-tolerance approach means that as far as reasonably practicable action will be taken to prevent violence. Appropriate action will be taken to protect staff, patients and visitors from the effects of violence, while ensuring clinical services continue to be provided in a way that maximises the safety of patients, staff and others. Action may include both clinical and / or non-clinical interventions as appropriate.

1.3 Legal and legislative framework

NSW Hospitals and Acute Health Services have statutory obligations regarding the care and protection of children and young people under the Children and Young Persons (Care and Protection) Act 1998.

For more information about other legal obligations with regards to the safety and wellbeing of children, please refer to relevant Policy Directives, or contact the Legal Branch at NSW Health for assistance.

2. CLINICAL CARE

Services must align with the eight standards outlined in the National Safety and Quality Health Service Standards.

2.1 Alignment with role delineation and service capability

NSW Hospitals must provide a defined scope of services as described in the NSW Health Guide to the Role Delineation of Clinical Services.

All NSW Hospitals must provide clinical services in line with the facility's scope of services for paediatric medicine and surgery for children and adolescents.

The NSW Health Guide to the Role Delineation of Clinical Services describes the minimum support services, workforce and other requirements for clinical services to be delivered safely. Service capability describes the planned activity and clinical complexity that a facility is capable of safely providing.

The NSW Health Guideline *NSW Paediatric Services Capability Framework* (GL2017_010) identifies the scope of planned activity for each paediatric service capability level and supports the provision of high quality, safe and timely care for infants, children and adolescents as close to home as possible.

Suggested links and reading

Charter on the Rights of Children and Young People in Healthcare Services
Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) Standards User guide for acute and community health services organisations that provide care for children
Integrated Prevention and Response to Violence, Abuse and Neglect Framework The first 2000 Days Framework
NSW Youth Health Framework 2017-24

2.2 A Networked Approach

NSW Health services must use appropriate networks to support the provision of high-quality healthcare across NSW as close to home as possible. There are a range of networks including the NSW Children's Healthcare Network, the Agency for Clinical Innovation Paediatric Network and other relevant peer networks.

Suggested links and reading
The Children's Healthcare Network The ACI Paediatric Network
The ACI Network Pages

2.3 Triage and Assessment in Emergency Departments

Triage is an essential function in Emergency Departments (EDs) and ensures that patients are treated in the order of their clinical urgency with reference to their need for time-critical intervention.

EDs must comply with the NSW Health Policy Directive *Triage of Patients in NSW Emergency Departments* (PD2013_047) which outlines the role, key responsibilities and the processes that support efficient and safe triage.

Following triage, the NSW Health Policy Directive *Emergency Department Patients Awaiting Care* (PD2018_010) outlines the requirements for communication, the environment, recognition of deterioration and commencement of clinical care.

Suggested links and reading
Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments
The ACI: Paediatric Network Resources

2.4 Recognising and Responding to Deteriorating Patients

NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018) mandates that local systems, structures and processes must be in place to support the recognition, response to and management of the physiological and mental state deterioration of patients.

Clinicians who provide care for children and adolescents must understand the clinical differences between deteriorating children, adolescents, and adults. This includes training in the recognition of the sick and deteriorating child or adolescent.

All NSW Hospitals must ensure all staff are made aware of the local Deteriorating Patient Safety Net System, including how to activate their local Clinical Emergency Response System (CERS), and their roles and responsibilities under the system. This includes
R.E.A.C.H. (Recognise, Engage, Act, Call, Help is on its way) for patients and parents/carers to escalate concerns about changes to a patient's condition.

All clinicians who provide direct patient care must complete the mandatory Between the Flags - Deteriorating Patient Learning Pathway training, including the Paediatric patient module.

2.5 Plan of Care

Paediatric patients in a hospital must have a clearly defined and documented treatment plan of care that includes:

- the name and contact details of the Attending Medical Officer (AMO) a diagnosis (provisional or definitive)
- a treatment plan consistent with clinical practice guidelines a plan for hydration, nutrition and fluid balance
- observation type and frequency, outline in the deteriorating patient policy expected frequency of clinical review and estimated date of discharge, and
- changes in patient condition aligned with the deteriorating patient policy.

A comprehensive and contemporaneous record of care must be documented in the patient's health record with changes in condition noted at the time they occurred including actions taken.

The process of care planning must reflect the preferences of the child, the adolescent, and their parents/carers and:

- be tailored to children and adolescents' individual needs
- consider the need for attachment, which allows a patient to connect with and gain reassurance from their parent/carer during times of need or distress
- involve the planning for continuity of care after admission.

All children and adolescents admitted to NSW Hospitals must have a risk screen completed to identify, escalate, and manage risks or concerns.

Clinicians must consistently use the risk screening and assessment approaches and processes as directed by state, district or network, and facility policies.

Districts, networks and facilities must facilitate access to validated screening tools and provide clinicians with clear pathways to follow when screening to identify need for further assessment and planning of risk mitigation strategies.

Suggested links and reading

Paediatric Clinical Practice Guidelines
NSW Health Information Bulletin *Paediatric Clinical Guidelines* (IB2020_041)
Australian Commission on Safety and Quality in Health Care, The National Safety and Quality Health Service (NSQHS) Standards
Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) Standards User guide for acute and community health services organisations that provide care for children
CEC: Fall and entrapment prevention

2.6 Escalation of Care

NSW Hospitals must have escalation plans in place to ensure the appropriate accommodation of a sick or injured child and/or adolescent, in accordance with NSW Health Policy Directive *Critical Care Tertiary Referral Networks (Paediatrics)* (PD2010_030) and NSW Health Policy Directive *Emergency Paediatric Referrals* (PD2005_157).

2.7 Consultation with on-call Specialists

General Practitioners who admit children or adolescents under their care must contact the local or regional paediatrician within 12 hours of admission to develop a collaborative plan for ongoing management. Consultation is required daily thereafter, or when there is handover to a new admitting doctor.

Consultation is required at any time when there is deterioration, inadequate response to treatment, diagnostic uncertainty or activation of the Clinical Emergency Response System (CERS) by staff, the patient or family/carer. Clinicians must refer to the local facility's CERS which outlines the requirement for response to a deteriorating patient within its care. The local CERS must include the escalation process for transferring patients that require higher- level care to a facility that can provide it.

Decisions regarding inpatient care for children and adolescents with mental health problems must be determined in line with the NSW Health Policy Directive *Children and Adolescents with Mental Health Problems Requiring Inpatient Care* (PD2011_016).

2.8 Workforce

Children and adolescents must be cared for by staff with appropriate skills, experience and qualifications to meet their physical, psychological, developmental, communication and cultural needs.

Staff caring for children and adolescents must have completed statewide and Chief Executive directed mandatory training requirements for clinical staff who provide care for children and adolescents. The mandatory training Matrix and Targeting Guide provides an overview of mandatory training requirements.

Completion of Health Education and Training Institute (HETI) core training modules in paediatric resuscitation, recognition of the deteriorating patient, child protection training, and, for staff administering medication, paediatric medication safety training, are recommended. Staff caring for children and adolescents must keep up to date with any changes to the mandatory training requirements.

All wards/units/departments must have access to clinical education.

There must be a nurse/midwife with appropriate experience in the In Charge of Shift role where a Nurse Unit Manager is absent. To ensure safe systems of work and patient safety, staffing should be determined by consideration of:

- requirements for paediatric drug checking and various other patient-related procedures
- the number and acuity of the patients within each ward, unit and department within a clinical service
- the skill level of nurses required to provide care.

Suggested link
Public Health System (Nurses' and Midwives') State Award

2.9 Improving Access to Care

To ensure children and adolescents receive the right care, at the right time, closer to home, NSW Hospitals must:

- provide a range of modalities of care to support the provision of child and adolescent care (this may include but is not limited to Hospital in the Home (HITH), outpatient and ambulatory care clinics, and virtual care, also known as telehealth)
- provide access to appropriate specialist staff and facilities in line with and networking arrangements and service capability.

Suggested reading
NSW Health Guideline *Adult and Paediatric Hospital in the Home Guideline* (GL2018_020)

2.10 Outpatient Care

Outpatient services for children and adolescents must be provided in line with the NSW Health Guideline *Outpatient Services Framework* (GL2019_011) and ensure the provision of youth friendly services for adolescents as outlined in the NSW Health Policy Directive *NSW Youth Health Framework 2017-24* (PD2017_019).

2.11 Continuity of Care

Systems must be in place to ensure continuity of healthcare, including:

- coordination between and within the various services working with children, adolescents and their parents/carers
- continuity across different geographically locations post discharge care
- appropriate planning for transition to adult services for those with chronic/long term health issues.

Suggested links and reading
NSW Health Policy Directive Departure of Emergency Department Patients (PD2014_025) CEC: Safety Huddles

3. SAFETY PROCEDURES

3.1 Safety of children and adolescents whilst in care

NSW Hospitals must ensure the safety of children and adolescents in terms of the following:

- cultural safety
- medication safety
- mental health
- safety emotional safety
- sexual safety
- online safety
- physical safety
- infection prevention and control.

All children and adolescents must be located in a paediatric safe bed regardless of the availability of a paediatric ward or unit.

A paediatric safe bed is a bed, located anywhere within a facility (including ED, imaging or a general ward or unit), that meets the criteria for ensuring the safety of the child and adolescent in line with the following principles.

Children and adolescents must be:

- cared for in a safe and appropriate environment that meets their physical, developmental, cultural and psychosocial needs
- easily observed and supervised at all times
- protected as much as possible from the sights and sounds associated with adult care in areas outside of designated paediatric wards, including EDs, Radiology, Operating Theatres and Recovery
- safe from harm from other patients, parents/carers and staff
- cared for by appropriately trained and skilled staff with access to ongoing professional development, current clinical guidelines and timely clinical guidance and advice
- communicated with and listened to in a manner that enables understanding and respect

NSW Hospitals that provide care to children and adolescents must:

- allocate the necessary workforce capacity to meet the needs of patients
- facilitate access to an Aboriginal Health Worker for cultural consideration for Aboriginal children and adolescents
- implement screening, supervision and training to staff to ensure children and adolescents are free from harm
- ensure the individual characteristics, beliefs and cultural contexts of the child, adolescent and their parents/carers are respected
- ensure that Healthcare interpreter services are available and offered to all children, adolescents and their families who do not speak English, or speak English as a second language
- facilitate support for children and adolescents from parents/carers, including the ability for a parent/carer to be accommodated with the child or adolescent
- enable patients to be partners in their own care, to the extent that they choose
- ensure that children, adolescents and their parents/carers are provided with information about their health care that takes into account their level of health literacy
- provide appropriately sized medical equipment, furniture and amenities
- ensure that painful procedures do not occur within a child or adolescent's bed space unless it is an emergency, there are infection concerns or moving the patient will cause more distress
- provide care and support to children, young people, parents/carers to minimise pain, anxiety and distress associated with treatment and procedures

- ensure compliance with NSW law on obtaining consent to medical treatment from patients or their substitute consent providers in line with the NSW Health Consent to Medical and Healthcare Treatment Manual. This includes enabling consent to treatment by mature minors (see definitions) who have the capacity to understand fully what medical or healthcare treatment is proposed.
- Where there are separate paediatric areas within EDs, they must remain available for children or adolescents.

Suggested links and reading

NSW Health Policy Directive *Responding to Sexual Assault (adult and child) Policy and Procedures* (PD2020_006)

NSW Health Policy Directive *Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services* (PD2013_038)

NSW Health Policy Directive *Infection Prevention and Control Policy* (PD2017_013) CEC: Medication Safety
Standard 4: Medication Safety, Safety and Quality Improvement Guide Office of the Children's Guardian: Child Safe Standards
CEC: Paediatric Cot and Bed Allocation Guide (CaBAG) ACI: Transition Care Network
Sydney Children's Hospitals Network: TRAPEZE

3.2 Cultural safety

NSW Hospitals must have strategies in place to ensure access to safe and holistic healthcare that supports Aboriginal peoples and people of culturally and linguistically diverse (CALD) backgrounds as partners in their own care.

NSW Health staff must have an understanding of health equity. Staff must provide healthcare that is responsive to the needs of Aboriginal and CALD children, adolescents and their families. All children, adolescents and their families who do not speak English, or speak English as a second language must be offered a NSW Healthcare Interpreter.

Section 2, Part F of the NSW Health guide to the role delineation of clinical services, outlines the levels of complexity for Aboriginal health services provided within any service level.

Suggested links and reading

NSW Health Guideline *Communicating positively: A guide to appropriate Aboriginal terminology* (GL2019_008)
The Aboriginal Cultural Engagement Self-Assessment Tool
National Standards user Guide for Aboriginal and Torres Strait Islander Health
NSW Health Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023 Refugee health policy
NSW Health guide to the role delineation of clinical services

3.3 Co-location of Adults with Children or Adolescents

The safety of the child or adolescent must be the primary consideration in decisions about co-location of adults and children/adolescents.

In a paediatric ward there must be only child and adolescent admissions.

Where there is an exceptional need for the child/adolescent to be cared for outside a paediatric ward for example in an intensive care unit, maternity unit (for the purposes of delivering), or a mental health unit, they must be in a paediatric safe bed (see Section 3.2).

In all exceptional circumstances a decision about where to admit the patient must be made by the paediatrician or senior clinician, be documented in the clinical notes, and reviewed for safety factors within 24 hours.

To protect children and adolescents from unwanted exposure, including casual overlooking and overhearing:

- children/adolescents must have separate bathrooms (no shared bathroom facilities with adults)
- adult patients must not pass through areas caring for children to reach their own facilities
- children/adolescents must not be required to pass through an adult ward or unit to access facilities
- appropriate security measures must be installed where appropriate, for example secure doors with swipe card access.

3.4 Child Protection

NSW Hospitals must undertake mandatory child related screening of employees and ensure all staff who care for children and adolescents receive education and training about the protection of children and adolescents.

NSW Hospitals must ensure that all staff are aware of and comply with their responsibility to protect the health, safety and wellbeing of children and adolescents as outlined in the Child Wellbeing and Child Protection Policies and Procedures for NSW Health.

NSW Health staff must follow the Child Wellbeing and Child Protection Policies and Procedures for NSW Health. This includes:

- use of the decision tree in the Mandatory Reporters Guide (MRG) to decide when to report and what to report in relation to child protection concerns
- consultation with the NSW Health Child Wellbeing Unit mandatory reporting
- documentation and information exchange as per the Child Wellbeing and Child Protection Policies and Procedures for NSW Health.

Suggested links and reading

NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007)

NSW Health Policy Directive *Domestic Violence: Identifying and responding* (PD2006_084) Mandatory Reporter Guide
Mandatory Reporters: what to report and when About
Child Protection and Wellbeing
Children's Guardian Act 2019: Part 4 - Reportable Conduct Scheme

Chapter 16A of the Children and Young Persons (Care and Protection) Act

3.5 Children or Adolescents under Assumption of Care Orders

Where the Department of Communities and Justice (DCJ) have assumed care responsibility of a child or adolescent in accordance with the Children and Young Persons (Care and Protection) Act 1988 and they are in a NSW Hospital, the Hospital must comply with the child wellbeing and child protection procedures for NSW Health. Section 9.9 *Assumption of Care Responsibility of a Child or Young Person by Community Services on Health Premises.*

Suggested reading

NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007)

3.6 Children and Adolescents leaving the ward or being discharged from hospital

NSW Hospitals must have systems in place to ensure that when children and adolescents leave a ward or unit that they are accompanied by an appropriate parent/carer, and that their whereabouts (including time of departure and return) is known and documented.

Systems must also be in place to ensure that when children and adolescents are discharged from hospital that they are accompanied by an appropriate parent/carer.

3.7 Management of Violence and Aggression

NSW Health facilities must maintain a zero-tolerance approach to violence and establish work systems and environments that enable, facilitate and support the zero-tolerance approach.

This includes a zero-tolerance approach to violence perpetrated by patients and others against staff, patients or visitors. Hospital managers must exercise their responsibilities in relation to preventing and managing violence, in line with NSW Health Policy Directive *Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach* (PD2015_001).

As part of the ongoing management of work health and safety risks, all NSW Hospitals must have in place a violence prevention program that focuses on the elimination of violence related risks.

3.8 Children and adolescents with acute behavioural or mental health problems

NSW Hospitals admitting children and adolescents for acute mental health care must comply with the NSW Health Policy Directive *Children and Adolescents with Mental Health Problems Requiring Inpatient Care* (PD2011_016) and the Mental Health Act 2007.

NSW Hospitals must:

- apply the principle of least restrictive care
- maximise the child or adolescent's choices, rights and freedom as much as possible whilst balancing safety (people accessing services, staff and others) and health care needs
- ensure consultation with an appropriate clinician if assessment and management is required
- ensure staff providing care have the appropriate knowledge, skills and capabilities to work with children and adolescents with acute behavioural or mental health issues. This includes completion of all mandatory training required to work with people experiencing mental health problems.

NSW EDs must have a Safe Assessment Room – a clinical area designed to accommodate the needs of patients with, or at risk of developing Acute Severe Behavioural Disturbance (ASBD), who require assessment in a therapeutically supportive environment.

Seclusion and restraint must only be considered as a last resort after less restrictive alternatives have been trialled or considered and the safety of staff must be maintained at all times in accordance with NSW Health Policy Directive *Seclusion and Restraint in NSW Health Settings* (PD2020_004).

Suggested links and reading

NSW Health Guideline *Management of patients with Acute Severe Behavioural Disturbance in Emergency Department* (GL2015_007)

Provision of Trauma Informed Care

3.9 Facilities for parents and carers

Facilities for parents/carers to stay nearby to their child or adolescent must be provided, for example a lounge chair or folding bed in the ward or unit or a chair in ED. Allowing parents/carers to stay with their child or adolescent in hospital has a positive impact on the child and parent/carer stress and increases the child or adolescent's coping ability.

NSW Hospitals must:

- make it possible for a parent/carer to always remain with their child or adolescent. The only circumstance in which this does not apply is for exceptional cases where the adolescent states they do not want their parent/carer to remain with them. In such cases a decision must be documented in the clinical notes and regularly reviewed with the adolescent.
- Provide amenities to facilitate the comfortable stay of parents/carers at the child or adolescent's bedside.
- Facilitate culturally appropriate arrangements to support Aboriginal children and adolescents.
- Orientate parents/carers to the relevant areas within the facility and relevant practices to enable them to safely assist with the basic care needs of their child/adolescent.
- Notify parents/carers of any pending transfer arrangements for their child/adolescent.
- Ensure that parents/carers of children and adolescents requiring surgery are able to accompany their child/adolescent to the operating theatre and have access to the recovery room.
- Ensure parents/carers are able to be present at the induction of anaesthesia for children and adolescents, and allowed into recovery as soon as possible.

Additional facilities for the parents/carers that must be provided are:

- facilities for nutrition, such as a kitchenette with fridge and microwave
- facilities for breastfeeding and for breast milk storage
- access to amenities such as a shower, toilet and washing facilities.

Suggested links and reading

NSW Health Guideline *Safe Assessment Rooms* (GL2020_001)
Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) Standards User guide for acute and community health services organisations that provide care for children

3.10 Gender Specific Accommodation

The needs and preferences of adolescent patients must be sought, recorded and respected, regardless of their sexuality, gender identity or intersex variations.

Bathroom facilities do not need to be designated as gender specific as long as they accommodate only one patient at a time and can be locked by the patient (with an external override for emergency use only).

Parents/carers accompanying children must use adult visitor bathroom facilities, except where their child or adolescent is in a single room with an en-suite bathroom.

Suggested reading

NSW LGBTIQ+ Health Strategy 2022-2027, Implementation Plan 2022-2027 and Summary of Evidence

3.11 Safe and Appropriate Transfers

NSW Hospitals must ensure the safe and timely transfer of children and adolescents whose medical condition requires care at a different level from that of the presenting hospital in line with NSW Health Policy Directive *Children and Adolescents – Inter-Facility Transfers* (PD2010_031).

When transporting children and adolescents around the hospital they must not be left unattended at any time. If the child or adolescent is acutely unwell or post-operative an appropriate clinical escort must be provided.

3.12 Transition of care

Health services must have a formal transition process in place to transition adolescents to adult services, in line with the principles outlined within Key Principles for Transition of Young People from Paediatric to Adult Health Care.

Facilities that manage children and adolescents with chronic conditions must identify a person within the patient's clinical team to act as a transition coordinator/facilitator. This person may be any member of the multidisciplinary team.

Their role is to identify children and adolescents, ensure that they receive education packages and are referred to appropriate services such as Trapeze and ACI Transitional Care Coordinators.

GUIDELINES FOR HOSPITALS AND MATERNITY STAFF IN THEIR RESPONSE TO PARENTS CONSIDERING THE ADOPTION OF THEIR CHILD (PD2005_545)

PD2005_545 supersedes circulars 82/296 and 82/297, Health Commission Policy on Adoption.

This is a circular for the NSW Health system that outlines principles and guidelines for hospitals and maternity staff in their response to parents considering the adoption of their child. These guidelines are being issued to ensure that current legislation is complied with and contemporary good practice principles are followed.

Local policies and protocols of public health organisations should be updated to reflect these guidelines. These guidelines are also recommended to private health care facilities for general use as a standard of good practice.

These guidelines are particularly relevant to and should be specifically noted by the following NSW Health staff:

Maternity services - nursing, medical and allied health staff;
Paediatricians and Paediatric Registrars;
Hospital Social Workers;
Medical Records Staff to note section 3.7 of the Guidelines.

The NSW Department of Community Services is currently preparing new adoption legislation which will repeal, replace and consolidate the *Adoption of Children Act 1965* and the *Adoption Information Act 1990*. In addition, it is anticipated that the new *Children and Young Persons (Care and Protection) Act 1998* will be proclaimed in the second half of 2000, and will replace the *Children (Care and Protection) Act 1987*. This circular has been written to reflect the directions of this new legislation. Following the proclamation of these new Acts this circular will be reviewed and updated.

GUIDELINES FOR HOSPITALS AND MATERNITY STAFF IN THEIR RESPONSE TO PARENTS CONSIDERING THE ADOPTION OF THEIR CHILD

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GUIDELINES FOR HOSPITALS AND MATERNITY STAFF IN THEIR RESPONSE TO PARENTS CONSIDERING THE ADOPTION OF THEIR CHILD

1. PRINCIPLES

1.1 Parents considering offering their expected or newly born child for adoption, should be accorded and advised of the same rights, privileges, responsibilities, treatment/s, information and support services as any other parent in the hospital. Parents should be cared for with sensitivity and in a non-judgemental manner.

1.2 As adoption severs a child's legal relationship with his/her family of birth, it is important that parents are informed of all alternative care options for their child and are assisted to consider these options. Adoption is one of the placement options for parents who do not wish or are unable to care for their child. It is the most radical form of substitute care for a child.

1.3 Parental choice throughout the process is to be respected. Parents should at all times be the ones to make the decisions about contact with, feeding and care of the baby. The decisions of the parent/s may change over time. For example, the decision to adopt is not always made antenatally, or if considered antenatally may change following birth of the baby. It is also useful to recognise that at any one point in time a parent may be ambivalent about adoption, that is have diverse feelings simultaneously.

1.4 The rights of both the child's parents to participate in decisions concerning the child should be taken into account.

1.5 Parental wishes for confidentiality regarding a decision about adoption of their child are to be respected by health professionals.

1.6 Parents are the legal guardians of their child, unless a Court has removed their parental responsibilities or made them joint guardians with a third party. Consent to medical treatment for the child is to be given by the child's legal guardian. NSW Health PD2005_406 department's policies in relation to consent to medical treatment and the provision of information to patients.

1.7 The parents of the child have the right to name the child. The name given to the child by the parents is the child's legal name and should be used to identify the child. However, that name may be changed by legal processes.

1.8 Unless specified in the medical report form required by the *Adoption of Children Act 1965*, a baby for adoption does not require any specific tests as a result of the adoptive process. The baby should receive the routine screening tests and any other that are medically indicated.

1.9 The loss experienced by parents through the adoption of a child may be profound and lifelong. Feelings of grief and loss may be accompanied by significant distress. Affected parents should be offered appropriate support and comfort. Follow-up counselling should be offered for persistent or severe distress or those at highest risk (eg poor social support, a history of significant losses or mental health problems) with identified pathways to specialist mental health care if required.

2. DEPARTMENTAL ROLES AND RESPONSIBILITIES

2.1 NSW Health System

2.1.1 The role of NSW Health staff is to ensure that the health needs of mother and baby are met. The aim is to ensure the best physical and emotional health outcome for the family. NSW Health staff also provide health care and assessment of the child. Information about the child is provided to the Department of Community Services or licensed private adoption agency.

2.1.2 While the mother and baby are the primary focus of the maternity service, the role of the father and extended family is also to be acknowledged and accommodated in the provision of care and support.

2.1.3 The NSW Health system has no role in arranging adoption or witnessing adoption consent.

2.2 Department of Community Services and licensed private adoption agencies

2.2.1 The Department of Community Services and the licensed private adoption agencies are the only bodies authorised to make adoption arrangements.

Making adoption arrangements involves:

- counselling which will include assisting the parents to explore their reasons for considering adoption, explaining alternatives to adoption and ensuring their understanding of the effects of an adoption order;
- witnessing consent;
- preparing the adoption plan;
- placement of the child;

and, facilitating the appropriate provision of:

- ongoing counselling and support for parent/s following consent;
- follow up for grief and loss issues of the parent/s and family.

2.2.2 Once all required consents to the child's adoption have been given by the parent/s, or dispensed with by the Court, the Director-General of the Department of Community Services becomes the legal guardian of the child. This includes cases where the adoption arrangements are being made by a private licensed adoption agency.

2.2.3 The Department of Community Services and the licensed private adoption agencies can make arrangements for the temporary care of the child. Temporary care is usually arranged with the consent of the parents, who are encouraged to maintain regular contact with the child. For most infants the period of temporary care is likely to be of only several weeks duration to enable the parents to resolve their situation.

2.2.4 The maximum period usually available for temporary care is 6 months. The temporary care arrangement may be terminated at any time by the parents or the agency that made the arrangement (the Department of Community Services or the licensed private adoption agency, as the case may be).

3. LEGISLATIVE FRAMEWORK

3.1 General

3.1.1 Adoption practice is principally governed by the *Adoption of Children Act 1965* (ACA), the *Adoption Information Act 1990* (AIA), some sections of the *Children (Care and Protection) Act 1987* (CC&PA), and their respective Regulations.

3.1.2 The NSW Department of Community Services is currently preparing new adoption legislation which will repeal, replace and consolidate the *Adoption of Children Act 1965* and the *Adoption Information Act 1990*. In addition, it is anticipated that the new *Children and Young Persons (Care and Protection) Act 1998* will be proclaimed in the second half of 2000, and will replace the *Children (Care and Protection) Act 1987*.

3.1.3 Parents are the legal guardians of their child, unless a Court has removed their parental responsibilities or made them joint guardians with a third party. The Director-General of the Department of Community Services becomes the child's exclusive guardian under the adoption process when all consents to the child's adoption by a parent or guardian have been given or dispensed with by the Supreme Court.

3.2 Adoption

3.2.1 Adoption is a legal process which ends the legal relationship and responsibilities between the child and his/her parents and establishes a new legal relationship and responsibilities with the adoptive parents. (Section 35 ACA)

3.2.2 Adoptive placements of non-related children can only be arranged by the Department of Community Services or a licensed private adoption agency. Any other adoptive placement of a child with a non-related person is an unauthorised adoption placement and in breach of the Act. (Section 51 ACA)

3.2.3 Relative is defined in the adoption law as the grandparent, uncle or aunt of the child, whether by blood, adoption or marriage. (Section 6 ACA)

3.2.4 Once all required consents to the adoption have been given by the parents or guardians of the child, or dispensed with by the Supreme Court, the Director-General of the Department of Community Services becomes the exclusive guardian of the child and remains exclusive guardian until:

- the making of the adoption order or an order in lieu of adoption;
- the adoption consent(s) are revoked; or
- the Director-General terminates the arrangement, including the return of the child to the parents (Section 34 ACA);
- the Supreme Court makes an interim order that the child become a ward of the Minister (Section 34(4) ACA).

3.2.5 Adoption orders are made through the NSW Supreme Court.

3.3 Adoption Consent

3.3.1 The Department of Community Services or the licensed private adoption agency is responsible for making the arrangements for a qualified person, under the legislation, to witness the adoption consent.

3.3.2 For the mother of a child, consent to adoption may legally be given at any time on or after the fifth day of the child's birth. (Section 31 (2) ACA)

- for many women the consent to adoption is given at a time well beyond this minimum period;
- a mother may be discharged from hospital without her child when she is ready/medically fit, without signing an adoption consent.

3.3.3 The father of a child can give his consent at any time after the child's birth.

a) The legislative provisions relating to the involvement of a child's father in the adoption decision are complicated. Men who acknowledge their paternity should be accorded the right to be involved in decisions concerning their child, including the adoption decision. (*The Status of Children Act 1996*, Sections 26 and 31A ACA)

b) Clarification of the adoption consent requirements in respect of fathers should be sought from the Department of Community Services or the licensed private adoption agency. A father's consent to his child's adoption is definitely required if:

- the child was born of his marriage; or
- the child was born of his defacto relationship and the child is part of the household; or
- **the father has been appointed a guardian by a court and has custody of the child.**

3.3.4 For adoption consent to be valid and legal (Sections 29 & 31 ACA, Regulations 21-24):

a) It must not have been obtained by fraud, duress or other improper means.

b) The parent must understand the nature of the consent and be in a fit condition to give consent. For example: the parent should not be ill, receiving medication or treatment that could affect decision processes, or suffering an acute psychiatric condition.

c) When medical certification of the mother's fitness to consent is provided, consent to adoption can legally be given by a mother before the fifth day of the child's life. However this situation is highly unusual. Adoption consent cannot be signed before the birth of the child.

d) Consent must be given on the prescribed form and attested to by a qualified witness. Only certain categories of people are qualified in the *Adoption of Children Regulation* to witness a consent.

e) The qualified witness has certain obligations to fulfil under the Regulations before the parent can sign the consent. These are:

- to be satisfied of the identity of the person giving consent;
- **to ensure the parent received, at least 72 hours before signing consent, written information about the effect of giving consent and the rights of the parties concerned in an adoption;**
- to afford the parent ample opportunity to read the consent documents;
- to be satisfied the parent understands the effect of signing the consent; and
- if the parent is under the age of 16, before consent is given, a report of a registered psychologist, or other appropriate expert, is required of the capacity of the parent to understand the effect of signing an adoption consent.

3.3.5 Following consent, the period for a parent to revoke or withdraw their consent is 30 days. (Section 28 ACA)

a) Consent is revoked by the parent notifying in writing the Deputy Registrar of the NSW Supreme Court of their intention to revoke their consent.

b) A form for revocation is included in the parent's consent documents.

c) The Department of Community Services or the licensed private adoption agency will notify the parent of the impending expiry of the revocation period at least 7 days before its expiry. (ACA Regulation 26)

d) On revocation, the parent resumes their guardianship of the child.

e) If a parent has revoked their consent, but is unable to resume the care of their child, a temporary care agreement will need to be signed while the parent considers the child's future.

3.4 Leaving Hospital

3.4.1 Under Section 27 (2) of the *Children (Care and Protection) Act 1987* it is an offence for a person to permit a child, unless s/he is in the care of his/her mother, to be taken from hospital without the consent of the Director-General.

3.4.2 When the child is ready to leave hospital, if a parent is unable to care for the child and has not signed the adoption consent, temporary care arrangements should be made for the child by the Department of Community Services/licensed private adoption agency. The parent/s will be asked to sign a Temporary Care Agreement with the Department of Community Services or enter into a private fostering arrangement with a licensed foster care or private adoption agency.

3.4.3 If the parent/s have not signed adoption consent, do not agree to sign a temporary care arrangement and are unwilling to resume the care of the child, the child should be notified to the local office of the Department of Community Services.

3.4.4 Where the child is to be discharged to the care of a Department of Community Services temporary foster carer, the carer must provide the hospital with a letter containing the consent of the Director-General of the Department of Community Services to their care of the child and show identification. The letter and copy of the identification are to be placed on the child's hospital record.

3.4.5 Where a child is to be discharged to the care of a licensed private adoption agency carer, the carer must provide the hospital with a letter signed by the Principal Officer of the agency and show identification. The letter and copy of the identification are to be placed on the child's hospital record.

3.5 Contact

3.5.1 The adoption legislation does not place any statutory restrictions on the degree of contact a parent may have with their child in hospital.

3.5.2 As a general rule, prior to adoption consent the child's parent/s decide on the level of contact they wish with the child, whether the child is to room in with the mother, or be cared for in the nursery etc. However, if an assessment of risk for the child has led to the Department of Community Services assuming the care of the child under the *Children (Care and Protection) Act* (Section 62A), the level of contact should be determined by the Department of Community Services.

3.5.3 Once all required adoption consents have been given, because the guardianship of the child has changed, the level of contact should be negotiated between the parent/s, Department of Community Services/licensed private adoption agency and the hospital.

3.6 Registering the birth and naming the child

3.6.1 The *Births, Deaths and Marriages Registration Act* requires a parent to notify the Registry of the birth of a child within a month of the birth. Where the parents are not married to each other, the father's details can only be included on the registration if both parents sign the information form. Both parents should be encouraged to record their names.

3.6.2 If the child is subsequently adopted, this acknowledgment of a man's paternity will affect the rights of the adopted person and the father under the *Adoption Information Act 1990*. Acknowledgment of a man's paternity will allow the adoptee to receive identifying information about his/her father and the father will be able to access identifying information about the child.

3.6.3 The name given to the child by the parents is the child's legal name (unless changed as a result of an adoption order) and should be used to identify the child.

3.7 Records

3.7.1 The *Adoption Information Act 1990* (AIA) gives adopted persons, their birth parents and adoptive parents the right to certain information about themselves and each other. This includes their access to medical and social work records. The information that can be accessed is prescribed by the AIA.

3.7.2 Access by an adopted person to records related to his/her birth parent require the person to present a 'Supply Authority' from the Department of Community Services or a copy of their original birth certificate released under the AIA prior to June 1998.

3.7.3 Similarly a birth parent cannot access information from an adopted child's records without the appropriate authority.

3.7.4 Since the NSW *Archives Act 1960*, adoption records have been retained in the State Archives in perpetuity.

3.7.5 NSW Health PD2010_050, *Adoption Act 2000* - Release of Information, outlines guidelines to be followed in respect of adoption related enquiries to public hospitals.

4. HOSPITAL PRACTICE

4.1 Antenatal care

4.1.1 If adoption is being considered, the maternity/hospital social worker would normally be involved in the management and care of the woman. A referral to a social worker should be made following discussion and agreement by the woman/couple.

4.1.2 Information, education, support and counselling should occur regarding the birth plan and birthing process. A birth plan should be agreed so that the hospital is able to offer appropriate care. The birth plan is to include:

- the wishes of the parent/s regarding their involvement with the baby after delivery;
- who else is to be involved, eg the grandparents of the baby and other support people;
- how much contact they will have with the baby;
- memorabilia of the baby that may be wanted by the parents, eg photographs, hand/foot prints, cot cards, identification bands, the Blue Book.

4.2 Birth

4.2.1 Antenatal staff are to ensure the appropriate transfer of information to the delivery suite and postnatal ward to ensure that appropriate care in line with the wishes of the parent/s is provided. Confirmation of the birth plan is to occur, along with reassurance to the woman/ couple that they are able to alter the birth plan at any time so that their needs are met.

4.2.2 At delivery there should be no obstacle to the parent/s being shown or handling their child should they wish to do so, providing this is medically feasible.

4.2.3 Following the birth, the midwife usually informs the maternity/hospital social worker (if involved) that the baby has been delivered. The decision and timing of notification of the birth to the adoption agency is made by the parent/s who may wish to consult with and seek the assistance of the hospital social worker.

4.2.4 If no prior discussion has occurred between hospital staff and the woman/couple and adoption is discussed at this point in care (ie birth/postnatal) a referral to the maternity/hospital social worker should be made as soon as possible.

4.3 Consent to medical treatment of the child

4.3.1 Generally, the parent/s are the legal guardian/s of the child, parental consent to medical treatment or a Court order is required. However, in an emergency, medical practitioners may act without the consent of a parent or guardian (Section 20A, *Children (Care and Protection) Act 1987*).

4.3.2 If there is an arrangement in place for temporary care, consent to medical treatment may be provided by the Department of Community Services or the licensed private adoption agency as the case may be, if the consent of the parent/s is unable to be obtained (the Department of Community Services or licensed private adoption agency will obtain parental consent where possible).

4.3.3 If the Director-General of the Department of Community Services has become the child's legal guardian, consent to medical treatment is required from the Department of Community Services.

4.4 Postnatal care

4.4.1 The parent/s choose where the baby is to be cared for following the birth, that is rooming in with the mother or cared for in the nursery. The parent/s choose the degree of contact they have with the baby and whether the baby is breastfed.

4.4.2 If an assessment of risk for the child has led to the Department of Community Services assuming the care of the child under section 62A of the *Children (Care and Protection) Act 1987*, postnatal care of the child and the degree of contact between the child and the parent/s should be determined by the Department of Community Services.

4.4.3 The parent/s have the right to name the child and are responsible for completing the birth registration form. The baby is to be identified at all times by the name given by the parent/s.

4.5 Mementos

4.5.1 Having first obtained the permission of the parent/s, two sets of mementos of the baby such as photographs, hand/foot prints of the baby, cot cards, identification bands should be gathered and two Blue Books (Personal Health Records) issued.

4.5.2 Mementos of the baby and the Blue Book should be offered to the parent/s. If the parent/s do not want to take these mementos at this time, permission from the parent/s should be requested for the mementos to be forwarded the Department of Community Services/licensed private adoption agency to be held on file for the parent/s if requested in the future.

4.5.3 It is usual practice for the Department of Community Services/licensed private adoption agency to request mementos on behalf of the child. A set of these items is to be gathered for the child and forwarded to the Department of Community Services/licensed private adoption agency on request. Hospital staff should explain to the parents that these items are given to the adoptive parents to provide the child with mementos of his/her birth.

4.5.4 No identifying details other than the baby's first name should appear on the set of mementos and Blue Book provided to the adoptive parent of the child.

4.6 Discharge

4.6.1 Temporary Foster Care

4.6.1.1 The baby should leave the hospital for temporary foster care as early as practicable. The Department of Community Services or licensed private adoption agency arranges the temporary foster care and ongoing access of the parent/s to the child in consultation with the parent/s.

4.6.1.2 The Nurse Unit Manager or delegate is to be advised by the Department of Community Services/licensed private adoption agency when the foster parents will be coming to collect the baby. The Department of Community Services or licensed private adoption agency provide the foster parents with a letter giving consent for the child to be discharged into their care. Identification should also be provided by the foster parents. This letter and a copy of the identification is to be placed in the child's hospital record.

4.6.2 Medical Report Forms

4.6.2.1 There are two statutory medical reports to be completed on a child to be placed for adoption (Clause 19 *Adoption of Children Act Regulation*). These are *Medical Report following Birth of a Child* and *Medical Report on Child*. These forms are to be completed by the relevant medical officer prior to discharge and forwarded to the Department of Community Services or licensed private adoption agency. Copies of the medical report forms are attached.

4.6.2.2 Before a child's discharge from hospital, it is helpful for the relevant medical officer to provide a referral to an appropriate medical practitioner for ongoing medical examination and care of the child. This will assist the Department of Community Services or licensed private adoption agency to comply with the relevant Regulation in regard to ongoing medical care.

4.6.3 Discharge Planning

4.6.3.1 Prior to the child's discharge from the hospital, the foster parent/s are to be advised by hospital staff of their local Early Childhood Health Service and encouraged to access this service while the child is in their care.

4.6.3.2 Discharge planning should also address the health needs of the parent/s, including the physical and mental health needs. The maternity/hospital social worker may remain available to the parent/s and their family following discharge for follow up consultation. Other options for ongoing support should be identified in consultation with the adoption agency. Parent/s who are severely affected by loss may be vulnerable to (postnatal) depression and may require specific follow-up to monitor their mental health with access to appropriate treatment, if necessary.

4.6.3.3 Hospital staff should ensure that the mother is given appropriate advice and information on all aspects of the postnatal period - physiological and emotional. As well as social work support this should include:

- information and explanation about normal and abnormal physiological processes after child birth;
- an offer of domiciliary midwifery visits after discharge;
- information on who to contact if problems arise;
- information on the importance of arranging a 6 week postnatal visit.

5. ADOPTION SERVICES

A parent considering the adoption of their child may be referred for information about adoption and counselling to the NSW Department of Community Services or one of the private adoption agencies licensed to make arrangements for an infant's adoption.

The contact details for these agencies are:

Adoption and Permanent Care Section
Adoption Services Branch
NSW Department of Community Services
Level 13, 130 George Street
Parramatta NSW 2150
Telephone: 9865 5900, 9865 5911, 9865 5966, 9865 5974, 9865 5992.
Website: http://www.community.nsw.gov.au
Email**:** adoption@community.nsw.gov.au

Anglicare Adoption Services
19A Gibbons Street
Telopea NSW 2117
Telephone: 9890 6855
Facsimile: 9890 6899
Email: adoptions@anglicare.org.au

Centacare Adoption Services
9 Alexandra Avenue
Croydon NSW 2132
Telephone: 9745 3133
Facsimile: 9744 7123
Email: adoption@centacare.aust.com

Barnardos Find-a-Family Program is also a licensed private adoption agency, however provides services to children over the age of 2 requiring adoptive placement.

These organisations also have information, pamphlets and resources on adoption.

6. MEDICAL FORMS

Copies of the two statutory medical reports to be completed on a child to be placed for adoption (Clause 19 *Adoption of Children Act Regulation*) are attached:

- Medical Report following Birth of a Child
- Medical Report on a Child

ADOPTION OF CHILDREN ACT 1965
REGULATION 29 (1)

Medical Report Following Birth of Child

NAME OF CHILD: _____
Sex: _____

Date of child's birth: _____
Time of birth: _____

Place of child's birth: _____

Birth Weight: _____
Length at birth: _____

Head circumference at birth: _____

Evidence of developmental defect, injury, infection or other disability: _____

APGAR RATING: (see overleaf)

	Score	Code		
Heart rate		A - 9 to 10		(A
Respiratory effort		B - 7 to 8		(B
Muscle tone		C - 5 to 6	This baby is	(C
Colour of infant		D - 3 to 4		(D
Reflex irritability		E - 0 to 2		(E
Total				

MOTHER'S NAME: _____

Age: _____

Parity: _____

Height: _____

Ethnic group: _____

Serological tests for syphilis done on the mother in puerperium: _____

2. PAEDIATRICS **2.88**

Result: _____

_____

Details of labour and delivery:

_____

_____

GENERAL COMMENT: (The examiner's assessment of the child's physical status)

_____

_____

_____

Name and address of doctor: _____

Date of examination: _____

Signature: _____

APGAR RATING -- at one minute

Estimated exactly 1 minute after birth -- preferably by 2 observers:

HEART RATE = 0 = 1 = 2 0 = No beat seen, felt or heard 1 = Rate of under 100 2 = Rate 100-140		A heart rate of 100-140 is considered good and given a score of two, a rate of under 100 receives a score of one, and if no heartbeat is seen, felt or heard, the score is zero.
RESPIRATORY EFFORT = 0 = 1 = 2 0 = Apnoeic at 60 secs. (including one or more gasps, then apnoea) 1 = Irregular shallow ventilation 2 = Breathed and cried lustily		An infant who is apnoeic at 60 seconds after birth receives a score of zero, while one who breathes and cries lustily receives a two rating. All other types of respiratory effort, such as irregular, shallow ventilation are scored one. An infant who has gasped once at thirty or forty-five seconds after birth and who then becomes apnoeic, receives a zero score, since he is apnoeic at the time decided upon for evaluation.
MUSCLE TONE = 0 = 1 = 2 0 = Completely flaccid 1 = Poor tone 2 = Good tone, spontaneously flexed arms and legs		A completely flaccid infant receives a zero score and one with good tone and spontaneously flexed arms and legs, which resist extension, is rated two points.
COLOUR = 0 = 1 = 2 0 = Cyanosed deeply 1 = Slightly cyanosed 2 = Entire child pink		A score to two is given only when the entire child is pink.
REFLEX IRRITABILITY = 0 = 1 = 2 0 = No response 1 = Feeble cry 2 = Vigorous cry		Response to external stimuli-lactile or thermal.

ADOPTION OF CHILDREN ACT 1965
REGULATION 29 (1)

Medical Report on Child

(To be made wherever possible by a Paediatrician but where necessary by other examining medical practitioner.)

Note for the Guidance of Examining Doctor:

The examination is intended to provide a record, available to the adoptive parents, of the child's apparent mental and physical condition so that information which would have been available to them as natural parents and which may be of importance for the future welfare of the child, so far as practicable will be available. The doctor is not asked to give his opinion as to the suitability of the child for adoption.

NAME OF CHILD: _____
Sex: _____

Date of Birth: _____
Estimated Gestation: _____

Present Weight: _____
Present Length: _____

Present head circumference: _____

BEHAVIOUR: Startle reflex: _____

General activity and vigour: _____

Capacity to take feedings: _____

Abnormal behaviour or posture: _____

EVIDENCE OF DEVELOPMENTAL DEFECT, INJURY, INFECTION OR OTHER DISABILITY:*

_____
_____
_____
_____

LABORATORY DATA

(H.B. Film _____
Blood (
(Serological Tests for Syphilis _____

(Reducing substances _____

(Urine (Albumin _____

(Phenyl Pyruvic Acid (or Guthrie Blood Test) _____

_____

GENERAL COMMENT: (The examiner's assessment of the child's physical status and behaviour)

_____

_____

_____

_____

_____

_____

Name and address of doctor: _____

Date of examination: _____

Signature: _____

_____

* The examination should include, if applicable, inter alia:

<u>At any age</u>

Capacity of infant to focus eyes on object held about 30 cms. from face and moved from side to side.
Squint. Visual activity. Nystaginus. Cataract. Retinopathy.
Mouth and Palate.
Hearing Bell. Watch. Human voice/whisper. If deaf - probable cause.
Evidence of developing head control. Size and tension of fontanelle.
Co-ordination. Laterality (Dominance). Posture. Tone. Congenital dislocation of hip. Talipes.
Descent of testes. Hernia. Naevi. Abdominal tumour or enlargement or organs.
Pyspnoea. Stridor. Productive cough. Asthma.
Evidence of Mongolian defect.
Pubescence, Menstruation.
Central or peripheral Cyanosis. Heart murmur or abnormal rhythm. Femoral pulse.

<u>Additional matters in respect of child over three months of age:</u>

Capacity to respond to invitation to smile; to follow movement of examiner; to grasp and hold rattle etc. Excessive rhythmical activity (e.g. head rolling, banging). Developing power to maintain sitting posture, with support.

MATERNITY - MATERNAL GROUP B STREPTOCOCCUS (GBS) AND THE MINIMISATION OF NEONATAL EARLY - ONSET GBS SEPSIS (GL2017_002)

GL2017_002 rescinds GL2016_021, PD2005_240

PURPOSE

This Guideline provides guidance for two standard approaches used to identify women for whom intrapartum antibiotic prophylaxis (IAP) should be offered to reduce the risk of intrapartum transmission of Group B Streptococcus (GBS) to the neonate and minimise the risk of early-onset Group B Streptococcus (EOGBS) sepsis.

KEY PRINCIPLES

This Guideline provides Local Health Districts (LHD) with current, evidenced-based information to facilitate LHDs to ensure:

- Women are identified for whom intrapartum antibiotic prophylaxis (IAP) should be offered to reduce the risk of intrapartum transmission of GBS to the neonate and minimise the risk of EOGBS
- Appropriate assessment, detection, and escalation of neonates at risk of, or exhibiting signs and symptoms of EOGBS which occurs in the first 0 - 7 days following birth
- The importance of information and support for maternal choice is acknowledged.

USE OF THE GUIDELINE

The Chief Executives of NSW LHDs are responsible to:

- Select either a routine antenatal culture-based approach or a risk factor-based approach
- Ensure the development and implementation of local protocols or operating procedures in line with the approach chosen across all maternity facilities offering maternity services
- Ensure the chosen approach is consistently applied and neonatal morbidity and mortality associated with EOGBS sepsis is monitored and reviewed as per NSW Health PD2011_076 *Deaths - Review and Reporting of Perinatal Deaths* and NSW Health Policy Directive PD2009_003 *Maternity - Clinical Risk Management Program.*

The guideline can be downloaded here:-
Maternity - Maternal Group B Streptococcus (GBS) and minimisation of neonatal early-onset GBS sepsis

NSW PAEDIATRIC CLINICAL CARE AND INTER-HOSPITAL TRANSFER ARRANGEMENTS (PD2023_019)

PD2023_019 replaced PD2010_030 and PD2010_031

POLICY STATEMENT

NSW Health is committed to providing the right care, in the right place, at the right time and as close to home as possible. Many infants, children and adolescents will be able to receive the clinical care they need at a local service. If their needs are outside a service's capability and capacity to deliver the required care, an inter-hospital transfer must be arranged.

SUMMARY OF POLICY REQUIREMENTS

To provide appropriate clinical care and inter-hospital transfers for paediatric patients, NSW Health services must operate at their designated service capability level within agreed local health service arrangements and in partnership with transport and retrieval services. NSW Health services may also have local arrangements in place for paediatric inter-hospital transfers with specialist health services and retrieval services in bordering jurisdictions.

NSW Health organisations are to develop local guidance in line with this Policy Directive. This guidance must outline local arrangements for services (including Multipurpose Services) to follow when accessing clinical consultation to support care delivered locally as well as care involving inter-hospital transfer. Inter-hospital transfer processes are to include escalation of care to higher-level services and return transfer close to home when medically appropriate.

All services must work together to provide a network of care for NSW paediatric patients. Within local arrangements, higher-level services are responsible for providing lower-level services with support, advice and management of paediatric patients, including patients requiring inter-hospital transfer.

As supra-Local Health District services, Level 5 and 6 neonatal and Level 6 paediatric services must provide services for paediatric patients located within NSW and the ACT.

When an inter-hospital transfer is being considered, clinical decision-making must primarily match the paediatric patient's condition to the most appropriate service and consider:

- service capability and capacity of referring and receiving services
- capability and capacity of transport and retrieval services
- providing care as close to home as possible
- child and adolescent and family needs and preferences
- logistics such as weather and modes of transport.

Transfer decisions are to be made through discussion between responsible clinicians at the referring and receiving services. The Newborn and paediatric Emergency Transport Service (NETS) must be involved when an immediate response for transfer is needed and when clinical escort decisions require additional specialist clinical advice. NETS will facilitate care plan decision-making for these transfers through hosting conference calls with all clinical decision-makers.

Retrieval teams are responsible for the clinical care of a patient from the time of handover from the referring treating team until the patient is handed over to the destination service.

If an infant, child or adolescent in a hospital close to the border with an adjoining state requires a cross-border inter-hospital transfer, NETS will arrange transport or retrieval via NETS or NSW Ambulance or request the relevant jurisdiction's retrieval service to respond.

If a bordering jurisdiction's retrieval team is conducting the transfer, NETS will maintain contact with the referring treating team and provide clinical leadership until NETS confirms that the bordering retrieval team has taken over direct patient care. On handover, governance of the transport process moves to the bordering jurisdiction's transport/ retrieval service.

Management of urgency and risk are shared responsibilities of all parties involved in the transfer.

When transfer to higher-level care is required, the patient is to be appropriately transported within the medically agreed time frame to the nearest service that can provide the needed care. Treating teams at higher-level services are responsible for accepting referrals or finding an appropriate alternative if they do not have capacity to provide the needed care.

For return transfers, destination planning (identification of most appropriate service and bed-finding) is led by referring services and must be assisted by higher-level services if required.

Local health districts and the Sydney Children's Hospitals Network will optimise access to appropriate care close to home through services operating at their designated service capability level and actively managing patient flow.
Infants, children, adolescents and their families/carers are to be provided with timely, culturally appropriate and accessible information about clinical care, decisions and the transfer process.

A family member/ carer must be supported to travel with their child during an inter-hospital transfer wherever possible and appropriate, in consultation with the transport/ retrieval service.

Infants, children, adolescents and their families/ carers are to be offered relevant services and supports including through Aboriginal health workers, Aboriginal Maternal and Infant Health Service (AMIHS) staff, interpreters, cultural and diversity supports, social workers and other services as required.

The NSW Paediatric Clinical Care and Inter-Hospital Transfer Arrangements policy is available at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_019

NEONATAL CONSULTATION, REFERRAL AND TRANSFER ARRANGEMENTS IN COLLABORATION WITH NETS (IB2020_015)

PURPOSE

This Information Bulletin clarifies the process for those seeking neonatal consultation, referral and transfer arrangements for an unwell neonate.

KEY INFORMATION

Newborn and paediatric Emergency Transport Service (NETS) is a statewide emergency service for clinical advice and/or retrieval of critically ill neonates, infants and children. NETS is a single point of access for public and private hospitals in NSW and the ACT.

All neonatal critical care transfer requests must be made through NETS.

NETS will coordinate a conference call between the referring clinician and receiving consultant in a tertiary and/or regional hospital to discuss neonatal patient care. This will include immediate care, escalation of local and regional support and transfer or neonatal retrieval.

NETS will provide advice to the referring facility on the final destination of the neonatal transfer and coordinate beds if required.

Where there is a difference of opinion regarding a neonatal transfer, the final decision to transfer will be made by the NETS medical retrieval consultant, in line with the NSW

Health Policy PD2010_030 *Critical Care Tertiary Referral Networks (Paediatrics).*

The Tiered Perinatal Network (TPN) Level 6 facility has a responsibility to accept the neonate if no other facility can accept the transfer.

The referring facility will update details on the Patient Flow Portal (PFP)/Inter-Hospital Transfer (IHT) with the patient details. For non PFP users, the receiving facility will enter the PFP/IHT.

Contact NETS on 1300 362 500

Early notification will enable early assistance.

In a time-critical emergency, NETS notification can occur

prior to full patient assessment and investigation.

NETS can be contacted on www.nets.org.au

PAEDIATRIC CLINICAL PRACTICE GUIDELINE (IB2020_041)

IB2020_041 rescinds PD2011_038, PD2013_053, GL2014_013, PD2012_056, PD2010_063, PD2011_024 and PD2010_053

PURPOSE

This Information Bulletin is to notify NSW Health that Paediatric Improvement Collaborative (PIC) Interstate Clinical Practice Guidelines have now been published and are hosted by the Royal Children's Hospital Melbourne.

The PIC is a collaboration between Royal Children's Hospital Melbourne, Safer Care Victoria (SCV, Victorian Department of Health), the NSW Agency for Clinical Innovation (ACI) and Clinical Excellence Queensland.

Provision of Interstate Clinical Practice Guidelines through PIC aims to reduce variation in care.

KEY INFORMATION

The PIC adapts Victorian State-wide and Royal Children's Hospital Melbourne Clinical Practice Guidelines (CPG) so that they can be used by Queensland, New South Wales & Victorian clinicians.

Interstate Clinical Practice Guidelines are reviewed on a rolling 2-year cycle. When a new guideline is required it is written using the tri-state collaboration process.

CPGs that have been reviewed and developed under the PIC process are hosted by the Royal Children's Hospital Melbourne webpage www.rch.org.au

Interstate clinical practice guidelines are now available at: https://www.rch.org.au/clinicalguide/

The Interstate Clinical Practice Guidelines are endorsed for use in NSW, therefore NSW Health policy documents for Clinical Practice Guidelines on the same topics as PIC Interstate Clinical Practice Guidelines are no longer current.

MANAGEMENT OF INFANTS AND CHILDREN WITH CONGENITAL TALIPES EQUINOVARUS (GL2014_014)

PURPOSE

The *Management of Infants and Children with Congenital Talipes Equinovarus (CTEV) Practice Guideline* has been developed to ensure a consistent, evidence based approach to the multidisciplinary management of infants and children born with structural CTEV in NSW. It is to be used in conjunction with the 'learnpaediatrics Congenital Talipes Equinovarus e-learning module' and practical training such as the Ponseti Education Day conducted by the Sydney Children's Hospitals Network (Randwick and Westmead).

The Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group.

KEY PRINCIPLES

This Guideline reflects what is currently regarded as a safe and appropriate approach to care and should be used as a guide to be followed in respect of each individual presentation. Each patient should be individually assessed and a decision made as to appropriate management in order to achieve the best clinical outcome. Local protocols may be developed based on this State-Wide guideline and all clinicians involved in the treatment of patients born with structural CTEV should be educated in the use of the guideline and locally developed protocols.

This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation.

It does not replace the need for the application of clinical judgement to each individual presentation.

USE OF THE GUIDELINE

Chief Executives should ensure:

- Local protocols are developed based on the *Management of Infants and Children with Congenital Talipes Equinovarus (CTEV)* Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage infants or children with CTEV.
- Ensure that all staff treating infants and children are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of the new guideline.

To download the Guideline go to http://www.health.nsw.gov.au/policies/gl/2014/GL2014_014.html

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF BRONCHIOLITIS (GL2018_001)

GL2018_001 issued 10/01/2018 rescinds PD2012_004.

PURPOSE

This Clinical Practice Guideline provides evidence based clinical direction for clinicians in the acute management of bronchiolitis in infants. It is aimed at achieving the best clinical care in the assessment, escalation and management of acute bronchiolitis in infants.

KEY PRINCIPLES

This Guideline applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and Specialty Health Networks to determine where local adaptations are required or whether it can be adopted in its current format in all hospitals and facilities required to manage acute bronchiolitis in infants.

The Clinical Practice Guideline reflects what is currently regarded as a safe and appropriate approach to the management of acute bronchiolitis in infants. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation**. It does not replace the need for the application of clinical judgement to each individual presentation.**

USE OF THE GUIDELINE

Chief Executives must ensure:

- This Guideline is adopted or local protocols are developed based on the Infants and Children: Acute Management of Bronchiolitis, Clinical Practice Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric patients with bronchiolitis
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this revised guideline

The Guideline can be downloaded from Infants and Children - Acute Management of Bronchiolitis

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF SORE THROAT (GL2014_021)

GL2014_021 rescinds PD2006_019.

PURPOSE

The *Infants and Children: Acute Management of Sore Throat, third edition* Clinical Practice Guideline has been revised to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of the state-wide Paediatric Clinical Practice Guideline Steering Group.

KEY PRINCIPLES

This guideline applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and specialty health networks to have local guidelines/ protocols based on the attached Clinical Practice Guideline in place in all hospitals and facilities required to assess or manage children with sore throat.

The Clinical Practice Guideline reflects what is currently regarded as a safe and appropriate approach to the acute management of sore throat in infants and children. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

USE OF THE GUIDELINE

Chief Executives must ensure:

- Local protocols are developed based on the *Infants and Children: Acute Management of Sore Throat: third edition* Clinical Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with sore throat.
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this new guideline.

To download the Guidelines please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_021.html

YOUTH HEALTH AND WELLBEING ASSESSMENT GUIDELINE
(GL2018_003 issued 1/2/2018)

PURPOSE

This guideline presents the current best evidence for conducting a youth health and wellbeing Assessment. Its purpose is to inform practice for healthcare providers to achieve the best possible care in NSW.

This guideline is primarily for clinicians caring for young people (12-24 years old) in a paediatric, adolescent or adult healthcare setting.

This guideline supports NSW Health's commitment to implement appropriate psychosocial assessment tools, such as HEEADSSS, to assess and respond to the holistic health and wellbeing needs of young people outlined in the *NSW Youth Health Framework 2017-2024* (PD2017_019).

KEY PRINCIPLES

Youth health and wellbeing assessments are important to assist clinicians to identify and respond early to areas of concern in a young person's life that might affect their health and wellbeing.

The youth health and wellbeing assessment is not a diagnostic tool. It is a holistic, flexible approach designed to build rapport and engage with a young person in a clinical setting. The information gathered can then be used to directly address any concerns and/or refer a young person for a specialist response.

The most widely used youth health and wellbeing assessment tool in Australia and internationally is known as a HEEADSSS assessment. Each letter of HEEADSSS reflects a major domain of a young person's life. Capturing information in each domain helps reveal risks, behaviours and protective factors. It helps to identify areas of intervention where the clinician can work with the young person to achieve better health outcomes.

- **H** Home
- **E** Education and Employment
- **E** Eating and Exercise
- **A** Activities, Hobbies and Peer Relationships
- **D** Drug Use (cigarettes, alcohol)
- **S** Sexual Activity and Sexuality
- **S** Suicide, Self-Harm, Depression, Mood, Sleeping Patterns
- **S** Safety and Spirituality

In general, a youth health and wellbeing assessment (12-24 years old) should be conducted with every young person who attends a health service or hospital. Where appropriate young people in an adult or paediatric inpatient area within a hospital should have a youth health and wellbeing Assessment completed in conjunction with other screening assessment/admission processes.

Clinical judgement should be used to determine the appropriateness of the assessment for 12-24 year olds. This includes considering the young person's health condition, maturity, the environment and health service context (for example, sufficient time or privacy may not be available in an Emergency Department context).

In general an assessment is done through conversation with a young person. On some occasions, where it is more appropriate a young person can be asked to complete the Youth Health and Wellbeing Assessment Chart (Appendix 1).

It is essential that clinicians/healthcare workers read and understand this guideline in particular Sections 6 to 11 of the Guideline.

- Section 6 Issues covered by a youth health and wellbeing assessment
- Section 7 When to conduct a youth health and wellbeing assessment
- Section 8 Youth health and wellbeing assessment flow diagram
- Section 9 Self-completed assessment using Youth Health and Wellbeing Assessment Chart
- Section 10 Setting up and concluding the assessment
- Section 11 Contraindications and cautions

USE OF THE GUIDELINE

This guideline should be considered when conducting Youth Health and Wellbeing Assessment with young people (12-24 years old) who attend a health service or hospital.

This document outlines the -

- approach that should be taken by NSW Health staff when conducting a youth health and wellbeing assessment (Sections 7 - 10)
- ssues to consider when implementing the youth health and wellbeing assessment within different health settings and with different age groups (Sections 11 - 12)

A range of resources for workers are available to support Youth Health and Wellbeing Assessment when needed (Appendices 1 – 4).

The document should not be seen as a prescriptive set of rules to be applied without the clinical input and discretion of the managing health professionals. Each patient should be individually evaluated and a decision made as to appropriate management in order to achieve the best clinical outcome.

To download the guideline go to Youth Health and Wellbeing Assessment

INFANTS AND CHILDREN: INITIAL MANAGEMENT OF FEVER OR SUSPECTED INFECTION IN ONCOLOGY AND STEM CELL TRANSPLANTATION PATIENTS (GL2015_013)

PURPOSE

The *Infants and Children: Initial Management of Fever or Suspected Infection in Oncology and Stem Cell Transplantation Patients, first edition* Clinical Practice Guideline has been developed to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of NSW Kids and Families.

KEY PRINCIPLES

This guideline applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and specialty health networks to determine where local adaptations are required or whether it can be adopted in its current Clinical Practice Guideline format in all hospitals and facilities required to manage infants and children undergoing therapy for cancer or stem cell transplantation presenting with fever or suspected infection.

The clinical practice guideline reflects what is currently regarded as a safe and appropriate approach to the management of fever or suspected infection in infants and children undergoing therapy for cancer or stem cell transplantation. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

USE OF THE GUIDELINE

Chief Executives must ensure:

- Hospitals and facilities either adopt this protocol or adapt local protocols to comply with the *Infants and Children: Initial Management of Fever or Suspected Infection in Oncology and Stem Cell Transpantation Patients, first edition* Clinical Practice Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric oncology and stem cell transplantation patients with fever or suspected infection
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this new guideline.

The guideline *Infants And Children: Initial Management Of Fever Or Suspected Infection In Oncology And Stem Cell Transplantation Patients* can be downloaded at the following link –

Infants and Children: Initial Management of Fever/Suspected Sepsis in Oncology /Transplant Patients

PAEDIATRIC PROCEDURAL SEDATION - GUIDE FOR EMERGENCY DEPARTMENTS, WARDS, CLINICS AND IMAGING

(GL2018_011 issued 4/5/2018)

PURPOSE

Paediatric Procedural Sedation - Guide for Emergency Departments, Wards, Clinics and Imaging provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The guide was prepared for the NSW Ministry of Health by an expert clinical reference group.

KEY PRINCIPLES

This guide applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and Speciality Health Networks to determine where local adaptions are required or whether it can be adopted in its current format in hospitals and facilities required to manage procedural sedation of paediatric patients.
This guide applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and Speciality Health Networks to determine where local adaptions are required or whether it can be adopted in its current format in hospitals and facilities required to manage procedural sedation of paediatric patients.

This guide reflects what is currently regarded as a safe and appropriate approach to the management of procedural sedation for paediatric patients. However, as in any clinical situation there may be factors which cannot be covered by a single guide. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. It does not replace the need for the application of clinical judgement to each individual presentation.

USE OF THE GUIDELINE

Chief Executives must ensure:

- This guide is adopted or local procedures are developed based on the PaediatricProcedural Sedation Guide for Emergency Departments, Wards, Clinics andImaging.
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric patients requiring procedural sedation
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this revised guideline.

To download this guidelines go to
Paediatric Procedural Sedation - Guide for Emergency Departments, Wards, Clinics and Imaging

NEONATAL - JAUNDICE IDENTIFICATION AND MANAGEMENT IN NEONATES ≥ 32 WEEKS GESTATION (GL2016_027)

GL2016_027 incorporates content from obsolete Guideline GL2007_001 Neonatal Exchange Transfusions in NSW as notified in IB2016_062.

PURPOSE

This Guideline provides a framework for the early identification and management of jaundice in neonates ≥ 32 weeks gestation. Approximately 60% of neonates born at term and 85% of preterm neonates will develop jaundice. Many of these neonates will develop 'physiological jaundice', which is usually benign. However, when unconjugated serum bilirubin levels are too high, bilirubin can cross the blood brain barrier. Bilirubin is neurotoxic, particularly to the auditory nerve and basal ganglia, which can result in brain injury and lifelong disability. It is important therefore, to identify those neonates at risk of acute bilirubin encephalopathy and kernicterus.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations providing care for neonates ≥ 32 weeks gestation which should include:

- The identification at birth of neonates with risk factors for neonatal jaundice
- Regular visual assessment from birth of all neonates
- Management of neonatal jaundice identified in the first 24 hours of age
- Management of neonatal jaundice identified ≥ 24 hours of age
- Follow-up care for neonates discharged at less than 3 days of age with risk factors for jaundice or jaundice at discharge
- Assessment and escalation of care for neonates with prolonged jaundice > 14 days of age in a term neonate, and beyond 21 days in a preterm neonate.

USE OF THE GUIDELINE

The Chief Executives of all NSW Local Health Districts are responsible for the implementation of this guideline within their services / facilities to ensure:

- Local processes and operating procedures are developed in line with this document to manage neonates ≥ 32 weeks gestation to ensure:
  - Prompt appropriate identification, management and escalation of neonatal jaundice
  - Equipment is used, maintained and its effectiveness is monitored
  - Discharge is planned and follow up processes are in place
  - Assessment and appropriate escalation of care for neonatal jaundice > 14 days of age in a term neonate and beyond 21 days in a preterm neonate.
- The Directors of Clinical Governance inform relevant staff in maternity, neonatal services and biomedical departments of this new Guideline
- Morbidity and mortality associated with neonatal jaundice is monitored and reviewed.

To download the Guidelines please go to
Neonatal - Jaundice Identification and Management in Neonates ≥ 32 Weeks Gestation

HYPOXIC ISCHAEMIC ENCEPHALOPATHY IN NEWBORNS - RECOGNITION, MONITORING AND EARLY MANAGEMENT (IB2023_028)

IB2023_028 replaced PD2010_006

PURPOSE

This Information Bulletin notifies the NSW Health system of the publication of the Clinical Practice Guide Hypoxic ischaemic encephalopathy in newborns - recognition, monitoring and early management.

KEY INFORMATION

The Hypoxic ischaemic encephalopathy in newborns - recognition, monitoring and early management provides guidance on the management of newborns with hypoxic ischaemic encephalopathy who may benefit from therapeutic hypothermia.

The Clinical Practice Guide is accompanied by a parent information sheet Therapeutic hypothermia (cooling) to protect babies with hypoxic ischaemic encephalopathy (HIE) and the evidence check document Therapeutic hypothermia in neonatal hypoxic ischemic encephalopathy.

The management of newborns with HIE includes:

- identification and management of newborns with encephalopathy through the use of the Newborn Encephalopathy Pathway
- assessment of the severity of encephalopathy in newborns using the Encephalopathy Severity Tool every hour in the first six hours of birth
- criteria for initiating therapeutic hypothermia for newborns and initial management in neonatal units.

General principles

Resuscitation and stabilisation of the newborn should be prioritised before commencing therapeutic hypothermia.

Therapeutic hypothermia must not be commenced without discussion with the Newborn and Paediatric Emergency Transport Service (NETS) and a tertiary centre neonatologist.

All newborns for whom therapeutic hypothermia has been commenced should be transferred to a neonatal intensive care unit (NICU) for ongoing management.

Reporting

Reporting processes via the incident management system (ims+) should be in place to monitor the incidence of newborns with moderate or severe encephalopathy. Serious incidents, including term newborns diagnosed with severe HIE or who receive therapeutic hypothermia, should be notified to the NSW Ministry of Health via a Reportable Incident Brief in accordance with the NSW Health Policy Directive Incident Management (PD2020_047).

CHILD WELLBEING AND CHILD PROTECTION POLICIES AND PROCEDURES FOR NSW HEALTH (PD2013_007)

PD2013_007 rescinds PD2005_299, PD2006_104, PD2007_023, PD2011_057, PD2011_065, GL2011_008, IB2010_005, IB2012_002.

PURPOSE

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents/carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

MANDATORY REQUIREMENTS

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

Children and Young Persons (Care and Protection) Act 1998

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children's Court proceedings when required.

Commission for Children and Young People Act 1998/*Child Protection (Working with Children) Act 2012*

- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).

Ombudsman Act 1974

- Maintain systems to prevent 'reportable conduct' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;

- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the Mandatory Reporter Guide and seek assistance from the NSW Health Child Wellbeing Unit to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the NSW Health Child Wellbeing Unit and the Family Referral Services to help respond to vulnerable families, children and young people below the ROSH threshold;
- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the Child Wellbeing and Child Protection - NSW Interagency Guidelines and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and/or other child protection training for NSW Health workers.

IMPLEMENTATION

Chief Executives across the NSW public health system are responsible and accountable for:

1. Ensuring that this policy and the associated *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers* are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

To access the **Child Wellbeing and Child Protection Policies and Procedures for NSW Health** please go to http://www.health.nsw.gov.au/policies/pd/2013/PD2013_007.html

STATEWIDE EYESIGHT PRESCHOOLER SCREENING (StEPS) PROGRAM (PD2018_015)

PD2018_015 rescinds PD2012_001

PURPOSE

The purpose of this policy directive is to guide StEPS coordinators in the consistent implementation and management of the Statewide Eyesight Preschooler Screening (StEPS) program at the Local Health District (LHD) level.

This policy directive describes the roles and responsibilities of StEPS personnel and training requirements, identifying four year old children for vision screening, vision screening protocols, referral processes and reporting requirements so that childhood vision problems can be detected early and treatment outcomes maximised.

MANDATORY REQUIREMENTS

LHDs must ensure compliance with the requirements set out in this policy directive as the basis for administering the StEPS program in LHDs. Mandatory requirements for the StEPS program are:

- Vision screening protocols relating to consent, vision screening, assessment, referrals, referral follow up, and reporting and data management (Section 2).
- All four year old children in LHDs, including disadvantaged groups and children with special needs, should be offered the StEPS program, to meet StEPS performance benchmarks (Section 3).
- StEPS vision screening staff must be suitably trained and provided with the necessary equipment and resources to conduct vision screening (Sections 4 and 5).
- All standardised templates attached to this policy are used by LHDs when administering the StEPS program (Section 7).
- LHDs must develop operating processes consistent with this policy directive, to maximise screening and meet local needs in each LHD.

IMPLEMENTATION

The Ministry of Health provides funding to assist LHDs in the implementation of the StEPS program in NSW. This policy directive applies to all staff and relevant managers involved in delivering the StEPS program in LHDs across NSW.

Roles and Responsibilities

Ministry:

- Provide mandatory requirements and guidelines for the implementation and management of the StEPS program.
- Evaluate the overall efficiency and performance management of the StEPS program in LHDs across NSW.
- Meet regularly with all LHDs through the StEPS Coordinators Meetings to review overall progress and implementation of the StEPS program in LHDs.
- Ensure the content of this StEPS policy directive is effectively communicated to all staff involved in coordinating the StEPS program in NSW.

LHDs:

- Actively identify all four year old children in their LHDs to offer them a free StEPS vision screen.
- Assign responsibility and personnel to implement the StEPS program in line with this policy directive.
- Ensure appropriate vision screening staff are employed, that vision screening staff are trained to undertake the StEPS vision screen, and staff are provided with appropriate equipment and resources to carry out the functions of the StEPS program.
- Ensure compliance and full implementation of this policy directive in their LHD.
- Ensure that the budget provided for the StEPS program is expended on implementing the StEPS program.
- Provide all required reports to the Ministry of Health relating to screening activity, referrals, assessments, follow ups, monitoring and reporting.
- ensure that StEPS performance benchmarks are achieved and maintained (Section 3.3)
- Ensure the content of this StEPS policy directive is effectively communicated to all staff involved in implementing the StEPS program in the LHD.

1. BACKGROUND

The Statewide Eyesight Preschooler Screening (StEPS) program is a universal, evidence based, free vision screening program for all four year old children in NSW.

The program actively identifies all four year old children in NSW to offer them a free StEPS vision screen and is designed to identify childhood vision problems early, prior to school entry, so that treatment outcomes can be maximised.

The StEPS program is an important component of the NSW Child Health Screening and Surveillance Program, as documented in the NSW Personal Health Record (PHR), the 'Blue Book'. The NSW PHR recommends a vision examination at the newborn health check, vision surveillance at the 1-4 week, 6-8 week, 6 month, 12 month, 18 month, 2 year and 3 year child health checks, and a monocular visual acuity screen at the 4 year child health check.

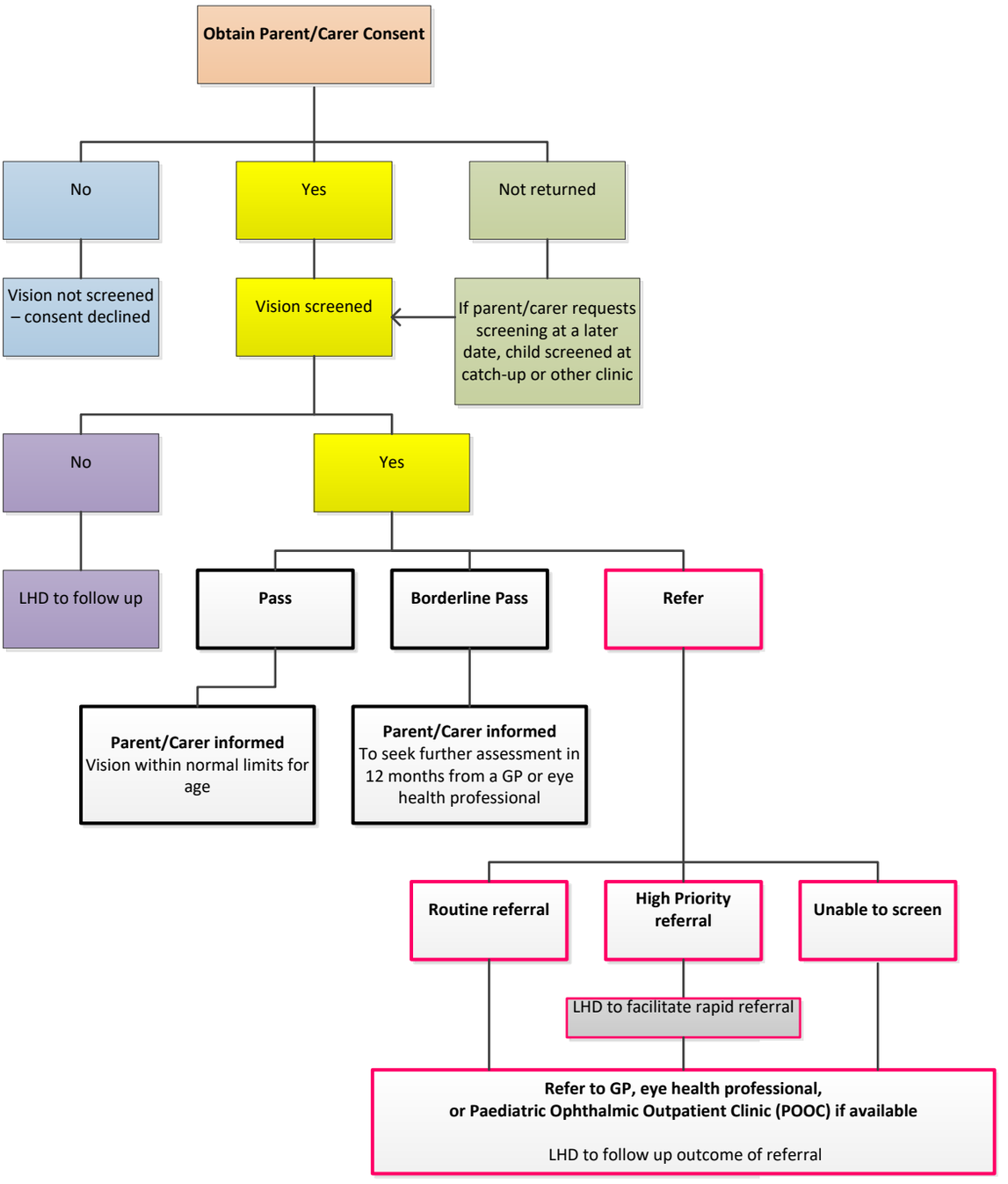
Vision develops from birth to approximately eight years of age, and is fully mature by the mid-teenage years. Early identification and treatment of eye and vision problems aims to optimise vision prior to starting school and reduces the likelihood of permanent vision loss. The StEPS program targets children at four years of age, the first opportunity for a child's visual acuity to be reliably screened at a population level.

While eye health surveillance can monitor a child for outward signs of eye or vision problems, the two most common childhood vision problems, amblyopia and refractive error, cannot be detected by family history, vision surveillance or observing a child's behaviour or appearance. These vision disorders can only be detected if a monocular visual acuity screen is conducted by a trained vision screener.

2 VISION SCREENING PROTOCOLS

2.1 StEPS Referral Pathway Flowchart

The figure below outlines the StEPS Referral Pathway:



2.2 Pathway for screening, referral, assessment and follow up

LHDs must have clearly documented protocols, consistent with this StEPS Policy Directive for approaching services to offer the StEPS vision screening program, offering parents/carers the StEPS vision screen for their child, the provision of the vision screening service, documenting the outcome of the vision screen, informing parent/carers of the outcome of the vision screen, and for referral and follow up of referrals.

Standardised templates attached to this policy (Section 7) must be used to implement and administer the StEPS program in NSW.

2.3 Consent

Consent from parent/carer for child to participate in the StEPS program at a preschool, child care centre or other service must be obtained prior to undertaking the StEPS vision screen. The following standardised information letter and consent forms are to be used to obtain signed consent:

- *StEPS Important Notice for all Parents/Carers (*Attachment 2).
- *StEPS Consent and Results Form* (Attachment 3).

Consent forms, information letters and flyers about the StEPS program and LHD privacy information should be provided to the preschool/child care centre where the screening will occur at least two weeks prior to the screening date. Completed and signed consent forms must be collected prior to the screening date or on the day of screening. Consent may be accepted by the StEPS vision screener up to and including the day of screening. If verbal consent is provided, this must be documented on the consent form by the vision screener.

If a consent form is returned and the parent/carer has consented to screening, but the child is absent on the day of screening, a follow-up screening offer should be made. At least two vision screening follow up offers should be made (and documented) where consent is obtained but screening is not conducted.

If the consent form is not returned, LHDs should have screening options available for parents/carers who request screening for their child at a later date, such as catch-up and other clinics.

If consent is not provided, that is, the consent form is returned but consent is declined, this must be recorded appropriately.

To monitor and assist in accurately recording the number of StEPS vision screenings offered, it is recommended that LHDs enquire about the number of children who:

- Are four years of age, or who will be turning four years of age.
- Are eligible to attend school in the following calendar year.
- Are attending the centre where the StEPS vision screening will take place
- Are able to provide the correct corresponding number of consent forms.

The target group of children for StEPS screening are those aged four years who are starting school the following year. Children who are five years of age and have not previously received a StEPS vision screen are also eligible to be offered the StEPS program. Three year old children who are eligible to start school the following year may be screened at the StEPS coordinator's discretion.

2.4 Vision Screening

LHDs must coordinate and organise the StEPS vision screening with relevant parties at a suitable screening location. Consideration should be given to preschools/childcare centres with specific attendance patterns such as split week attendance to ensure a high uptake of screening and the number of screening days required to screen all children appropriately. StEPS vision screening staff should arrange an appropriate area to conduct the StEPS vision screening in consultation with the preschool/child care centre.

Wherever possible, StEPS vision screening staff must conduct a monocular visual acuity screening test using the approved 6 metre HOTV logMAR chart or Sheridan Gardiner Linear Chart. If the screening location does not have the required space available for the 6 metre chart, the approved 3 metre HOTV logMAR or Sheridan Gardiner Linear Chart can be used. The matching board corresponding to the chart used is to be provided to all children to enable children to match the letter indicated to by the vision screener with the letter on the matching board.

Vision screeners should also review the consent form carefully noting any parental/carer concerns, perform a visual inspection of the eyes and observe the child carefully (for example, does the child constantly close one eye in sunlight, do both eyes move together equally in all direction of gaze, does the child consistently tilt their head or turn their face to one side) to determine if any abnormalities may be present which could affect either the vision or the child's general eye comfort. If there are concerns following visual inspection of the eyes, for example, red eyes, red lid margins, or excessive watering, the child should be referred to their General Practitioner. Vision screeners should carefully observe and refer any possible eye or vision abnormalities even if the visual acuity result is within normal range.

To conduct a monocular visual acuity test, the screener must occlude the left eye first using the recommended occlusion glasses. A folded tissue is placed between the occluded eye and the glasses. If the child already wears glasses, use a single-use eye patch with a tissue between their glasses and the eye patch. LHD infection control procedures must be followed.

The test results for each eye must be accurately recorded by the vision screener on the *StEPS Consent and Results Form* (Attachment 3) and *Notification of StEPS Vision Screening Results Letter* (Attachment 4) as appropriate.

2.5 Documenting Results of the Vision Screening

2.5.1 Consent and Results Form

The vision screener must complete the results section of the *StEPS Consent and Results Form* (Attachment 3) to document the vision screening results.

All sections of the *StEPS Consent and Results Form* must be completed, signed and dated. Relevant actions relating to completing a *StEPS Results Notification Letter* and *StEPS Referral Letter* must be identified on the form. All *StEPS Consent and Results Forms* must be promptly forwarded to the StEPS Coordinator as per LHD procedures.

2.5.2 Notification of StEPS Vision Screening Results Letter

The *Notification of StEPS Vision Screening Results Letter* (Attachment 4) is used to inform parents of the outcome of vision screening and must be completed and forwarded to all parents/carers of children who participated in the StEPS program.

Notification of the vision screening result should be provided as soon as practical, preferably on the day of the screening.

If the parent/carer has indicated on the *StEPS Consent and Results Form* (Attachment 3) that the child is under the care of an eye health professional, the vision screener must advise on the *Notification of StEPS Vision Screening Results Letter* (Attachment 4) for parent/carer to continue care. If there are any concerns about the child's current treatment, vision screeners must discuss this with their StEPS Coordinator. LHDs should encourage parents/carers to add the *Notification of StEPS Vision Screening Results Letter* to their child's Personal Health Record.

All parents are encouraged to ensure their child attends a Before School Health Assessment at 4 years of age, as per the NSW Personal Health Record (Blue Book).

2.5.3 Inclusion of forms and letters in the electronic medical record

If the child's electronic medical record is available, the *StEPS Consent and Results Form* (Attachment 3) is scanned and forms part of the child's electronic medical record. The *StEPS Referral Letter* (Attachment 5) may be scanned and included as correspondence accompanying the child's medical record.

2.5.4 Confidentiality

All information collected and results are confidential and must not be provided to or discussed with others, including staff at the preschool or child care centre, without parent/carer consent. To ensure privacy, all *Notification of StEPS Vision*

Screening Results letters (Attachment 4) are to be placed in a sealed envelope with the child's name on the outside of the envelope. Vision screeners must liaise with relevant parties (e.g. preschool/child care director) at the screening location to determine the most appropriate mechanism for providing the results of the StEPS vision screen to parents/carers.

2.5.5 StEPS Referral Letter

All parents/carers of children who require a referral must be provided with a *StEPS Referral Letter* (Attachment 5). The referral letter may be completed by the vision screener, StEPS Coordinator or Administration Officer as per LHD procedures.

2.6 Referral Criteria

The StEPS program uses pass/refer criteria that correlate to specific, evidence-based visual acuity results. Following the StEPS vision screen, the criteria for making a referral based on the vision screening result are as follows:

a) Pass - visual acuity of 6/9 (3/4.5) or above

- A child with visual acuity of 6/9 (3/4.5) or above in both eyes is considered to have passed the StEPS visual acuity screen.
- Referral is not required.

b) Borderline Pass - visual acuity of 6/9-1 (3/4.5-1) or 6/9-2 (3/4.5-2)

- A child with visual acuity of 6/9-1 (3/4.5-1) or 6/9-2 (3/4.5-2) in one or both eyes is considered a borderline pass.
- Parents/carers are advised to re-test in 12 months by an Eye Health Professional.

c) Refer - visual acuity of less than 6/9-2 (3/4.5-2) in one or both eyes

- A child with visual acuity of less than 6/9-2 (3/4.5-2) in one or both eyes is considered to have not passed the StEPS visual acuity screen.
- Parents/carers are advised to have their child's eyes tested by a General Practitioner or Eye Health Professional.

d) Refer - obvious pathology

- A child with obvious pathology on observation of external eye and adnexa that is currently untreated should be referred for review.
- Parents/carers are advised to have their child's eyes reviewed by a General Practitioner.

e) High Priority Referral - visual acuity of 6/18 (3/9) or less in one or both eyes

- A child with visual acuity of 6/18 (3/9) or less in one or both eyes is considered a high priority referral.
- Parents/carers are advised to have their child's eyes tested by a General Practitioner or Eye Health Professional as a matter of urgency.
- Referral may be made to Paediatric Ophthalmic Outpatient Clinics (POOCs) according to *StEPS Referral Protocols for POOCs* (Attachment 6).

f) Refer - unable to be screened

- A child who has a valid consent but is unable to be screened, for example if they are uncooperative or unable to perform the test, should be referred.
- Parents/carers are advised to follow up with an Eye Health Professional.

2.7 Follow-up of referrals

All referrals from the StEPS Program must be actively followed up by the StEPS Coordinator as per this Policy Directive and LHD procedures. Wherever possible, StEPS Coordinators should ensure that High Priority Referrals receive a diagnostic vision assessment within one month, and other referrals receive an assessment within six months.

StEPS Coordinators are to offer assistance to families to ensure the child receives a diagnostic eye assessment within the appropriate timeframe. This may include, but is not limited to, offering secondary screening Orthoptic services and/or referral to the StEPS Paediatric Ophthalmic Outpatient Clinics (POOCs). StEPS Coordinators should consider any barriers to receiving a diagnostic assessment and subsequent treatment and assist families wherever possible to access appropriate services.

StEPS Coordinators must monitor all follow up referrals and report on the outcomes. If no eye health professional report is received and the outcome is unknown, the parent/carer must be contacted to determine the outcome and the result recorded. If possible, the name of the eye health professional who provided the assessment/treatment should be sought from the parents and the eye health professional then contacted to confirm the outcome.

The *StEPS Referral Outcomes Report* (Attachment 10) must be completed to record the outcome of the referral as a result of the StEPS vision screening. These reports can be used to demonstrate the accuracy of vision screening undertaken and the effectiveness of the StEPS program.

2.8 Mandatory Reporting for the StEPS program

StEPS Coordinators must complete and submit StEPS Screening Activity and StEPS Referral Outcomes reports for the StEPS program to the Ministry. Where an electronic medical record system is available in the LHD, electronic reporting and data extraction files should be submitted as reports to the Ministry. If electronic medical records are not available, these may be submitted as manual reports using the following templates:

- Quarterly *StEPS Screening Activity Report* (Attachment 9)
- Quarterly *StEPS Referral Outcomes Report* (Attachment 10)

2.9 Data Management

LHDs are responsible for developing and maintaining a database to record all children who have participated in the StEPS program. This will enable ease of scheduling, screening, tracking referrals, follow up referrals, reporting on referral outcomes and responding to enquires from parents/carers on vision screening.

All children who have participated in the StEPS program must be recorded on a database developed and maintained by LHDs. This database must include client/patient identifying details and parents contact details in accordance with PD2007_094 Client Registration Policy', as well as screening location, date of screening, result of screening, follow up of referrals, and the outcome and diagnosis following referral where applicable. It is recommended that terminology used to record the outcomes of referrals is consistent with language used in the referral outcomes report.

Where an electronic medical record system is available in the LHD, the appropriate electronic documentation for StEPS should be completed and data extraction files submitted as reports to the Ministry of Health.

2.9.1 Retention and Disposal of StEPS patient/client records

For all children who receive a StEPS vision screen, the *StEPS Consent and Results Form* (Attachment 3) must be incorporated into the main Community Health client record system and retained until the child attains or would have attained the age of 25 years. This applies to children who are found to have no abnormality on screening, as well as those children who receive a borderline pass or are referred for any reason.
Where the StEPS Consent and Result Form is in paper format and is not imaged or scanned, the original paper form must be retained for 25 years. It can then be disposed of according to LHD procedures.
Where the StEPS Consent and Result Form is imaged or scanned, the original Form should be retained until it has been verified that the scanned copy clearly displays all elements of the original record, as per NSW State Records 'General Retention and Disposal Authority – Public Health Services: Patient/Client Records' (GDA 17). Once verified, the paper Form can then be disposed of according to LHD procedures. The imaged Form must be retained for 25 years.

3 IDENTIFYING FOUR YEAR OLD CHILDREN

3.1 Identifying Four Year Old Children

All four year old children in NSW are to be actively identified to be offered a free StEPS monocular visual acuity screen by StEPS Coordinators within their designated LHDs. Strategies to identify four year old children may include, but are not limited to, contacting the following services to offer the StEPS program:

- preschools
- child care centres
- family day care services
- early intervention services
- refugee services
- Child and Family Health Services
- Playgroups
- immunisation clinics
- Department of Education and Communities, Schools for Specific Purposes

- Community vision screening days
- School Orientation programs (this strategy should only be used where the eligible child was not able to be identified through alternative strategies).

3.2 Disadvantaged groups of children and children with special needs

Disadvantaged groups of children and children with special needs are to be actively identified to ensure they are offered StEPS screening. For the purposes of the StEPS program, the following groups of children are classified as 'disadvantaged groups':

- Aboriginal and Torres Strait Islander children.
- Children attending 'Early Intervention Services'.
- Children attending 'Schools as Community Centres (SACCs) Playgroups'.
- Children whose parents attend Mental Health Services.
- Children in 'Out of Home Care'.
- Refugee children.
- Socioeconomically disadvantaged children.

Children with special needs are children who have been identified with developmental delay and/or neurological deficits.

StEPS Coordinators are to develop local strategies that meet the needs of their LHD in order to ensure maximum vision screening and equity of access to the StEPS program for all four year old children.

3.3 Service Level Agreement

The Service Level Agreement of the StEPS program is:

- A minimum of 80% of eligible four year old children have screening conducted

Wherever a parent/carer completes a StEPS consent form and agrees to their child participating in the StEPS program the LHD must make every effort to ensure that the child's vision is screened according to StEPS protocols.

LHDs are to ensure that the StEPS Service Level Agreement is maintained according to the estimated target population numbers of four year olds in their LHD provided by the Ministry of Health.

4 StEPS PERSONNEL

4.1 Vision Screening Staff

StEPS vision screening staff are employed by LHDs, under the supervision of LHD StEPS Coordinators to conduct monocular visual acuity screening assessments for four year old children.

StEPS vision screening must be conducted by suitably trained staff competent in using the StEPS vision screening equipment to undertake vision screening for four year old children. Screening assessments are undertaken in locations deemed appropriate by LHDs and can include settings such as preschools, child care centres, community settings and Child and Family Health Services.

StEPS vision screening staff are responsible for:

- liaising effectively with preschool and child care centre staff, parents, team members and other health care professionals in a professional and caring manner

- conducting vision screening according to vision screening protocols consistent with this StEPS policy directive relating to obtaining consent, referral processes, appropriate testing set up, vision screening equipment gathering and utilising information as required for effective vision screening
- ensuring the vision screening process creates minimal disruption to the location where screening is undertaken
- ensuring the confidentiality and privacy of the child is maintained at all times and all relevant information about the screening process and vision screening results is provided to parents/carers
- ensuring all mandatory requirements and reporting mechanisms relating to vision screening, consent, referrals processes, notification of results and LHD protocols are undertaken
- adhering to all LHD Work Health and Safety and Infection Control protocols
- maintaining vision screening equipment and reporting malfunctioning equipment to the StEPS Coordinator
- advising the StEPS Coordinator of any issues, incidents, problems or concerns that arise during a vision screening session.

4.2 StEPS Coordinator

StEPS Coordinators are employed by LHDs to implement, coordinate and manage the day to day operations of the StEPS program.

StEPS Coordinators develop and maintain strong links with all relevant stakeholders in their LHD, such as child health services, parents and carers, early childhood education and care providers, eye health professionals, general practitioners, medical specialists, Aboriginal Community Controlled Health Services, early intervention and coordination programs and other government and non-government agencies, to promote the StEPS program and to ensure the StEPS program is delivered effectively in their respective LHDs.

StEPS Coordinators are responsible for:

- ensuring all four year old children in their LHD are actively identified and offered a StEPS vision screen, including providing screening services as required
- recruiting vision screening staff as required, training and/or arranging the training to be provided to StEPS vision screeners by a suitably qualified health professional
- supervision and professional development of StEPS vision screeners to ensure that competency in vision screening is achieved and maintained, and that all applicable LHD protocols are followed
- ensuring transportation is available for StEPS vision screeners to travel to screening locations, according to resources available in the LHD. This may include access to a motor vehicle or approval to use private vehicles with the provision of a mileage allowance according to LHD protocols
- ensuring all appropriate supplies and maintenance of equipment, relevant forms and promotional material is available to conduct StEPS vision screening
- maintaining the confidentiality and privacy of the children screened and providing support to parents as appropriate in the period between vision screening and diagnostic assessment

- developing vision screening protocols for screening, referral, assessment and follow up consistent with the StEPS Policy Directive
- developing local processes to ensure disadvantaged groups of children and children with special needs are actively identified for the StEPS program
- data management and monitoring of key performance indicators, vision screening referral rates, referral outcomes, follow up referrals and submitting relevant reports to the NSW Ministry of Health as required.
- setting up and maintaining a database to record information on all four year old children who participated in the StEPS program for quality management
- effectively managing the LHD StEPS budget to ensure the program is implemented efficiently in the LHD including all printing costs relating to information flyers, brochures, letters and forms on the StEPS program
- attending NSW Ministry of Health StEPS Coordinators meetings as required and being the main point of contact for the StEPS program in their LHDs

4.3 StEPS Administration Officer

StEPS Administration Officers are employed by LHDs to provide administrative duties as deemed appropriate by the StEPS Co-ordinator. Duties may include, but are not limited to, arranging and confirming vision screening bookings, organising consent form packages, StEPS data entry and general office tasks.

4.4 Orthoptist

Orthoptists may be employed to provide comprehensive secondary vision screening for children referred via the StEPS program. Orthoptists may also provide vision screening services for children identified with 'special needs' and undertake additional vision screening tests considered appropriate to a child's individual developmental level. Orthoptists may also investigate and diagnose ocular motility disorders and assist in transitioning the family to timely diagnostic assessment services where appropriate.

Orthoptists may also assist in the training of vision screening staff.

4.5 StEPS Outpatient Clinics

Dedicated StEPS tertiary Paediatric Ophthalmic Outpatient Clinics (POOCs) have been established for children identified with potentially significant vision loss and referred as a 'High Priority Referral'. POOCs will ensure that such children receive a diagnostic vision assessment in a timely manner so that treatment outcomes can be maximised. Ongoing management and treatment of a child diagnosed with a vision problem via POOCs should be at the discretion of the eye health professional in consultation with the parent/carer.

Referrals to POOCs are available from anywhere in NSW. Children can be referred according to *StEPS Referral Protocols for Paediatric Ophthalmology Outpatient Clinics (POOCs)* (Attachment 6). The *StEPS Referral Form for POOCs* is at Attachment 7.

5 TRAINING

5.1 StEPS Training Package

To be certified as competent, vision screening staff must:

- satisfactorily complete modules one and two of the *StEPS Training Package* through the NSW Health Education and Training Institute (HETI).

- complete a minimum of four hours practical experience at a screening location (with the StEPS Coordinator or an Orthoptist if possible).
- be assessed as competent after three months of screening using the *StEPS Competency Checklist for Vision Screeners* (Attachment 8) and annually thereafter.

5.2 Supervision and Professional Development

Following completion of modules one and two, in addition to supervised practical experience, ongoing professional development and mentoring opportunities for vision screeners should be locally arranged by LHDs as appropriate. This may involve opportunities to work with an experienced vision screener for the first three months of vision screening wherever possible; participation in Orthoptic clinics; and/or other professional development opportunities identified by the LHD.

It is the responsibility of the StEPS Coordinator to ensure that all dedicated StEPS vision screening staff, and all LHD staff who undertake StEPS vision screening, are proficient in undertaking a StEPS vision screen prior to being deemed qualified to undertake a StEPS vision screen unsupervised.

Ongoing supervision and performance management of vision screening staff, and other health staff who provide StEPS vision screening, is to be undertaken by LHDs according to LHD protocols. This should include performance reviews of vision screening staff referral rates and where appropriate, actions undertaken to address performance factors and skill development.

6 GLOSSARY OF TERMS

Adnexa
For the purposes of this document, adnexa refers to the appendages of the eye. These include but are not limited to the eyelids, conjunctiva, lacrimal apparatus and orbit.

Amblyopia
Amblyopia is reduced or 'dim' vision in an eye which appears to be normal. It is sometimes called 'Lazy Eye'. This is a serious eye defect which often goes undetected in childhood. If amblyopia is not diagnosed and treated early, the vision in the affected eye may be permanent and cannot be corrected with glasses or surgery.

Eye Health Professional
For the purposes of this document, an *Eye Health Professional* refers to registered ophthalmologists, orthoptists and optometrists.

Refractive Error
A refractive error occurs when the shape of an eye is abnormal or does not bend (or refract) light properly, which results in blurred vision. The three most common refractive errors are myopia (short sightedness), hyperopia (long-sightedness) and astigmatism.

HOTV logMAR chart
A visual acuity screening chart used in the StEPS program. LogMAR charts feature the same number of letters on each line, which progressively reduce in size according to a geometrical progression.

Sheridan Gardiner Linear Chart
A visual acuity screening chart used in the StEPS program. Linear charts feature an increasing number of letters on each line, which linearly reduce in size.

Visual Acuity
Visual acuity refers to the measurement of the eye's capacity to see an object, for example a letter on a vision chart, at a certain distance. This measurement is taken one eye at a time with the child wearing their correcting glasses or contact lenses (when needed). It is usually recorded in a format that compares the child's vision results to a certain standard.

Visual Acuity Screening
Also referred to as vision screening, this is the testing of visual acuity using pass/fail criteria to a specific standard correlated to an age appropriate level of acceptable vision.

Vision Surveillance
Vision surveillance is defined as the monitoring of vision development for signs of eye or vision problems and includes observation, family history, reported visual behaviours and some vision tests, e.g. corneal reflections, ocular movements and response to occlusion.

7 LIST OF ATTACHMENTS

To view attachments listed below please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2018_015

1. Implementation Checklist
2. StEPS Important Notice for all Parents/Carers
3. StEPS Consent and Results Form
4. Notification of StEPS Vision Screening Results letter
5. StEPS Referral Letter
6. StEPS Referral Protocols for Paediatric Ophthalmology Outpatient Clinics
7. StEPS Referral Form for Paediatric Ophthalmology Outpatient Clinics
8. Competency Checklist for Vision Screeners
9. StEPS Screening Activity report
10. StEPS Referral Outcomes report

PAEDIATRIC PROCEDURAL SEDATION - GUIDE FOR EMERGENCY DEPARTMENTS, WARDS, CLINICS AND IMAGING (GL2018_011)

PURPOSE

Paediatric Procedural Sedation - Guide for Emergency Departments, Wards, Clinics and Imaging provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The guide was prepared for the NSW Ministry of Health by an expert clinical reference group.

KEY PRINCIPLES

This guide applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and Speciality Health Networks to determine where local adaptions are required or whether it can be adopted in its current format in hospitals and facilities required to manage procedural sedation of paediatric patients.

This guide reflects what is currently regarded as a safe and appropriate approach to the management of procedural sedation for paediatric patients. However, as in any clinical situation there may be factors which cannot be covered by a single guide. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. It does not replace the need for the application of clinical judgement to each individual presentation.

USE OF THE GUIDELINE

Chief Executives must ensure:

- This guide is adopted or local procedures are developed based on the Paediatric Procedural Sedation Guide for Emergency Departments, Wards, Clinics and Imaging.
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric patients requiring procedural sedation
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this revised guideline.

This Guideline and the attachements are available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2018_011

NEW STREET SERVICE POLICY AND PROCEDURES (PD2018_035)

PURPOSE

This Policy specifies the procedures and minimum standards for delivering New Street Services, and sets out the NSW Health framework for effective clinical practice in responding to children and young people with harmful sexual behaviours and their carers.

MANDATORY REQUIREMENTS

This Policy requires that New Street Services:

- prioritise the safety and wellbeing of young people who have been sexually harmed and those who are potentially at risk
- facilitate access to treatment for eligible families and caregivers of children and young people aged between 10 and 17 years who have engaged in harmful sexual behaviour, with priority given to those aged between 10 and 14 years, Aboriginal children and children with complex needs
- deliver services in ways which minimise harm
- integrate with NSW Health Violence Abuse and Neglect services, particularly Sexual Assault Services
- collaborate with interagency partners at local and district levels
- operate under a Service Agreement between the Local Health District in which the New Street service is located and the Sydney Children's Hospital Network, to receive clinical direction, advice and support
- comply with New Street staffing profiles as set out in the New Street Service Policy and Procedures
- deliver services in a culturally safe way
- participate in the New Street Advisory Committee
- apply the clinical processes and practices set out in the New Street Service Policy and Procedures
- comply with NSW Health Violence Abuse and Neglect Service Standards.

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- establishing mechanisms to ensure the directives and requirements of the New Street Service Policy and Procedures are applied, achieved and sustained
- ensuring that NSW Health staff understand and are aware of their obligations in relation to the New Street Service Policy and Procedures and related policies and procedures
- ensuring resources are available to deliver and meet the directives and requirements of the New Street Service Policy and Procedures
- ensuring that NSW Health staff are trained to operationalise and implement the New Street Service Policy and Procedures
- communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the New Street Service Policy and Procedures
- ensuring NSW Health staff are advised that compliance with the New Street Service Policy and Procedures is part of their patient / client care responsibilities.

New Street managers are responsible for:

- ensuring the requirements of the New Street Service Policy and Procedures are disseminated and implemented in their service
- monitoring implementation and compliance with the New Street Service Policy and Procedures.

NSW Health workers are responsible for:

- implementing and complying with the directives and requirements of the New Street Service Policy and Procedures.

This policy and the procedures are available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2018_035

321(21/09/18)

PASTEURISED DONOR HUMAN MILK FOR VULNERABLE INFANTS
(PD2018_043)

PURPOSE

NSW Health is committed to the safe, equitable and ethical provision of pasteurised donor human milk (PDHM) to vulnerable infants in Neonatal Intensive Care Units (NICU).

Vulnerable infants refer to those infants at an increased risk of necrotising enterocolitis. This includes preterm infants, very low birth weight infants and other infants assessed as clinically high risk.

A partnership between NSW Health and the Australian Red Cross Blood Service (ARCBS) has been established in order to provide PDHM to these infants through the 'NSW Health Agreement for Pasteurised Donor Human Milk'. PDHM is supplied to NICUs on a cost-recovery basis.

This Policy supports mothers of vulnerable infants to optimise lactation; to supplement breast milk feeding of vulnerable infants with PDHM when mothers own milk is insufficient and ensure access to PDHM is equitable across NSW and in accordance with clinical need.

Only facilities with NICUs are eligible to receive PDHM. This Policy outlines the responsibilities of local health districts (districts) and Sydney Children's Hospital Network (SCHN) NICUs who choose to participate in the provision of PDHM to vulnerable infants under the NSW Health Agreement.

MANDATORY REQUIREMENTS

To receive PDHM districts and SCHN must:

- Implement the attached, Pasteurised Donor Human Milk for Vulnerable Infants Protocol (the Protocol)
- Ensure they have sufficient resources to meet the requirements of this service.
- Ensure each ARCBS Milk Bank Coordinator complies with:
    - NSW Health Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases policy.
    - NSW Health Code of Conduct.
    - National Criminal Record completed by ARCBS and sighted by facility.
    - Local orientation procedures.

321(27/11/18)

- Support donor recruitment within their facilities.
- Provide appropriately trained staff to ensure that adequate ongoing lactation support is offered, and that NICU breastfeeding rates on discharge are optimal.
- Provide facility-specific data for the purpose of quarterly performance monitoring in accordance with Section 1.6 in the Protocol.
- Coordinate the management of reactive serology screening results for hospital-based donors as per Appendix 1 in the Protocol.

IMPLEMENTATION

The districts/SCHN Chief Executives or delegated officers must ensure the NICUs undertake the following actions:

- All NICU staff are made aware of the Policy and Protocol.
- Appoint an authorised person to act as the 'Agency Contract Manager', as outlined in Section 14 in the Protocol, who will also be the point of contact for supply management in case of PDHM shortage.
- Key personnel are made aware of their responsibilities in the Protocol.
- Designated lead to develop local guidelines to support the implementation of the Policy and Protocol.

Supply of PDHM to NICUs during a shortage is determined by the principles of state-wide equity, with state-wide eligibility being determined as per the attached Protocol and not by the individual NICU. The monitoring reports will be compiled quarterly by the Health and Social Policy Branch, Strategy and Resources Division, Ministry of Health. These reports will be provided to the PDHM Governance Committee and Clinical Advisory Group for review.

Documentation of ARCBS Milk Bank Coordinator compliance with NSW Health policy and Code of Conduct can be performed at one site and these documents shared with other relevant sites to streamline credentialing processes in NSW.

Other relevant NSW Health Policies are:

- Breastfeeding in NSW: Promotion, Protection and Support
- Breast Milk: Safe Management

This policy and the Pasteurised Donor Human Milk for Vulnerable Infants – NSW Health and Australian Red Cross Blood Service Partnership Service Protocol is available at:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2018_043

FIRST 2000 DAYS FRAMEWORK (PD2019_008)

PURPOSE

The First 2000 Days Framework (the Framework) is a strategic policy document which outlines the importance of the first 2000 days in a child's life (from conception to age 5) and what action people within the NSW health system need to take to ensure that all children have the best possible start in life.

MANDATORY REQUIREMENTS

Local Health Districts and Speciality Health Networks will ensure that strategies to implement the First 2000 Days Framework appear within their local plans, commencing by 1 July 2019.

Local Health Districts and Specialty Health Networks will provide an annual report, on request, to the NSW Ministry of Health on progress against their implementation plan.

IMPLEMENTATION

Local Health Districts and Specialty Health Networks have lead responsibility for implementing the Framework within their district or network. They are to use the information provided in the Framework about the first 2000 days and opportunities for action to inform local priority setting and planning against the Framework's strategic objectives. The three objectives of the Framework are:

1. All staff in the NSW health system understand and promote the importance of the first 2000 days and the best opportunities for action
2. The NSW health system provides care to all and works in partnership to promote health, wellbeing, capacity and resilience during the first 2000 days
3. The NSW health system provides additional services for those who need specialised help, when they need it.

NSW Ministry of Health, will support implementation of the Framework. The Branch will monitor implementation through annual reports that will be requested from Local Health Districts and Speciality Health Networks about progress towards priorities in their local plans.

This policy and the First 2000 Days Framework are available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2019_008

321(08/02/19)

FIRST 2000 DAYS IMPLEMENTATION STRATEGY (IB2021_011)

SUMMARY

The NSW Health First 2000 Days Implementation Strategy was developed to assist Local Health Districts and Specialty Health Networks in implementing the First 2000 Days Framework, including providing information to assist them in developing their local plans.

This information bulletin and the Frist 2000 Days Implementation Strategy are available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2021_011

336(23/03/21)

MATERNITY - MANAGEMENT OF MONOCHORIONIC TWIN PREGNANCY (GL2020_011)

PURPOSE

This Guideline provides best practice guidance to clinicians caring for women with monochorionic (MC) twin pregnancies. It promotes consistent recognition, monitoring, reporting, management and appropriate referral within the tiered NSW Maternity and Neonatal (Perinatal) Networks to optimise fetal and maternal wellbeing.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations (PHOs) providing maternity services. The Guideline:
 endorses the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) recommendations for MC twin pregnancies (see Section 2)
 recommends that women with MC twin pregnancies require as a minimum, antenatal care from a Level 4 maternity service in consultation with a Level 5 or 6 maternity service, and planned birth at a Level 5 or 6 maternity service in line with *NSW Maternity and Neonatal Service Capability Framework* GL2016_018 (see Section 1.6)
 defines minimum standards for the frequency of ultrasound scanning and ultrasound reporting for women with a MC twin pregnancy (see Section 2.2 and Appendix 1)
 recommends all Tiered Perinatal Networks have an agreed pathway to communicate ultrasound scan results between ultrasound departments and maternity care providers in line with *Tiered Networking Arrangements for Perinatal Care in NSW* PD2020_014 (see Section 1.6).

USE OF THE GUIDELINE

Chief Executives of Local Health Districts are responsible for:

- ensuring appropriate referral, escalation and transfer of care for women with MC twin pregnancies in line with this Guideline and *NSW Maternity and Neonatal Service Capability Framework* GL2016_018 (see Section 1.6)
- developing local referral to and reporting pathways for appropriate obstetric ultrasound providers with capability to assess a twin pregnancy (see Section 1.5)
- monitoring and review of outcomes for women diagnosed with MC twin pregnancy (see Section 6).

The Maternity - Management of Monochorionic Twin Pregnancy Guideline can be downloaded at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_011

MANAGEMENT OF POSITIONAL PLAGIOCEPHALY BY ALLIED HEALTH PROFFESIONALS (GL2020_013)

GUIDELINE SUMMARY

The Guideline was developed to provide best practice guidance for management of infants with positional plagiocephaly.

The objectives of the Guideline are to:

- assist clinicians working in primary and secondary health service areas with early detection and assessment and of infants with positional plagiocephaly
- provide clinicians with best practice guidance for management of infants diagnosed with positional plagiocephaly
- provide clinicians with best practice guidance for referral of infants with positional plagiocephaly to tertiary services (e.g. Craniofacial–Helmet clinic).

KEY PRINCIPLES

The Guideline should be used in conjunction with the *Physiotherapy management of plagiocephaly* eLearning module available through the NSW Health Education and Training Institute (HETI) online learning portal, My Health Learning.

Key principles for the Guideline are outlined further in Section 1.3. The Guideline is one component of clinical decision making and provides a guide for best practice for clinicians working with infants with suspected or diagnosed positional plagiocephaly.

USE OF THE GUIDELINE

Chief Executives must:

- ensure that the Guideline is adopted and that local policies based on the Guideline are in place in all hospitals and facilities likely to be required to care for children with positional plagiocephaly.

Directors of Clinical Governance are required to:

- inform relevant clinical staff treating paediatric patients of this guideline
- ensure that all staff treating infants are educated and supported in the use of the locally developed protocols for referral and management of positional plagiocephaly.

The Management of Positional Plagiocephaly by Allied Health Professionals Guideline can be downloaded at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_013

CLINICAL DETERMINATION FOR BOARDER BABY REGISTRATION (GL2020_020)

GUIDELINE SUMMARY

This Guideline clarifies when a neonate (a baby up to 28 days of age) is required to be registered in the **Patient Administration System (PAS)** as a boarder. It sets out the responsibilities for the assessment and care of neonates who are accommodated in a NSW Public Health Organisation (PHO) to ensure patient safety and quality care.

KEY PRINCIPLES

- A neonate less than 10 days of age who is in hospital cannot be registered as a 'boarder'. Neonates under 10 days of age who remain in hospital or return to hospital because the caregiver (usually the mother) is unwell must be an admitted patient.
- A neonate 10 or more days of age **not requiring clinical care**, may be a boarder when accompanying the caregiver who is an admitted patient. In this case the neonate is not an admitted patient and should be registered as a boarder.
- A neonate in a PHO must have a clinical assessment by an appropriate medical officer prior to admission or registration as a boarder.
- Regardless of the admission status all neonates should have two identification bands in place preferably on each ankle.
- Care planning for the neonate should be individualised and take into consideration the caregiver's clinical condition, physical and mental health, the impact of treatment on the caregiver's capacity to care for the neonate, and any additional supports required for the family,
- Any neonate, irrespective of age, whose caregiver (or sibling of the same multiple birth) is admitted for treatment of sepsis, must be physically assessed, investigated where appropriate and monitored for sepsis. A neonate in these circumstances would usually be admitted and should not be registered as a boarder.
- Wherever possible caregivers and neonates should not be separated. Support, protection and promotion of breastfeeding is essential.

LOCAL HEALTH DISTRICT RESPONSIBILITIES

Local health districts are responsible for developing local Guidelines, pathways and resources to ensure:

- neonates receive appropriate care in an appropriate place
- assessment, care and care planning is documented
- correct registration of all neonates in the PAS

The Clinical Determination for Boarder Baby Registration Guideline can be downloaded at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_020

SYPHILIS IN PREGNANCY AND NEWBORNS (PD2023_029)

POLICY STATEMENT

NSW Health is committed to addressing concerning increases in the number of women diagnosed with syphilis in pregnancy (maternal syphilis) and mother-to-child transmission of syphilis (congenital syphilis) resulting in adverse outcomes including preterm birth, low birth weight, congenital anomalies, fetal loss or stillbirth, and neonatal death. Congenital syphilis is an entirely preventable disease and its occurrence reflects a failure of delivery systems for antenatal care and syphilis control programs.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive introduces new antenatal syphilis screening intervals for all pregnant women, and outlines Local Health Districts (Districts), Specialty Health Networks (Networks) and service level responsibilities to ensure appropriate referrals, assessment and management of syphilis in pregnancy and neonates.

This Policy Directive must be read as a supplement to existing gold-standard clinical guidance outlined in the current edition of the Australasian Society for Infectious Diseases (ASID) guidelines Management of Perinatal Infections.

Assessment, diagnosis, and treatment of maternal and congenital syphilis is multifaceted and requires a multidisciplinary response. Leadership at Districts and Networks must ensure that local processes are in place to enable effective implementation of this Policy Directive including identified referral pathways and responsibilities for follow-up of women at risk of syphilis in pregnancy, and pregnant women diagnosed with syphilis in pregnancy.

All pregnant women in NSW must be offered syphilis screening as part of their first antenatal visit blood screen and again at 26-28 weeks gestation. Pregnant women who have received minimal or no antenatal care, or are at risk of missing an appointment, should be opportunistically screened for syphilis and blood-borne viruses Hepatitis B and HIV at the service they present at, regardless of gestation. Documentation of all antenatal syphilis screening must be entered into the relevant District maternity database and medical records.

All positive syphilis results in pregnancy should be discussed with a clinician who has expertise in managing and treating syphilis. Local pathways must be developed to ensure pregnant women are referred to maternity services, and all relevant services are informed including sexual health services, the local public health unit and primary care services to facilitate appropriate contact tracing and treatment where relevant.

Timely assessment and initiation of treatment is essential for all cases of maternal syphilis per the Australasian Society for Infectious Diseases (ASID) guidelines Management of Perinatal Infections. All pregnant women diagnosed and treated for syphilis in pregnancy need the details of their investigations and management, and recommendations for future testing requirements clearly documented in their medical records. Local pathways must be developed to ensure maternal and neonatal assessment is clearly documented in the patient's medical record in a manner that ensures this is flagged at the time the pregnant women presents for birth.

Responsibility for neonatal follow-up must be clearly defined on discharge identifying the most appropriate service as relevant to the local context and woman's needs (such as paediatric outpatient clinic or outreach service). Auditing processes must be developed to monitor and review follow-up care and clinical outcomes.

All cases of congenital syphilis are to be investigated as a clinical incident and entered into the Incident Management System (ims+) with a harm score relevant to the case. NSW Health employees must be aware of the importance of reporting incidents and near misses to ensure timely investigation and ensure lessons are learnt to facilitate the elimination of congenital syphilis in NSW

The complete Syphilis in Pregnancy and Newborns policy is available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_029

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NSW HEALTH & CIVIL CHAPLAINCIES ADVISORY COMMITTEE NSW MEMORANDUM OF UNDERSTANDING (PD2011_004)

PD2011_004 rescinds PD2005_123.

PURPOSE

This policy sets out the privileges and requirements for accredited chaplains to provide chaplaincy and pastoral care services in the NSW Health System. The process for appointment and accreditation of chaplains is provided, as well as a description of the duties which accredited chaplains typically undertake. Privacy and patient confidentiality issues are addressed, and chaplaincy terms are clearly defined. Associated funding and financial agreements are also addressed together with the obligations of NSW Health, the Civil Chaplaincies Advisory Committee (http://www.ccacnsw.org.au) and their member religious organisations.

MANDATORY REQUIREMENTS

Health Service Chief Executives and other NSW Health Agencies should have effective systems and procedures in place in order to make sure that the provision of chaplaincy and pastoral care services are managed according to the requirements set out in the memorandum of understanding.

IMPLEMENTATION

Health Network Chief Executives and other NSW Health Agencies are to ensure that the requirements of this policy are communicated to all the appropriate staff (including Hospital Chaplaincy Coordinators, Privacy Contact Officers, Hospital Accredited Chaplains and Pastoral Care Workers, Hospital Administration, Clinical/Patient Services and Social Workers.

The CCAC will facilitate the distribution of the policy and its obligations on behalf of its member organisations.

1. Introduction and background to the NSW Health & Civil Chaplaincies Advisory Committee NSW Memorandum of Understanding (PD2011_004)

2. NSW Health & Civil Chaplaincies Advisory Committee NSW Memorandum of Understanding (PD2011_004)

CHAPLAINCY SERVICES AND PRIVACY LAW (IB2008_044)

Introduction

This Information Bulletin replaces PD2005_412 *Chaplaincy Services and Privacy Law* and complements PD2011_004 *NSW Health & Civil Chaplaincies Advisory Committee NSW Memorandum of Understanding*.

This Information Bulletin and PD2011_004 *NSW Health & Civil Chaplaincies Advisory Committee NSW Memorandum of Understanding* both support the role of chaplaincy services in the NSW public health system. Chaplaincy services are considered an important part of the health support services provided through hospitals and other health facilities to patients and their families.

Questions have arisen as to whether provision of information to hospital chaplains is within the terms of NSW privacy law, particularly given the additional restrictions imposed by privacy laws on access to information about religious and philosophical beliefs.

A regulation has therefore been made under the *Health Records and Information Privacy Act 2002* to clarify the situation in relation to the provision and use of information for NSW Health chaplaincy services, and to provide a sound legal basis for information sharing with chaplaincy services in the NSW Health system.

The regulation is entitled *Health Records and Information Privacy Amendment (Accredited Chaplains) Regulation 2008*.

This Information Bulletin provides guidance to NSW Health accredited chaplains and NSW Health staff as to the operation of the regulation.

This Information Bulletin will become effective on the date of commencement of the regulation which is 1 October 2008.

How will the regulation work?

The regulation recognises that chaplaincy services form part of the health services available at a hospital or health facility.

It allows information to be released to a chaplain provided that release is for the purposes of chaplaincy services and the release is within the reasonable expectation of the patient or other person to whom the information relates.

Patient consent for release of personal information to accredited chaplains is not required under the regulation. Consequently it is not necessary to include a consent question in admission procedures or on admission forms.

It is important to recognise:

- Access to information under the regulation is limited to accredited chaplains, that is chaplains who have been accredited by the Chief Executive of the public health organisation through PD2011_004;
- The test that the disclosure is within "the reasonable expectation" of the patient is the same test applied in relation to the sharing of information for the purposes of providing ongoing medical care. To support compliance:
  - steps should be in place to ensure that patients are aware that information will be provided to a hospital's chaplaincy department or chaplaincy services;
  - where a patient indicates they do not wish information to be provided, steps should be taken to ensure these views are complied with.
- Accredited chaplains are routinely provided with the name and religious faith or denomination of patients. When necessary, accredited chaplains may also be provided with additional personal and health information to enable the chaplain to fulfil his or her duties in a manner which is within the patient's reasonable expectation or that of the patient's relatives.

The Information Privacy Leaflet for Patients has been revised to include reference to chaplaincy services (see http://www.health.nsw.gov.au/utilities/privacy/patient.asp). Health services have developed local Information Privacy Leaflet for Patients based on this. Facilities may also have local information and brochures on chaplaincy services which can be used for this purpose.

Compliance with *Health Records and Information Privacy Act 2002*

The regulation means that accredited chaplains will now be covered by the *Health Records and Information Privacy Act* in relation to the information they obtain from hospitals and hospital chaplaincy services.

This means chaplaincy services will need to comply with certain requirements under privacy law in relation to access and retention of records. For assistance with these requirements, accredited chaplains should refer to the 'Information Sheet for Accredited Chaplains: Compliance with the *Health Records and Information Privacy Act 2002'* which can be found on the NSW Health privacy website: http://www.health.nsw.gov.au/utilities/privacy/info_chaplains.asp.

Public health organisations are encouraged to use their Chaplaincy Services Steering Committee to establish local protocols and procedures for communication between hospital staff and accredited chaplains and to provide support for chaplaincy services in complying with the terms of the *Health Records and Information Privacy Act* and the regulation. Where no Chaplaincy Services or Pastoral Care Department exist in a public health organisation, a process of accreditation of local clergy or religious leaders should be established through the Human Resources Department or equivalent personnel office.

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 4 – DENTAL CARE

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Eligibility of Persons for Public Oral Health Care in NSW	PD2017_027
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Oral Health Patient Record Protocol	GL2015_017
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Growth Assessment and Dietary Advice in Public Oral Health Services	GL2019_001
Teledentistry	GL2020_019

ELIGIBILITY OF PERSONS FOR PUBLIC ORAL HEALTH CARE IN NSW (PD2017_027)

PD2017_027 rescinds PD2016_050

PURPOSE

This Policy Directive establishes the eligibility criteria for NSW residents who wish to access NSW Health public oral health services.

MANDATORY REQUIREMENTS

Public Oral Health Services managed by NSW Local Health Districts (LHD) must provide oral health care to persons who meet the eligibility criteria set out in this document.

At each appointment, staff of NSW Public Oral Health Services must ensure a person meets the eligibility criteria set out by this document prior to providing care.

IMPLEMENTATION

The NSW Ministry of Health is responsible for ensuring the requirements of this policy and attached procedures are monitored and acted on accordingly, and that the eligibility criteria are openly communicated to the public.

LHD Chief Executives are responsible for ensuring the public oral health services in their LHD provide oral health care to eligible persons in accordance with this document.

Oral Health Managers, **Clinical Directors** and **staff of public oral health services** are responsible for ensuring compliance with the eligibility criteria set out in this policy and attached procedures, and that the eligibility criteria are openly communicated to the public.

This Policy Directive should be read in conjunction with the following NSW Health policies:

- Priority Oral Health Program and Waiting List Management
- Oral Health Fee for Service Scheme (OHFFSS)
- Oral Health Specialist Referral Protocols
- Oral Health Chart & Referral Form for Medical Emergency Departments

1 BACKGROUND

1.1 About this document

NSW Public Oral Health Services provide a range of dental care services through funding provided or managed by the NSW Government. To ensure available resources are used efficiently, NSW Health limits access to these services to those populations at higher risk of dental disease or who are less able to afford dental care through private providers. This is achieved through the setting of eligibility criteria through this Policy Directive.

Section 2 sets out the criteria for a person to be eligible to receive dental care through NSW Public Oral Health Services. Public Oral Health Services managed by NSW Local Health Districts (LHDs) must provide oral health care to persons who meet these criteria.

Staff of NSW Public Oral Health Services must ensure a person meets the eligibility criteria set out by this document prior to providing care (section 2.3).

Section 3 provides additional detailed information on how staff from public oral health services should manage the delivery of patient care. It provides information on variations and exceptions to eligibility criteria, including patients admitted to hospital for other health care, ineligible patients, and patients who are accessing care outside their LHD.

The NSW Ministry of Health is responsible for ensuring the requirements of this policy are monitored and acted on accordingly, and that the eligibility criteria are openly communicated to the public (section 4).

LHD Chief Executives are responsible for ensuring the public oral health services in their LHD provide oral health care to eligible persons in accordance with this document.

Oral Health Managers, **Clinical Directors** and **staff of public oral health services** are responsible for ensuring compliance with the eligibility criteria set out in this policy and that the eligibility criteria are openly communicated to the public (section 4).

1.2 Key definitions

An episodic course of care is defined as a limited course of care provided with the intent of only addressing a specific, clinically urgent presentation.

An oral health emergency is defined as a child or adult patient categorised as Priority 1 through the PD2017_023 *Priority Oral Health Program and Waiting List Management* policy directive triage. Dental pain by itself is not considered an oral health emergency.

2 ELIGIBILITY

2.1 Eligibility of Adults for Non-admitted Oral Health Care Services

For an adult to be eligible for free public oral health services they must:

- Be normally resident within the boundary of the providing LHD , **and**
- Be eligible for Medicare, **and**
- Be 18 years of age or older, **and**
- Hold, or be listed as a dependent on, one of the following valid Australian Government[1] concession cards:
  - ⇒ Health Care Card
  - ⇒ Pensioner Concession Card
  - ⇒ Commonwealth Seniors Health Card.

Note that holders of the State Seniors Card are not eligible for care unless they also hold one of the other concession cards listed above.

2.2 Eligibility of Children and Young Persons for Non-admitted Oral Health Care Services

For a child or young person to be eligible for free public oral health services they must:

- Be normally resident within the boundary of the providing LHD , **and**
- Be eligible for Medicare, **and**
- Be less than 18 years of age.

Additional eligibility criteria may apply for some specialist oral health care. These are detailed in the Oral Health Specialist Referral Protocols.

[1] Includes Centrelink and the Department of Veterans Affairs.

2.3 Confirmation of Eligibility

At each visit the patient is responsible for proving their eligibility prior to receiving treatment, by showing a valid Medicare card and, for adults, a valid concession card. Electronic versions of cards may be used through the Centrelink mobile app on a smart phone.

If a valid concession card cannot be produced, the patient must seek a temporary concession card to establish that they are eligible for treatment, except where the person requires emergency treatment (as defined in Section 1.2).

The patient may also be asked to produce secondary identification such as a drivers licence to confirm their identity. A formal letter of identification from a homelessness agency is also acceptable as a secondary identification.

Where programs exist that involve partnerships and referral pathways between Oral Health Services and Aboriginal Community Controlled Health Services or LHD Aboriginal Service, LHDs may apply discretion to waive eligibility requirements for the clients of these programs. This may also be extended to client's partners and children.

3 PATIENT CARE

3.1 Inter-district agreements

Due to funding and reporting arrangements, dental care will normally be provided by the LHD in which a patient lives. However, LHD's may have inter-district arrangements that allow for patients to receive care in a bordering LHD to facilitate accessibility to an appropriate service.

3.2 Admitted or Day Only Oral Health Care Patients.

Where a patient's oral health treatment requires them to be treated as an inpatient, they may be treated as:

- Non Chargeable Patients
- Compensable Patients
- Private Patients.

Standard LHD procedures for processing and charging patients should be followed, in accordance with Section Two of the NSW Health Fees Procedures Manual.

3.3 Patients Admitted for Other than Oral Health Treatment

Free oral health care will only be provided to adult patients admitted for care other than oral health treatment where:

- The oral health treatment is an emergency (as defined in Section 1.2), or
- The oral health treatment is an essential part of the surgical or medical management of the patient, and
- They hold, or are a listed dependent of the holder of, a current concession card (see section 2).

Treatment of hospital inpatients referred for oral health care will be negotiated with the LHD oral health clinical director if the oral health treatment is not an intrinsic part of their medical treatment. Patients who do not hold, or are not listed dependents on, a current concession card may be charged for services. The treatment sought will need to be prioritised in adherence with current LHD and NSW Health prioritisation policies for access to public oral health care.

Note that private admitted patients must pay for oral health care provided.

3.4 Services Provided to Ineligible Patients at Oral Health Clinics or at an Emergency Department

Persons not meeting the eligibility criteria set out above, including interstate visitors, may receive emergency treatment only and should see their own private general dental practitioner for all other treatment. Emergency treatment (as defined in section 1.2) may be provided to such patients who present at either a public oral health clinic or at a hospital emergency department.

Unless covered by an inter-district agreement, residents of NSW who are outside of their LHD of residence, but are otherwise eligible for free public oral health care, should only be provided with an episodic course of care (as defined in Section 1.2) and / or an Oral Health Fee For Service voucher if required. Additional dental care may be provided at the discretion of the clinical director, taking into account any additional personal circumstances of the patient.

In consultation with the patient, the LHD that provides this episodic care should make arrangements for the patient to receive any follow-up treatment required from the patient's LHD of residence.

Emergency oral health treatment and an episodic course of care (as defined in Section 1.2) may be provided to a person who is unable to prove eligibility because they are experiencing homelessness or are seeking asylum on humanitarian grounds. The person must be referred to the oral health service by an established agency and the requirement for proof of eligibility may be waived in these circumstances. Identification and treatment of these patients should be provided in accordance with PD2016_055 *Medicare Ineligible and Reciprocal Health Agreement – Classification and charging*

Compensable patients are to be charged at the compensable rate for an occasion of service (see Fees Procedures Manual). These patients should be advised that oral health treatment does not attract Medicare rebates and may not attract private health insurance rebates.

4 COMMUNICATION STRATEGY

Eligibility criteria and information on how eligible persons can access NSW Public Oral Health Services is made available through the NSW Health website at http://www.health.nsw.gov.au/oralhealth/Pages/eligibility.aspx.

The Centre for Oral Health Strategy, NSW Health has developed brochures that identify the eligibility criteria and process for accessing public dental care. The brochures that are available include; 'Public Dental Services', 'Oral Health Fee for Service Scheme', 'Child Dental Benefits Schedule Fact Sheet', Child Dental Benefits frequently asked questions'.

These brochures can either be downloaded from Centre for Oral Health Strategy website (http://www.health.nsw.gov.au/oralhealth/Pages/resources.aspx) or, alternatively, be ordered free of charge from Better Health Centre – Publications Warehouse 02 9887 5450

ORAL HEALTH FEE FOR SERVICE SCHEME (PD2016_018)

PD2016_018 rescinds PD2008_065

PURPOSE

This Policy Directive establishes a clear, patient focused, referral pathway that ensures a care management focus between public oral health services and private practitioners who participate in the scheme.

MANDATORY REQUIREMENTS

Local Health Districts and participating private dental businesses and practitioners must establish business rules that address the requirements in this policy's procedures and change from a paper based administration system to the NSW Health web-based administration system.

IMPLEMENTATION

The responsibilities of the key parties to ensure the mandatory requirements and standards of this policy are monitored and acted on accordingly.

Chief Executives:

Assign responsibility and personnel to implement the policy.

Oral Health Clinical Directors and Oral Health Managers:

Ensure timely and open communication to establish a patient focused outsourcing dental program with participating private practitioners.

All Local Health District Staff and contracted Private Dental Practitioners and Businesses:

Comply with the policy directive and actively participate in establishing efficient patient referral processes and effective dental care.

1 BACKGROUND

The Oral Health Fee for Service Scheme (Scheme) provides a framework by which Local Health Districts (LHDs) may engage private dental practitioners (practitioners) and associated dental businesses (businesses) to provide care to public oral health service patients.

This document provides an overview of the Scheme and outlines the processes for:

- Web based administration
- Approving businesses and practitioners to participate in the Scheme
- Utilisation and payment for services under the Scheme
- Terms and conditions, and
- Governance of the Scheme.

1.1 Key definitions

In this document the term:

- **Must** – indicates a mandatory action required that must be complied with.
- **Should** – indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

The following is clarification of key terms used throughout the document:

Episodic dental care voucher	Is the voucher type for emergency or acute course of care that is associated with a limited examination (013).
General dental care voucher	Is the voucher type for a general course of care (excludes dentures) that is associated with a full examination (011).
Denture provision voucher	Is the voucher for full or partial dentures and is associated to a limited examination (013) for dentists and consultation (014) for dental prosthetists.
Business	Is a facility where dental services are rendered either by a single dental practitioner or a group of dental practitioners, and/or, a business purely associated with an ABN that has been identified as a place for payment of services.
Practitioner	Is a dental practitioner registered with the Dental Board of Australia in the appropriate division (dentist, dental therapist, dental hygienist, oral health therapist and dental prosthetist) under the Health Practitioner Regulation National Law http://www.dentalboard.gov.au/Registration.aspx
Clinical Director	Is an LHD/Speciality Network clinician who is employed as an Area Clinical Director Level 1 – 3, or is a LHD delegated senior clinician.

1.2 Regulatory and legislative framework

The regulatory and legislative framework within which this procedure operates is set out in the *Health Practitioner Regulation National Law (NSW)* (http://www.legislation.nsw.gov.au/maintop/view/inforce/act+86a+2009+cd+0+N), and further information in relation to the registration of practitioners can be sourced from the Dental Board of Australia and the Australian Health Practitioner Regulation Agency.

1.3 Related NSW Ministry of Health policies, guidelines and information bulletins

The implementation of this procedure should be read in conjunction with the following NSW Ministry of Health policy directives, guidelines and information bulletins as updated from time to time:

- Clinical Procedure Safety
- Complaint Management Policy
- Complaint or Concern about a Clinician - Management Guidelines
- Complaint or Concern about a Clinician - Principles for Action
- Complaints Management Guidelines
- Consent to Medical Treatment – Patient Information
- Employment Checks – National Criminal Record Checks and Working with Children Checks
- NSW Health Privacy Manual for Health Information
- OHFFSS Schedule of Fees
- Oral Health - Eligibility of Persons for Public Oral Health Services in NSW
- Oral Health Record Protocols
- Oral Health: Cleaning, Disinfecting and Sterilizing
- Priority Oral Health Program and Wait List Management

NSW Ministry of Health policy directive, guidelines and information bulletins are public documents and are available on their website. (http://www.health.nsw.gov.au/policies/pages/default.aspx)

2 SCHEME OVERVIEW

The Scheme allows LHDs to engage private businesses and practitioners to provide dental care for eligible child and adult patients that have requested care from the LHD directly. LHD representatives will issue a voucher to eligible patients. Vouchers can be redeemed by patients at a business approved to participate in the Scheme. Once the patient's treatment is completed, the business or practitioner, forwards the voucher to the LHD for payment. The principal of the business and practitioner agrees to a set price schedule and the terms and conditions as listed in the current OHFFSS Schedule of Fees. The Schedule of Fees is updated annually and is indexed against the Department of Veterans Affairs fee schedule for dental care - http://www.dva.gov.au/Pages/home.aspx.

2.1 Participating Practitioners

All dental practitioners registered with the Dental Board of Australia are encouraged to apply to be approved practitioners under the Scheme.

All dentists and oral health practitioners must only provide dental services within their scope of practice under the OHFFSS.

The LHD may indicate to the patient the practitioner type most suitable for the treatment required.

2.2 Service Types

The OHFFSS provides the opportunity for referred public dental patients to receive dental care through the following service types:

- Episodic care for children and adults
- General care for children and adults
- Dentures
- Domiciliary, and
- Specialist services such as oral surgery and periodontics.

2.3 OHFFSS Voucher

An OHFFSS voucher can only be provided through the Priority Oral Health Program triage questionnaire, which assesses the patient's oral heath need, or an authorised mechanism approved by NSW Health.

There are three types of vouchers that may be issued, these are:

1. Episodic care – The intent of this voucher is to address the most urgent treatment needs of a patient
2. General care – A voucher that covers comprehensive care identified by a full examination of a patient
3. Denture provision – A voucher that specifically includes denture care.

2.3.1 Voucher expiry timeframes

An OHFFSS voucher has an expiry date from the date of issue. The expiry timeframes for the three voucher types are:

- One (1) month for episodic care, and
- Three (3) months for general care and dentures.

2.4 Specific conditions related to the provision of dental treatment under the Scheme.

- The items claimable are restricted by the voucher type (refer to Point 2.3) and the Schedule of Fees.
- Generally dentures will be acrylic, unless specified by the LHD. If a patient wishes to have a chrome denture that is not specified or approved on the voucher, or any other additional feature, the business and/or practitioner may enter a private agreement with that patient to cover the additional expense.
- Dentures are to comply with the Therapeutic Goods Administration (TGA) Standards (http://www.tga.gov.au/).
- Surgical removal of tooth needs to be supported by a pre-surgical radiograph
- The provision of pulp extirpation and Root Canal Therapy (RCT) is limited to those vouchers where the need for this item is specifically recorded/authorised.
- The provision of orthopantomogram radiographs (OPGs) is limited to those vouchers where the need for this item is specifically recorded/authorised.

2.5 Recording of dental treatment provided under the Scheme.

The recording of dental care items for the Scheme is to be in accordance with the Australian Schedule of Dental Services and Glossary (http://www.ada.org.au/publications/schedule.aspx).

3 OHFFSS ADMINISTRATION PROCESSES

3.1 Web Based System

To participate in the Scheme a business and practitioner must agree to the OHFFSS conditions of access (Attachment A) and establish an electronic profile within the OHFFSS web based administration system (System) that is located at http://ohffss.health.nsw.gov.au/

This web based participation process is divided into two profile pathways - business and practitioner - each containing mandatory requirements (Point 5).

These two pathways support the process of the business profile allocating practitioner(s) to their services, nominating the service type and LHD(s) of their choice. The practitioner's profile independently maintains their contact details and relevant mandatory requirements (refer to Point 5).

Upon receipt of the mandatory information (refer to Point 5) and subsequent processing by the relevant LHD(s) and/or OHFFSS State-Wide Coordinator, all businesses and practitioners will be notified of their participation status as accepted or not accepted via a system email.

3.1.1 Conditions of Access

To start a business and practitioner profile, or to login as an existing participant, the conditions of access (refer to Attachment A) must be agreed to.

3.1.2 Conditions of Use

To access the System authorised LHD staff must agree to conditions of use (refer to Attachment B).

3.1.3 System Security

All business and practitioner information uploaded to the OHFFSS online profile will be stored securely and only authorised Local Health District staff, OHFFSS and Scheme administrators will have access to this information. Business and practitioner information will only be used and disclosed for the purposes of the OHFFSS.

The LHD must only allocate authorised staff to the System. The LHD must also ensure that any staff who have left the employment of the LHD have their profile to access the System made obsolete.

3.1.4 Confidentiality

To ensure confidentiality businesses and practitioners will only be able to view and edit their profile. Businesses and practitioners maintain responsibility for the username and password of their profile, including changing the password regularly and ensuring proper use and access.

Authorised LHD staff and OHFFSS State-Wide Coordinator must comply with NSW Health Privacy Manual for Health Information.

3.1.5 Finding a Participating Practitioner

The web-based System provides easy access for NSW residents and LHD staff to find a current participating OHFFSS practitioner, dental clinic contact details, type of service/s provided, scope of practice and other services such as languages spoken and disability access.

3.1.6 Mandatory Expiry Date Alerts

The System will send businesses and practitioners a reminder email twenty one (21) days, fourteen (14) days and seven (7) days prior to the expiry date, and on the expiry date of the mandatory requirements identified in Point 5.

If the associated information has not been updated, the business and/or practitioner name will be suspended from the OHFFSS and patient referrals will be postponed until this has been rectified. After 30 days from the expiry date the business and/or practitioner profile will be made obsolete. If this occurs the business and/or practitioner will be required to contact either the LHD or OHFFSS State-Wide Coordinator to reactivate their profile.

3.2 NSW Ministry of Health Caveat

NSW Health and/or the relevant LHD/s retain discretion with regards to accepting a business or practitioner for approval to the Scheme. A business or practitioner may be denied approval for a number of reasons, including and not limited to:

- Not providing the required documentation
- Concerns about service standards, or the practitioner’s registration with the Dental Board of Australia
- Infection control standards are inadequate and/or
- No demand for the Scheme in the geographical region where the practitioner or business are located.

3.3 Complaints and Disputes

Complaint/dispute handling processes are to follow NSW Ministry of Health policies and guidelines.

Complaints can be managed:

- At the point of service
- Through a staged process, or
- Through referral to an external body/agency or NSW Health OHFFSS Governance Committee (refer to Point 3.3.2).

If a dispute cannot be satisfactorily resolved or the business and/or practitioner does not comply with the terms and conditions of this policy NSW Health and/or the relevant LHD retain discretion to remove a business or practitioner from the Scheme.

3.3.1 Complaint/Dispute Issues

Complaint/dispute issues may include but are not limited to:

- Receipt of a complaint from a patient, family member or person external to the NSW Health System
- Complaints or concerns raised by other clinicians
- Coronial Inquiries or Health Care Complaints Commission (HCCC) investigations
- Investigation of an incident
- Concerns about questionable claims or the quality of care, or
- Compliance with Code of Conduct and Scope of Practice.

3.3.2 OHFFSS Governance Committee

The OHFFSS Governance Committee is to be established and will meet on an as needs basis to provide the following functions:

- Review clinical treatment procedures or manage waiting lists/times
- Provide a forum where issues can be discussed in a confidential manner
- Mediate unresolved disputes concerning the nature/quality or application of the OHFFSS
- Provide recommendations/actions for unresolved disputes to the Chief Health Officer and Chief Executives of LHDs, and
- To allow opportunities for a complainant to contact the Chair regarding their grievance.

The membership of this Committee consists of:

- A NSW Health Manager (Chair),
- NSW Chief Dentist
- An LHD Clinical Director
- One representative of the Australian Dental Association NSW Branch and/or the Australian Dental Prosthetists Association and/or the Australian Dental and Oral Health Therapists Association, as relevant to the issues being discussed, and
- A minimum of two community representatives.

3.4 Leave Notification

Businesses and practitioners may either withdraw or have periodic leave from the Scheme at any time by using the ‘leave request’ functionality in the System.

It is preferable to give two weeks written notice to the relevant LHD. Any outstanding claims must be forwarded to the relevant LHD(s) prior to their withdrawal date.

4 NSW HEALTH AND LOCAL HEALTH DISTRICT CONTACT DETAILS

4.1 OHFFSS State-Wide Coordinator

NSW Health provides a state-wide administration service for the implementation of the Scheme, complaints/dispute handling and support to businesses, practitioners and LHDs in relation to the System.

Contact details are:

Centre for Oral Health Strategy NSW
1 Mons Road, Westmead NSW 2145
Phone: 1800 938 133 (toll free)
Email: WSLHD-ohffss@health.nsw.gov.au
Fax: (02) 8821 4302.

4.2 Local Health Districts OHFFSS Coordinators

Each LHD employs an OHFFSS Coordinator whose role is to implement the Scheme and to respond to businesses or practitioners inquiries regarding clarification of patient dental history, patient's treatment, approval status or non-payment.

Contact details for LHD OHFFSS Coordinators can be located in the OHFFSS System or oral health call centre numbers at www.health.nsw.gov.au/oralhealth.

5 BUSINESSES AND PRACTITIONERS

5.1 Mandatory Participation Requirements

5.1.1 Businesses

- Company/Trading name
- Australian Business Number (ABN)
- Relevant bank details
- Certification of Public liability insurance to the value of $20 million*****
- Relevant Workers Compensation Insurance policy*****
- Radiation Management Licence***** (excluding Dental Prosthetists), and
- Completed Health Share vendor form*****. (http://www.healthshare.nsw.gov.au / or ring the Master File Maintenance Team on 1300 477 679 option)

5.1.2 Practitioners

- Australian Health Practitioner Regulation Agency (AHPRA) registration number and conditions of registration
- Certification of Professional indemnity insurance of $20 million*, and
- Working with Children Check number. (www.kidsguardian.nsw.gov.au)

Key: ***** indicates documents requiring uploading into the System.

5.2 Terms and conditions

5.2.1 Proof of Documentation

All mandatory documentation (*****) must be certified by an appropriately authorised person before being uploaded on the OHFFSS System.

5.2.2 Environmental Protection Agency

For those practitioners who offer OPGs under the Scheme, evidence of a current Environmental Protection Agency (EPA) licence (http://epa.nsw.gov.au/) will be required and uploaded into the OHFFSS System.

5.2.3 Maintaining Participation

To maintain approval to participate in the Scheme:

- Businesses must update their profiles on changes to: their contact and banking details; practitioner(s), service delivery type(s) and LHD(s); and the annual renewals of:
    - Public Liability Insurance certificate*
    - Workers Compensation Insurance policies*, and
    - Radiation Management Licence*.
- Practitioners must immediately update their profiles with any changes of their AHPRA registration status including AHPRA registration number and any conditions on registration; contact details; banking details (if applicable); and also the renewal of:
    - Professional indemnity insurance annually*, and
    - Working with Children Check (WWCC) every five (5) years.

5.2.4 Patient Care

All practitioners are required to:

- Review and be satisfied with the patient's medical history
- Review the treatment proposed (if provided) and if necessary to adjust the treatment plan according to the current condition, first consult with the LHD for approval
- Document the informed consent from the patient before carrying out any treatment that is covered by the voucher
- Complete all the required details of treatment provided on the voucher form (i.e. tooth number, surfaces, denture teeth replaced, and date of service)
- Ensure that the patient signs the voucher at completion of treatment verifying that they have received the treatment claimed, and
- Provide post-treatment instructions and any reasonable after care management.
- All practitioners understand they:
    - must fully discuss any treatment that is not covered by the voucher with the patient for which they will be charged (as part of a private agreement);
    - they may be asked to provide radiological evidence for all surgical extractions, and any pre-approved endodontic treatment;
    - they must provide at least three or more denture adjustments, as necessary, following the issue of a denture(s).

5.3 Businesses and Practitioners Joint Roles and Responsibilities

- All businesses and practitioners are required to:
    - Be compliant with current infection control standards (http://www.nhmrc.gov.au/guidelines-publications/cd33)
    - Cooperate with the LHDs in resolving complaints from patients and disputes about claims
    - Check that vouchers have not exceeded the expiry date and, if expired, contact the relevant LHDs prior to commencement of the treatment
    - Check the patient's identity, current Medicare Card, and Centrelink concession status if the patient is an adult before treatment is started

5.3.1 Processing of Vouchers

- To ensure payment the following must occur:
    - The patient must provide an original OHFFSS voucher that has been approved by a LHD (refer to Point 6)
    - The dental care outlined on the voucher must have been completed by the expiry date on the voucher, unless otherwise agreed with the LHD
    - All details of the voucher must be completed
    - The voucher must be forwarded to the LHD within 30 days after completion of treatment, and
    - The treatment must have been authorised by a LHD staff member.
- If payment is greater than the maximum entitlement, as identified in the Schedule of Fees, it must be approved by the LHD Manager or Clinical Director before the treatment is carried out
- If goods and services tax (GST) is to be claimed a tax invoice is to be submitted for processing as per LHD policy and procedures.
- Non-payment of a voucher may result if:
    - Dentures provided are non-compliant with TGA standards
    - There has been a surgical removal of a tooth that is not supported by a pre-surgical radiograph
    - A pulp extirpation has been provided where the voucher has specifically stated 'No Root Canal Therapy (RCT)'
    - The voucher is received after 30 days from the date treatment is completed
    - Treatment items have been provided after the voucher expiry date (unless prior authorisation has been obtained from the LHD)
    - Services have been provided by a business or practitioner not currently approved to participate in the OHFFSS
    - Treatment has been provided that is over and above that recommended
    - The treatment provided is not of a required standard, or
    - If treatment items used are not identified in the Schedule of Fees

6 LOCAL HEALTH DISTRICTS

6.1 Administration Requirements

Once a business or practitioner is approved in one LHD, other LHDs can engage that business or practitioner. Businesses and practitioners should therefore be advised that authorised officers from all LHDs and System administrators can access their profiles.

LHDs are required to:

- Use the OHFFSS System to process and communicate with private businesses and practitioners to approve participation in the Scheme
- Ensure that there is a designated employee who is responsible for the implementation of the Scheme
- Confirm via email that the business or practitioner has been approved to participate in the Scheme
- Ensure that all fields in the System have been completed
- Provide an explanation to the business or practitioner if they are not approved
- Request an Environmental Protection Agency (EPA) licence for those practitioners who have offered to provide OPGs
- Provide accurate and complete information to patients about the Scheme and the patient's right to choose an approved practitioner
- Issue voucher(s) with or without undertaking a clinical assessment
- Either post the voucher to the patient or hand to the patient at the time of the appointment
- If an initial appointment is not made for the patient by the LHD, the patient should be advised to make an appointment within ten working days
- Maintain a process of auditing and governing the efficient use of the Scheme, including periodic audits of relevant businesses and practitioners records. This auditing should encompass the following areas:
    - Financial accountability (errors of accounting and claiming) and
    - Clinical auditing (ensuring the quality of clinical care is within a reasonable standard and that accurate and complete medical records are kept for each patient and each visit).

Note that: NSW Health agencies may not apply for or pay for WWCCs on behalf of individuals (Section 5.3 Employment Checks – National Criminal Record Checks and Working with Children Checks PD 2013_028)

6.2 OHFFSS Voucher

The OHFFSS voucher is a combined authority, claim form, and treatment plan.

- The LHD must use the OHFFSS voucher that is required to have:
    - An oral health IT system unique ID authority number and bar code
    - Patient details
    - Date of issue
    - Maximum amount of the voucher as per Schedule of Fees, and
    - Treatment required (if applicable).

- The public dental practitioner should include on the voucher information relevant to the patient's clinical need:
    - Assessed treatment need and related tooth numbers,
    - Whether an OPG is authorised for the patient,
    - Number of teeth required for a denture, or
    - Indicate pre-prosthetic mouth preparation for clasps and rests if required.

6.2.1 Payment

- To ensure payment the following must occur:
    - Payment for one (1) diagnostic service per authorised voucher (episodic, general and denture) as per the Schedule of Fees
    - Issue of the appropriate voucher type for the service type required
    - The voucher was submitted for payment by an approved business or practitioner, and
    - The business or practitioner has complied with the policy's roles and responsibilities (refer to Point 5).
- The following may result in non-payment of the voucher:
    - The business and practitioner has not complied with the policy's roles and responsibilities (refer to Point 5)
    - Vouchers received more than 30 days after the treatment has been completed
    - Vouchers with treatment items that were provided after the voucher expiry date (unless prior authorisation has been obtained from the LHD)
    - Services provided by a business or practitioner that is not currently approved to participate in the OHFFSS
    - Treatment over and above recommendation
    - Treatment not to a required standard, or
    - Treatment items not included in Schedule of Fees.
- Once the above procedures have been followed, the LHD are required to:
    - Return any radiograph(s) supplied by the business or practitioner unless double radiographic films have been used, and
    - Forward the claim to the relevant LHD Manager, or nominee, for authorisation and HealthShare payment processing.

6.3 Quality Assurance

LHDs are accredited institutions and therefore undertake quality assurance activities on a regular basis. The operation of the OHFFSS and the care provided under the Scheme is included in these accreditation processes.

The NSW Ministry of Health, the Australian Dental Association NSW Branch and the Australian Dental Prosthetist Association NSW support the use of quality assurance measures.

The evaluation of the Scheme may include relevant Australian Council of Healthcare Standards clinical indicators and other quality activities.

Attachment A: Conditions of Access to Web-based Oral Health Fee for Service Scheme

The conditions of access set out below need to be read in conjunction with the Oral Health Fee for Service Scheme Implementation Procedures. Non-compliance with the conditions of access set out here and in that Policy Directive could lead to suspension or removal from the OHFFSS.

1. Access to the facility is via a user name and password. The user is responsible at all times for the proper use of an allocated password and for all access under the password, which should be changed regularly to prevent misuse.
2. To protect both business and practitioner personal information that is uploaded onto the OHFFSS web based system, users will only be able to view and edit their own profile.
3. It is the policy of NSW Health (the administrator of the Oral Health Fee for Service Scheme) that:
    - Access to the web-based scheme be monitored on an ongoing, continuous basis to guard against intentional inappropriate use and
    - Records of access are maintained and routinely audited to ensure appropriate use of the web based system.

Personal information – In agreeing to be registered with the OHFFSS, you acknowledge that your personal information will be stored and backed up securely and that only authorised Local Health District or OHFFSS administrators will have access to the information. Your personal information will only be used and disclosed for the purposes of the Oral Health Fee for Service Scheme or as lawfully required.

If at any time you have concerns about how your personal information is being used, accessed or disclosed, please contact the Local Health District's Privacy Liaison Officer or State-Wide OHFFSS Coordinator on 1800 938 133 or WSLHD-ohffss@health.nsw.gov.au .

Acceptance

In accepting entry I confirm that I have read, understood and will comply with the NSW Health Policy Directive on the Oral Health Fee for Service Scheme and Schedule of Fees, and agree to the conditions and requirements set out in that Policy Directive and Schedule of Fees. I agree that my use of the web-based administration tools will be in accordance with the conditions and requirements set out in the conditions of use and the Policy Directive. I understand and accept that my access and usage is liable to be monitored on an ongoing and continuous basis. I understand and accept that my registration on the OHFFSS may be suspended or removed if I breach the Policy Directive or the conditions of access.

If I provide dentures I will comply with the Therapeutic Goods Administration Standards (http://www.tga.gov.au/). I understand and accept that my participation in the Oral Health Fee for Service Scheme will be monitored on an ongoing and continuous basis.

To read the Oral Health Fee for Service Scheme Policy and Schedule of Fees, click on **Read** for the Policy and click on **Read** for the Schedule of Fees.

Click **Accept** to comply and to access the Oral Health Fee for Service Scheme and Schedule of Fees.

If you click on **Reject** it means that you do not wish to comply and you will not be able to proceed any further.

Attachment B: Conditions of Use to Web-based Oral Health Fee for Service Scheme

These conditions of use apply to staff of the relevant Local Health District and the NSW Ministry of Health who as part of their role, have access to the Web-based Oral Health Fee for Service Scheme system.

All staff are required to comply with the *Health Records and Information Privacy Act (HRIP) 2002* to protect the privacy of health information in NSW. All staff are also required to comply with the *Privacy and Personal Information Protection (PPIP) Act 1998* which covers other personal information such as employee records.

NSW Health is committed to safeguarding the privacy of patient, employee and personal information and has implemented measure, to comply with these legal obligations.

Guidance for staff in relation to their legal obligations is provided in the *NSW Health Privacy Manual for Health Information*. All staff are also bound by a strict code of conduct to maintain confidentiality of all personal and health information which they access in the course of their duties.

In addition to the legislative and policy related obligations, staff must comply with the following conditions of access:

1. Staff may only access patient/employee, personal or health information where this is required in the course of their employment.
2. Access to the OHFFSS web-based system is by staff employee number and password. The user is responsible at all times for the proper use of an allocated password and for all access under the password, which should be changed regularly to prevent misuse.
3. Personal and health information contained in the OHFFSS web based system must not be used or disclosed for improper purposes.
4. To protect both business and practitioner personal information that is uploaded onto the OHFFSS web based system LHD staff, unless approved to have super users rights, will only view and edit records of businesses and practitioners who are participating in the OHFFSS within their LHD.
5. It is the policy of NSW Health, the administrator of the Oral Health Fee for Service Scheme, that:
    - Access to the web-based scheme be monitored on an ongoing, continuous basis to guard against intentional inappropriate use and
    - Records of access are maintained and routinely audited to ensure appropriate use of the web based system.

If at any time you have concerns about how system information is being used, accessed or disclosed, please contact the State-Wide OHFFSS Coordinator on 1800 938 133 or WSLHD-ohffss@health.nsw.gov.au .

Acceptance

In accepting entry I confirm that I have read, understood and will comply with the NSW Health Privacy Manual for Health Information, the Code of Conduct (PD2015_049), the OHFFSS Policy Directive and these Conditions of Use. I understand and accept that my access and usage will be monitored on an ongoing and continuous basis.

To read the NSW Health Privacy Manual for Health Information (http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf), click on **Read** and click on **Read** for the Code of Conduct PD2015_049. (http://www0.health.nsw.gov.au/policies/pd/2015/pdf/PD2015_049.pdf)

Click **Accept** to comply with NSW Health Privacy Manual for Health Information and Code of Conduct PD2015_049. If you click on **Reject** it means that you do not wish to comply and you will not be able to proceed any further.

SCHEDULE OF FEES FOR ORAL HEALTH FEE FOR SERVICE SCHEME
(IB2023_015)

IB2023_015 replaced IB2022_017

PURPOSE

This Information Bulletin provides information on the current Oral Health Fee for Service Scheme (OHFFSS) Schedule of Fees. Fees have been indexed in alignment with movement in the Department of Veteran's Affairs Fee Schedules of Dental Services.

The Schedule of Fees can be found on the NSW Health Oral Health webpage Oral Health Fee for Service Scheme.

KEY INFORMATION

This Information Bulletin is to be read in conjunction with NSW Health Policy Directive Oral Health Fee for Service Scheme (PD2016_018), and Australian Dental Association *The Australian Schedule of Dental Services and Glossary, (Twelfth Edition*).

Voucher limits

The maximum amounts payable for authorised vouchers are:

- Episodic Voucher: **$450.00 or as printed on voucher**
- General Voucher: **$1000.00 or as printed on voucher**
- Denture Voucher: **$1750.00 or as printed on voucher**

NSW Public Health Organisations may:

- raise or lower voucher limits in line with local policy
- pre-authorise and fund other Australian Dental Association items not listed in this schedule where it is applicable to an individual patient or model of care.

Note that actual limits are printed on each voucher.

ORAL HEALTH PATIENT RECORD PROTOCOL (GL2015_017)

GL2015_017 rescinds PD2008_024

PURPOSE

The Oral Health Patient Record has been updated to assist oral health care providers within NSW Health maintain records that meet the Dental Board of Australia Guidelines on Dental Records (July 2010).
(http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx)

KEY PRINCIPLES

The Oral Health Patient Record has been reviewed and updated to reflect a contemporary view of patient centred care. The guideline applies to dentists, dental therapists, dental hygienists, oral health therapists, dental prosthetists and dental specialists.

USE OF THE GUIDELINE

The Oral Health Patient Record will result in a review of current work practices in such areas of odontogram, charting techniques and abbreviations. This will ensure that all Oral Health practitioners create and maintain a high level of quality in record keeping including detailed documentation of relevant patient information, both current and historical.

These practices are to serve the best interests of NSW residents who access public oral health services and that contribute to their safety, confidentiality and continuity of dental care. This guideline describes the base line requirements for oral health patient records whether they are in paper-based or electronic form.

1 BACKGROUND

1.1 About this document

The Oral Health Record Procedures provides a standard of documentation in clinical dentistry with a list of commonly accepted abbreviations and charting symbols for both paper based and electronic software programs across NSW. Electronic software programs will differ in charting methods and symbols. It is however prudent that these charting methods and symbols provide a clear definition of presenting condition(s), treatment required and treatment provided.

This document provides an overview of the key elements of an oral health clinical record:

- Medical history
- Examination and treatment planning
- Primary and permanent odontograms and
- Charting symbols and definitions.

1.2 Key definitions

Examination	Includes the examination of both soft and hard tissues, and findings are recorded using an odontogram and/or text. The charting needs to comply with the World Dental Federation (FDI) system and should include: (i) restored teeth (tooth code, surface/s involved and materials used) (ii) sound and unrestored teeth (iii) missing teeth (iv) hard tissue and soft tissue abnormalities (v) occlusion, including tooth mobility (vi) periodontal status including periodontal pocket depth, supra-gingival calculus, sub-gingival calculus and oral hygiene status and type of prosthetic appliances present.

1.3 Evaluation framework

LHDs to put in place an audit process to ensure compliance with the minimum requirements of this guideline.

1.4 Associated NSW Health policies and guidelines

It is the role and responsibility of treating dental practitioner and supporting dental staff to read the Oral Health Patient Protocol guideline in full and implement them accordingly. This guideline is to be read in conjunction with:

- Clinical Procedure Safety
- Consent to Medical Treatment – Patient information
- Health Care Records – Documentation and Management
- Privacy Manual
- Record Management – Department of Health
- Records_ Disposal Authority (DA 25) (Use of functional) by NSW Department of Health
- State Health Forms
- Student Training and Rights of Patients

Ministry of Health policies and guidelines are public documents and are located on NSW Health website. www.health.nsw.gov.au/

2 KEY ELEMENTS

2.1 Patient identification

Patient identification by the dental practitioner needs to be in compliance with NSW Health Clinical Procedure Safety policy.

To ensure compliance the dental practitioner and clinical team must undertake the time out procedure and note accordingly in patient's progress notes with relevant signatures.

2.2 Medical History

The patient dental record should document a medical history as taken by the dental practitioner.
A medical history should include the following elements:

- Positive and negative responses
- Any adverse reactions, allergies, or events

- Medical history updates are to be completed at the beginning of each course of care. Check verbally, and if there are:
  - No changes, document 'medical history checked, no update' (MH – nil update)
  - Amend changes to the existing history or if necessary document a new medical history.
- Each dental practitioner has to ensure and sign off that the medical history is completed to their satisfaction.

2.3 Consent for treatment

Obtaining consent for treatment needs to be in compliance with the NSW Health 'Consent to Medical Treatment – Patient Information' and Multilingual Health Resources by AHS, DoH and NGOs Funded by NSW Health (Guidelines for Production).

2.4 Emergency Care

Clinical notes should indicate the following elements:

- Chief complaint/reason for attendance
- Diagnostic data
- Clinical findings
- Radiograph(s) taken
- Results of investigations – imaging, vitality tests etc
- Management plan or treatment given.

2.5 Examination and Treatment Plan for a Course of Care

Clinical notes should indicate the following elements:

- Presenting complaint
- Past dental history
- Full dental charting of dentition on examination when providing a full course of care
- A separate charting of treatment required (which may be amended to note the progress of treatment)
- Notes regarding:
  - Soft tissues,
  - Extra-oral findings,
  - Intra-oral findings,
  - Periodontal health,
  - Preoperative and postoperative risks and treatment options,
  - Sterilization tracking labels, and
  - Brochures, fact sheets and Oral Health Fee for Service vouchers provided, if required.
- A treatment plan of appropriate detail.

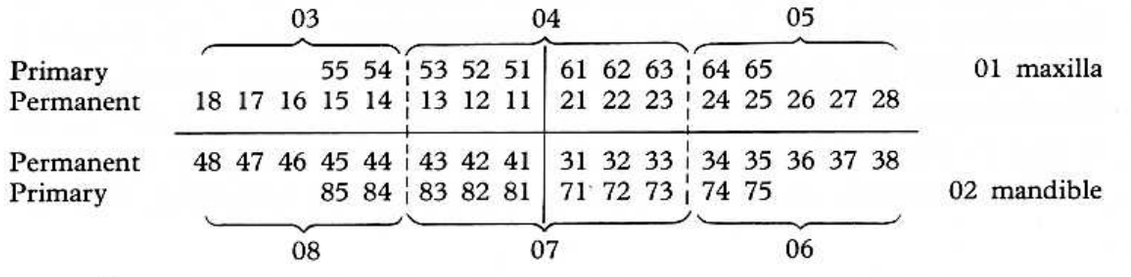
2.6 Charting and Tooth Identification

The Federation Dentaire Internationale (FDI) notation for recording tooth number is to be used (Refer to Diagram A), as follows:

Two digit codes for the jaws and sextants of the mouth are:

- 00 indicates the mouth
- 01 indicates the maxilla
- 02 indicates the mandible
- 10 to 40 indicate the quadrants in clockwise order starting on the top right.

Diagram A

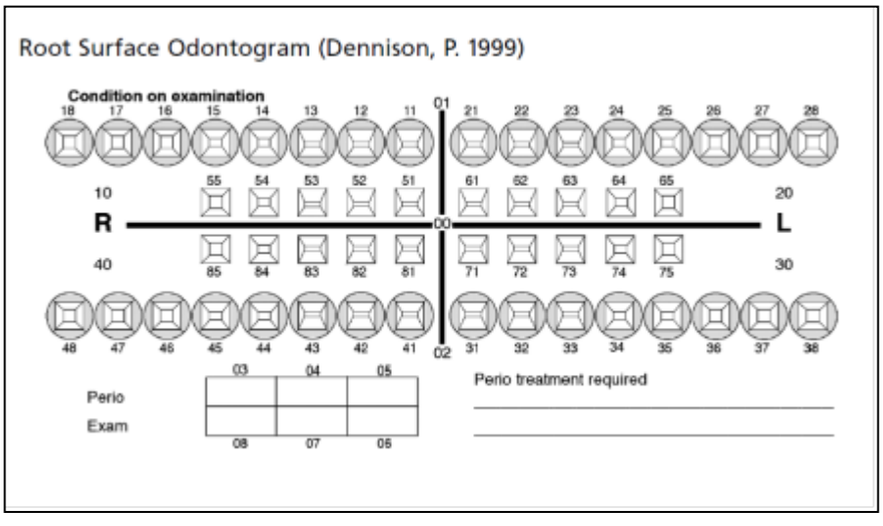


2.6.1 General Odontogram

The odontogram for permanent teeth may have root surfaces and a primary odontogram should be available where applicable (refer to Diagram B).

Diagram B

Dennison, P (1999) 'A Modified Odontogram to enable Root Surface Charting' Community Oral Health and Epidemiology, Westmead Centre for Oral Health, Faculty of Dentistry University of Sydney Australia.



2.6.2 Periodontal Charting

When a periodontal charting is required it should include the recording of:

- Recession
- Pocket depth
- Suppuration
- Bleeding on probing
- Furcation involvement
- Mobility.

2.7 Anaesthetics

Clinical notes should indicate the following elements:

- Type of anaesthetic used
- Amount of anaesthetic used
- Type of injection given
- Any adverse reactions, allergies, or events.

2.8 Restorations

Clinical notes should indicate the following elements:

- Tooth involved
- Surface/s involved
- Base/linings used
- Restoration material and shades used
- Unusual depth or other features
- Pin placement, if used
- Pulp exposure (size, location, mechanical/carious), if this has occurred.

2.9 Exodontia

Clinical notes should indicate the following elements:

- Tooth to be extracted
- Reasons for extraction
- Tooth extracted
- Radiographic evidence to support decision for extraction
- Any complications
- An indication if post-operative instructions were given
- An indication if haemostasis has been achieved
- Need for review, as required.

2.10 Minor Oral Surgery

Clinical notes should indicate the following elements:

- Reason for procedure
- Procedure undertaken including technique used
- Supporting test/data/symptoms
- Any complications
- An indication if haemostasis has been achieved
- An indication if post-operative instructions were given
- Need for review, as required.

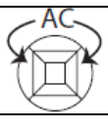
2.11 Medication

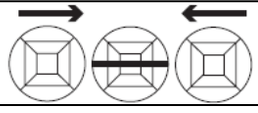
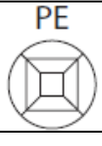
Clinical notes should indicate the following elements:

- The type of medication prescribed
- Reason for administration of prescription
- The dose of medication and indication of the method of delivery
- If antibiotic prophylaxis is used, the time of administration and the time of commencement of treatment
- Any adverse reactions, allergies, or events
- Results of antibiotic sensitivity testing, as required
- Discussions with the patient's medical practitioner.

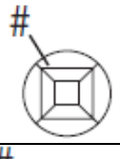
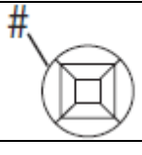
3 TERMS, ABBREVIATIONS AND SYMBOLS

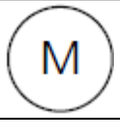
Abbreviations and symbols may vary depending on the patient record type (paper or electronic).

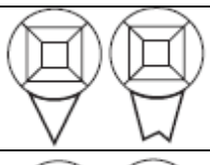
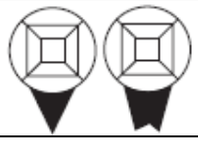
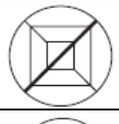
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
ANATOMY			
Anterior	Ant		
Arrested Caries	AC		
Bilateral(ly)	bilat		
Buccal	B		
Cardiovascular System	CVS		
Caries Free	CF		
Cemento-enamel junction	CEJ		
Central Nervous System	CNS		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Centric Occlusion	CO		
Centric Relation	CR		Contextual note
Distal	D		
Drifted Tooth			
Incisal	I		
Labial	Lab		
Lateral	Lat		
Left	L		
Left Hand Side	LHS		
Lingual	L		
Lower Left	LL		LL – not to be used when referring to teeth
Lower Right	LR		LR - not to be used when referring to teeth
Maxillo-Mandibular Relationship/record	MMR		
Mesial	M		
Mesial-occlusodistal	MOD		Sample of combination for tooth surfaces
Missing tooth			
Occlusion (notes)	Occl		
Occlusal Vertical Dimension	OVD		
On Examination	O/E		
Over Retained	O/R		
Overbite	O/bite		
Overjet	O/jet		
Palatal	P		
Partially erupted	PE		
Posterior	Post		

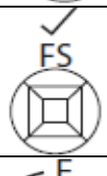
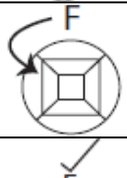
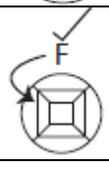
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Quadrant	Q		
Quadrant, lower left	Q3		
Quadrant, lower right	Q4		
Quadrant, upper left	Q2		
Quadrant, upper right	Q1		
Secondary Caries	2°C		
Retained Root	RR		
Retruded Position	RP		
Right			
Right Hand Side	RHS		
Supernumery			
Temporo-mandibular joint	TMJ		
Unerupted	UE		
Upper Left	UL		
Upper Right	UR		
Vertical Dimension	VD		
EXAMINATION			
Assessment	Assess		
Bite Wing radiograph/s or film/s	BW		
Cephalometry/ic	Ceph		
Cerebro-Vascular Accident	CVA		
Chief Complaint	CC		
Cigarettes	Cigs		

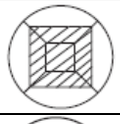
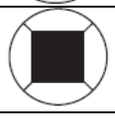
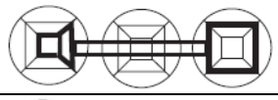
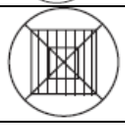
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Community Periodontal Index of Treatment Needs	CPITN		
Complains (ing) of	C/O		
Cone Beam Imaging	CBCT		
Consultation	Consult		
Decrease (d) (ing)			
Dental History	DH		Contextual note
Diagnosis	Dx		
Differential Diagnosis	DDx		
Division	Div		
Emergency	Emerg		
Examination	Exam		
Extra-oral	E/O		
Family History	FH		
Family and Social History	F/SH		
Father			
Female			
Fracture	#		Fractured tooth – contextual note
			Fractured root
General Dental practitioner	GDP		
General Medical Practitioner	GMP		
History of Present Complaint	HPC		
Increase (d) (ing)			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Intra-Oral	I/O		
Lateral Cephalometic radiograph	LCeph’		
Male			
Medical History	MH		
Mother			
Motor Vehicle Accident	MVA		
No Abnormalities Detected	NAD		
Non Vital	NV		
Occlusal radiograph/s or film/s	Occl		
On Examination	O/E		
Orthopantomogram	OPG		
Past Medical History	PMH		
Periapical Film/s or Radiograph/s	PA		
Periodontal screening and recording	PSR		
Prognosis	Px		
Provisional Diagnosis	PDx		
Social History	SH		
Tender to Percussion	TTP		
Toothache	T/ache		
Treatment	Tx		
Treatment Plan	TP		
Within normal limit(s)	WNL		
ANAESTHESIA			
Inferior Alveolar Dental Block	IANB		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Infiltration	Infilt		
Local Anaesthetic	LA		
Nitrous Oxide	N_2O		
Relative Analgesia	RA		
ENDODONTIC			
Cotton Pellet	CP		
Endodontic (s)	Endo		
Ferric sulphate	FeSO		
Gutta Percha	GP		
Hydrogen Peroxide	H_2O_2		
Ledermix	led		
Master Apical File	MAF		
Number, size, gauge of endo file	No.		
Root Canal Therapy	RCT		
Root Filling			Root filling required
			Root filling present
Sodium hypochlorite	NaOCl		
Working length	WL		
ORAL SURGERY			
Black Silk Suture	BSS		
Extraction or Exodontia	Exo		Tooth to be extracted
			Tooth extracted

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Haemostasis Achieved	HA		
Inter-maxillary Fixation	IMF		
Interrupted Cat Gut Suture	ICGS		
Oral & Maxillo Facial Surgery	OMFS		
Oral Surgery	OS		
Post-operative instructions given	POIG		
Removal of sutures	ROS		
Surgical removal	SR		
ORTHODONTIC			
Cross bite	X-bite		
Full Fixed Orthodontic Appliance	FFA		
Index of Orthodontic Treatment Needs	IOTN		
Mandibular Removable Orthodontic Appliance	LRA		
Maxillary Anterior Crowding	UAC		Upper
Maxillary Removable Orthodontic Appliance	URA		
Orthodontics	Ortho		
Rapid Maxillary Expansion	RME		
PAEDIATRIC			
Paediatric dentistry	Paedo		
Pulpectomy	Pulpect		
Pulpotomy	Pulpot		
Stainless Steel	SS		
Stainless Steel Crown	SSC		
To-be-left	TBL		
PERIODONTIC			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Acute Necrotising Ulcerative Gingivitis	ANUG		
Bleeding on Probing	BOP		
Hand Scale	H/Scale		
Loss of Attachment	LOA		
Mucogingival junction	MGJ		
Periodontics	Perio		
Root Planing	RP		Contextual comment
Subgingival	Subging		
Supragingival	Supraging		
PREVENTIVE			
Acidulated phosphate fluoride	APF		
Fissure Sealant	FS		Fissure Sealant required
			Fissure Sealant present
Fluoride	F^-		Fluoride application required
			Fluoride application given
Mouthguard	M/guard		
Oral Health Promotion	OHP		
Oral Hygiene	OH		
Oral Hygiene Instruction	OHI		
Preventive Resin Restoration	PRR		
Prophylaxis	Prophy		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Scale & Clean	S+C		
Sodium Fluoride	NaF		
Stannous Fluoride	SnF2		
Toothbrushing Instruction	TBI		
PROSTHETICS FIXED			
Acrylic Dentures	Acr		
Acrylic Jacket Crown	AJC		
Crown			Crown required
			Crown present (insert other examples)
Crown and Bridge	C+B		Crown and bridge required
			Crown and bridge present
Full Gold Crown	FGC		
Implant	Implant		
Metallo-ceramic restoration/metal ceramic crown	MCC		
Porcelain Jacket Crown	PJC		
Post core	P/core		
PROSTHETICS REMOVABLE			
Addition	Add		
Chrome Cobalt	CrCo		
Full Denture, Mandibular Only	-/F		
Full Denture, Mandibular and	F/F		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Maxillary			
Full Denture, Maxillary only	F/-		
Immediate Denture	Immed		
Partial Denture, Mandibular Only	-/P		
Partial Denture, Mandibular and Maxillary	P/P		
Partial Denture, Maxillary only	P/-		
Primary Impression	1º Imp		
Prosthetic	Pros		
Secondary Impression	2º Imp		
RESTORATIVE			
Amalgam	Amal		
Calcium Hydroxide	Ca(OH)2		
Class	Cl		
Composite Resin	CR		
Glass Ionomer Cement	GIC		
Interim Restoration	Temp		
Intermediate restorative material	IRM		
Overhang	o/hang		
Resin Modified Glass Ionomer	RMGI		
Restoration	Rest		Restoration required – outline entire surface where lesion is identified (eg. is two surfaces)
Vitrebond	Vbond		
Zinc Oxide Eugenol	ZOE		
Zinc Phosphate	Z_nPO_4		
OTHER			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Adjustment	Adj		
Alginate	Alg		
Biopsy	Bx		
Carbon Dioxide	CO_2		
Chlorhexidine	CHx		
Impression	Imp		
Issue	Iss		
Management	mgt		Contextual note
Not Caries Free	NCF		
Post-operative (ly)	Post-op		
Post-Operative Instructions given	POIG		
Pre-operative	Pre-op		
Prescribe	Rx		
Rubber Dam	RDam		
Advise	Adv		
Appointment	Appt		
Date of Birth	DOB		
Dental Assistant	DA		Contextual note
Dental Hygienist	DH		Contextual note
Dental Officer	DO		Contextual note
Dental Prosthetists	DP		Contextual note
Dental Therapist	DT		Contextual note
Oral Health Therapist	OHT		
Fail to attend	FTA		
Further appointment made	FAM		
New Patient	N/P		
Next Visit	N/V		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Patient	Pt		
Primary Oral Care	POC		
Priority Oral Health Program	POHP		
Recall	R/C		
Refer	Ref		
Relief of Pain	ROP		
Required	Req		
Review(ed)	Rev		
School Assessment Program	SAP		
Unable to attend	UTA		
Visiting Dental Officer	VDO		
Waiting list	W/L		

ORAL HEALTH SPECIALIST REFERRAL PROTOCOLS (PD2011_071)

PD2011_071 rescinds PD2010_027.

PURPOSE

This policy statement and attached protocol aim to improve referral pathways from public and private medical and dental practitioners to public specialist oral health services by establishing clear and consistent patient flow pathways for eligible NSW residents who require specialist oral health services.

MANDATORY REQUIREMENTS

Referral centres and referring practitioners are to ensure compliance with specific oral health speciality referral criteria, as approved by Public Dental Services and the processes as detailed in the Oral Health Specialist Referral Protocol.

The oral health specialist referral form is to be completed by a referring practitioner when referring a patient to a specialist service.

IMPLEMENTATION

Chief Executives must:
- assign responsibility and personnel to implement the guidelines;
- approve specific public dental services specialist referral criteria.

Medical and Dental Practitioners, Oral Health Clinical Directors and Oral Health Managers must:
- promote efficient patient flow pathways;
- monitor the implementation of the policy and specific public dental services criteria.

Referral Centres must:
- comply with the responsibilities detailed at section 3.3

Local Oral Health Staff must:
- comply with public dental services approved specialist referral processes and specific public dental services criteria.

1. BACKGROUND

1.1 About This Document

This policy directive is aligned to the NSW Oral Health Strategic Directions 2005-2010, which sets the platform for oral health action in NSW into the next decade. The Oral Health Specialist Referral Protocols reflects the operating principles:

- Create better experiences for people using health services.
- Make smart choices about the costs and benefits of health services.

The Oral Health Specialist Referral Protocols aims to improve referral pathways from public and private medical and dental practitioners to public specialist oral health services. By standardising procedures and protocols between referring practitioners and specialist oral health services the policy will:

- increase the efficiency of specialist oral health services;
- improve the continuum of patient care;
- improve the level of feedback to referring practitioners.

The Oral Health Specialist Referral Policy and Protocols have been prepared by the Centre for Oral Health Strategy NSW and the State Oral Health Executive through a specialist referral review working group.

1.2 Key Definition

In this document the term:

- **Must** – indicates a mandatory action required that must be complied with.
- **Should** – indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

NSW Public Dental Service

Throughout this document the term public dental service is used to describe the team of administration and clinical staff who provide public oral health services to eligible NSW residents.

1.3 Patient Management

As stated in NSW Health Policy Directive PD2008_056 'Priority Oral Health Program and List Management Protocols', dental treatment provided during a general course of care will depend on the patient's oral health needs, as determined by the treating clinician and as per public dental service's policies. In a general course of care the treatment that is provided should result in the patient being dentally fit.

Treatment flows depend on the severity and urgency of the condition; patients may be offered an appointment or placed on a list. List options are: assessment, treatment, referral and managed care. Should a patient require a specialist service following an assessment appointment, and they meet the clinical criteria for that service, a referral to a specialist Dental Officer can be made.

It is important that each dental patient referred for specialist consideration has a general dental clinician to act as his/her case manager. This clinician acts as the patient's advocate, first point of contact for specialist advice and follow-up and co-ordinator for referrals to other dental or medical specialists. Without a general dental practitioner as case manager, patients have the potential to undergo multiple cycles of specialist assessment and treatment, preventing other patients from accessing specialist assessments and treatments.

A guiding principle of the referral process, in both medical and dental practice, is that the patient remains under the clinical case management of the referring general practitioner. As such, the patient is to be managed at the referring oral health clinic for all emergency dental procedures, and for all presentations which are not covered by the referral and for ongoing management and follow-ups after the specialist course of care is completed.

1.4 Eligibility for Public Oral Health Services

The NSW Health 'Eligibility of Persons for Public Dental Care' policy directive defines eligibility for public dental care for NSW residents. Adult patients will require a valid health care card or pension card to qualify for specialist oral health care.

Only adults (18yrs and over) who are self holders of a valid Centrelink concession card are eligible for inpatient specialist dental services including orthodontic surgery and for non-admitted procedural dental specialist services such as endodontics, orthodontics, oral surgery, prosthodontics and periodontics.

All children and young persons (0-<18yrs) are eligible:

- to be referred for consultation;
- for the provision of non-admitted treatment in all specialties, except orthodontics;
- for admitted paediatric dental specialty services for conditions outlined in 11.2.1 – 11.2.4.

However, only children and young persons (0-<18yrs) who are self holders or whose parents/ guardians are holders of a valid Centrelink concession card, are eligible for admitted paediatric dental specialty services for conditions outlined in 11.2.5 and 11.2.6 and for any orthodontic specialty service.

Exemption to these eligibility criteria can only be made for patients for teaching purposes and those patients with special clinical needs as authorised by Clinical Directors of Local Health District Oral Health Services or their formally authorised delegate/s. For these cases a service charge may be applicable.

1.5 Related Policy Directives and Guidelines

This Policy Directive should be read in conjunction with:

- Prevention of Osteonecrosis of the Jaw (ONJ) in Patients on Bisphosphonate Therapies[1]
- Consent to Medical Treatment - Patient information[2]
- Correct Patient, Correct Procedure and Correct Site[3]
- Data collections - Disclosure of unit record data held for research or management of health services[4]
- Eligibility of Persons for Public Dental Care'[5]
- Medical Records in Hospitals and Community Care Centres[6]
- Oral Health Record Protocols[7]
- Priority Oral Health Program and Wait List Management[8]
- Student Training and Rights of Patients[9]
- Waiting Times and Elective Patient Management Policy[10]

2. ORAL HEALTH SPECIALIST SERVICES

2.1 Referral Centres

Public oral health services in NSW provide specialist dental care at the three major oral health teaching facilities (Referral Centres) which are mainly associated with the University of Sydney, Faculty of Dentistry.

[1] http://www.health.nsw.gov.au/policies/gl/2010/GL2010_010.html
[2] http://www.health.nsw.gov.au/policies/PD/2005/PD2005_406.html
[3] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_079.html
[4] http://www.health.nsw.gov.au/policies/pd/2015/PD2015_037.html
[5] http://www.health.nsw.gov.au/policies/PD/2009/PD2009_074.html
[6] http://www.health.nsw.gov.au/policies/pd/2012/PD2012_069.html
[7] http://www.health.nsw.gov.au/policies/pd/2008/PD2008_024.html
[8] http://www.health.nsw.gov.au/policies/pd/2008/PD2008_056.html
[9] http://www.health.nsw.gov.au/policies/pd/2005/PD2005_548.html
[10] http://www.health.nsw.gov.au/policies/pd/2012/PD2012_011.html

These Referral Centres are:

- Sydney Dental Hospital (SDH), 2 Chalmers Street, Surry Hills 2010, telephone: 02 9293 3200.
- Westmead Centre for Oral Health (WCOH), Darcy Road, Westmead 2145 or PO BOX 533, Wentworthville 2145, telephone: 02 9845 7178.
- The Children's Hospital Westmead, Dental Department, Westmead, corner of Hawkesbury Road and Hainsworth Street, NSW 2145, 02 9845 2582.

Other NSW Local Health District Oral Health Services may also provide a limited range of specialist services. For further information contact the local Oral Health Service Call Centre (refer to http://www.health.nsw.gov.au/cohs/contacts.asp) closest to the patient's place of residence.

2.2 Specialist Service Type

The following specialist services are offered:

- General Anaesthesia
- Conscious sedation for dental procedures
- Endodontics
- Oral and maxillofacial surgery
- Oral radiology
- Oral medicine, oral pathology
- Orthodontics
- Paediatric Dentistry
- Periodontics
- Prosthodontics
- Special Care Dentistry

2.3 List Management

Referral Centres who place referred patients on a wait list for either assessment or treatment are required to inform both the patient and the referring practitioner. NSW Health has developed a policy directive for Waiting Times and Elective Patient Management, which identifies benchmark waiting times.

Note: that specialist waiting lists are not to be included in LHD general wait lists (refer to POHP and List Management Protocol Policy Directive).

3. REFERRAL PROCESSES

3.1 Reason for Referral

Referrals may be made for the following reasons:

- an opinion only, regarding a specific condition or particular aspect of the patient's care;
- management of a specific complaint or condition, subject to acceptance of the referral; or
- ongoing management of a patient whose oral health condition/overall medical status dictates that his/her oral health treatment needs be undertaken by a specialist clinician/institution, subject to acceptance of the referral.

3.2 Referring Practitioner Responsibilities

- Complete the oral health specialist referral form and write the date of the referral on the form.

- Ensure that all fields are completed for every patient. This includes:
  - patient's full name, address details and phone number;
  - Medicare card number, including the eleventh digit and expiry date;
  - any entitlement card numbers, stipulating type and expiry dates;
  - copies of relevant radiographs including OPGs (to avoid unnecessary repeat radiation exposure);
  - access issues and special requirements where relevant;
  - any medical test results; and
  - a brief medical history and indication of disability
- Ensure that the contact details of the referring practitioner are clearly recorded on the form.
- Ensure that the contact details (including telephone numbers) of the patient's general and specialist medical practitioner/s are clearly recorded on the form.
- When complete, post or transmit the referral form to the appropriate specialist service/referral centre.
- Send only one referral per clinical issue. That is, do not send a referral to multiple referral centres to increase the probability of an early outcome. Similarly, do not refer for multiple clinical issues on the same referral form, e.g TMJ, exodontia and endodontics, as this risks the referral being held up in one specialist department, while the second or third issue do not get prioritised.
- Inform the patient that waiting times for assessment and treatment usually apply, and that, until a specialist course of care commences, all dental treatment is to be managed at the local general dental practice level.

3.3 Referral Centre Responsibilities

- Acknowledge receipt of the referral in a timely manner.
- Log patient details into the NSW Health Information System for Oral Health (ISOH), attach the referral form to the patient's paper record and place a scanned copy into the patient's electronic record in ISOH.
- Review the referral (to a Specialist or Department Head) in accordance with the Specialist Referral Policy and Protocols and specific LHD referral criteria.
- Prioritise the patient according to identified need.
- Contact the patient to offer a consultation appointment. Inform the patient and the referring practitioner if wait lists are applicable for either consultation or treatment appointments.
- When an offer of assessment has been returned unacknowledged, the Referral Centre is to discontinue the referral and return the referral to the referring clinician for local management.
- Advise the referring practitioner of the outcome of the consultation/s and the proposed course of care, or the reasons for not proceeding with specialist service.
- Advise the referring practitioner on how to best manage the patient whilst waiting for a general anaesthesia if deemed required.
- Consult with the referring practitioner when proposed specialist care will impact on ongoing general oral health care and when necessary return the patient for general treatment to be completed before specialist services can commence. Maintain patient records by:
  - retaining a copy of the Specialist Referral Form and the original or duplicated radiographs as appropriate; and
  - attaching relevant documentation on the feedback process
- Comply with NSW Health Consent to Medical Treatment - Patient Information policy directive by informing the patient and/or carer/guardian about the risks and benefits of procedures such as intravenous sedation or general anaesthesia.

3.4 Referral Centre Caveats

- All referrals will be logged for consultation if they meet Specialist Referral criteria.
- Depending on the outcome of the specialist consultation, including further tests or analyses, a referral may not necessarily lead to treatment.
- Patients who do not meet the criteria for specialist referral will not automatically qualify for general treatment at the Referral Centre and will be returned to the referring clinic.
- Post-graduate trainees, students, registrars, or general dentists/therapists/hygienists may provide some or all of the treatment as appropriate under supervision of a specialist.

3.5 General Advice for Referred Patients

The Referral Centre should advise the referred patient and/or their carer/guardian that:

- they need to bring their valid Medicare card and any other entitlement cards (e.g. health care card or pension card) to their consultation appointment and their first treatment appointment;
- should a patient's eligibility status change during the course of treatment, they may be required to meet the costs of completing the treatment;
- if they are unable to consent to treatment a legal guardian must accompany them to the assessment appointment;
- treatment will continue only if patients actively maintain good oral health status, including compliance with recommended changes of behaviour (e.g. effective oral hygiene, cessation of nail-biting, wearing of functional appliances) and attendance for diagnostic tests;
- patients have a right to an interpreter or Aboriginal Liaison officer/health worker if they require assistance (Consent to Medical Treatment - Patient information PD). The interpreter or Aboriginal Liaison officer/health worker may attend the patient's appointments and the Referral Centre can organise this. (*Note: that this information is to be logged into ISOH.*);
- the initial specialist appointment is a consultation only to assess dental needs;
- if accepted for a specialist course of care, patients will invariably be placed on a treatment wait list, in accordance with the urgency of their assessed dental needs;
- treatment under oral sedation, intravenous sedation or general anaesthesia will be determined by the appropriate specialist service and not by the referring clinician.

4. GENERAL ANAESTHESIA FOR DENTAL PROCEDURES

The need for general anaesthesia (GA) represents the clinician's ultimate solution to treating a patient's dental problem. The decision to recommend general anaesthesia is not to be taken lightly as a risk of serious complications always exists. When deciding to place a patient under general anaesthesia, the treating dental clinician must consider the whole care of the patient.

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card) (Point 1.4).

4.1 Key Referral Information

Prior to GA assessment appointments must be made to ensure a suitable treatment plan has been proposed and consented to, the patient's behaviour is such that a satisfactory outcome can be achieved and a home-care program is established which includes such aspects as tooth brushing instruction, referral to a dietician, instruction on the use of home fluorides and follow-up visits, as appropriate.

4.2 Index of Treatment Needs

Certain clinical situations strongly indicate the need for general anaesthesia, these are:
- severe odontogenic cellulitis or abscess/s;
- facial trauma;
- surgical management of pathology;
- multiple carious teeth requiring extraction and/or restoration.

Patients indicated for GA are to be assessed in accordance with the American Society of Anaesthesiologists (ASA 2008) categories of anaesthetic risk. These are:
- ASA Class 1 Health patient
- ASA Class 2 Mild to moderate systemic disease without significant limitations
- ASA Class 3 Severe systemic disturbance without limitations
- ASA Class 4 Life-threatening systemic disorder
- ASA Class 5 Moribund patient not expected to survive >24hrs
- ASA Class E Emergency patient

Most patients who are ASA 1 or 2 will be suitable for day-stay anaesthesia.

However, patients with more severe systemic disease (ASA 3 or 4) may need overnight hospital care to ensure that they are maintaining their airway, tolerating oral food and fluids, that any pain is satisfactorily managed and that there is no ongoing bleeding. This overnight hospitalisation would be in an acute or general hospital.

4.3 General Anaesthetic Services

General anaesthetic services for dental procedures are provided by a multidisciplinary anaesthetic and anaesthetic assistant workforce with specialist dental expertise in the management of the patient's presenting oral health condition (QG 2009).

Dental treatment made available under GA can be provided by a dental specialist, a general dentist who has been appropriately credentialed by local public dental services and/or a post-graduate specialist registrar under appropriate supervision.

The patient will have a pre-anaesthetic assessment with an anaesthetist prior to the GA to ensure that the patient is in an optimal state of health for the planned procedure (QG 2009).

The GA may be postponed if the anaesthetist determines risk factors such as:
- medications have not been attested by the patient, such as warfarin and/or bisphosphonate;
- respiratory tract infection; or
- patient has not fasted according to hospital instructions.

5. CONSCIOUS SEDATION FOR DENTAL PROCEDURES

Sedation for dental procedures (with or without local anaesthesia) includes the administration by any route or technique, of all drugs that result in depression of the central nervous system. Conscious sedation offers an efficient and effective way of providing the patient with profound anxiety relief and pain management during dental procedures.

For further information, refer to the Australian & New Zealand College of Anaesthetists, Faculty of Pain Medicine Australian and New Zealand College Of Anaesthetists, Gastroenterological Society of

Australia, Royal Australasian College of Surgeons, Australasian College for Emergency Medicine, College of Intensive Care Medicine of Australia and New Zealand, Royal Australasian College of Dental Surgeons, Royal Australian and New Zealand College of Radiologists Professional Document PS9 (2010): "*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*".

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card) (Point 1.4).

5.1 Key Information

The choice of general anaesthesia or conscious sedation will be decided at the specialist assessment/ consultation using specific criteria based on health assessment, treatment complexity, behavioural problems and an anxiety assessment.

Detailed instructions will be given to the patient before any appointment for sedation or general anaesthesia. The patient must have a responsible adult to drive them home after the procedure.

5.2 Index of Treatment Needs

Referral for Conscious Sedation procedures includes patients in the following categories:
- Paediatric.
- Dento-alveolar surgery.
- Special Care Dentistry.
- Dental and/or needle phobias.

Patients who are unsuitable for Conscious Sedation include:
- IV drug users.
- Methadone patients.
- Patients with psychiatric disorders.
- Patients with significant health problems, e.g. ASA III or higher.

6. ENDODONTICS

All referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card). (Point 1.4)

Prior to referral for endodontics it is essential that:
- the tooth is functional, free of active dental caries and well temporised by the referring practitioner. This may require placement of an orthodontic band;
- the referring clinician understands and accepts responsibility for all emergency and other dental care of the patient whilst waiting for specialist treatment;
- all other restorative treatment is completed prior to referral.

Where the patient is advised that a tooth is assessed as endodontically untreatable, they will be returned to the referred clinician for management.

6.1 Key Referral Information

Teeth that can be added to an existing functional partial denture without detriment to a patient's oral condition will not be considered for endodontic treatment.

Additional factors that must be considered are the:

- status of the root canal *per se* and the reason for treatment (calcified, blocked, perforated, incompletely filled);
- condition of apical third of the root canal (i.e. open, closed, resorbed or eroded);
- strategic value of the tooth to the patient's future restorative needs, for example, as an abutment tooth for a denture;
- patient's medical and psychological conditions, age or infirmity which may impact on treatment provision or outcome;
- number of teeth already lost in the arch and presence of a partial denture;
- overall extent of treatment required in the mouth.

6.2 Index of Treatment Needs

Patients will be placed on a waiting list for definitive endodontic treatment according to the following Priority Codes:

6.2.1 Priority 1 (High Priority)

- traumatized and avulsed teeth. These include luxated, avulsed and fractured teeth;
- teeth with resorptive lesions or abnormalities. These include dens invaginatus & dens evaginatus, external or internal root resorption.

6.2.2 Priority 2 (Medium Priority)

- multi-rooted, restorable teeth important for function with difficult access to pulp chamber, or complications following attempted endodontic treatment, in a well maintained mouth;
- re-treatment cases, with history of pain, involving removal of root filling materials, procedural errors and cases involving surgery.

6.2.3 Priority 3 (Low Priority - Unlikely to be offered specialist care)

- single rooted teeth in a well maintained mouth that require straightforward endodontic treatment not necessarily requiring specialist attention;
- unopposed multi-rooted restorable functional teeth:
  - in a poorly maintained mouth with no prospects of sustainable improvement in periodontal condition, or
  - in a heavily restored mouth requiring multiple endodontic therapies.

7. ORAL AND MAXILLOFACIAL SURGERY

Oral and maxillofacial surgery offers treatment to patients requiring surgical management of trauma, developmental disorders or diseases involving the dento-facial, dento-alveolar or dento-maxillary complexes and associated structures.

To be exempt from a service charge, including anaesthetic, theatre and ancillary fees, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card). (Point 1.4)

7.1 Index of Treatment Needs

The scope of Oral and Maxillofacial Surgery Services is broad and includes:

7.1.1 Emergency treatment

- trauma - management of fractures of the facial skeleton including the primary and secondary management of hard and soft tissues and other injuries involving the mouth, jaws and associated structures;
- other - management of acute infections of the jaws and associated areas including complications following dental treatment, eg bleeding, infection.

7.1.2 Dento-alveolar surgery

- management of complex oral surgical procedures such as, endodontic surgery, removal of impacted teeth, management of benign tumours and cysts of the oral cavity, and oral surgical management of patients with significant medical problems

7.1.3 Orthodontic/Orthognathic Surgery

- the investigation, diagnosis and surgical correction of deformities of the face, jaws and related structures, including cleft lip and palate, utilising the principles of, and in association with, orthodontic management

7.1.4 Prosthetic and pre-prosthetic surgery

- surgical preparation of hard and soft tissues for prosthodontic treatments;
- the placement of implants into the jaws to provide retention for prostheses which replace missing teeth and/or missing tissues;

the placement of extra-oral implants can provide retention for a range of prostheses, such as maxillo-facial prostheses. These procedures are usually managed in conjunction with a maxillo-facial prosthodontist.

8. ORAL RADIOLOGY

This service provides intra-oral imaging for specific diagnostic needs, extra-oral planar and panoramic imaging, including cone beam volumetric imaging for:

- pathology screening and case work-up;
- oral surgery case work-up;
- prosthodontic case work-up including implant case work-up;
- orthodontic/Orthognathic case work-up;
- endodontics screening;
- paediatric dental screening; and
- periodontal screening.

With the advent of digital radiography, it is possible to take radiographs at referral centres or remotely, e.g. at acute care hospitals or private radiology practices, and have an oral radiologist or other dental specialist interpret the images. This electronic transmission or teleradiography may assist in rapid diagnosis, or even avoid patient travel.

9. ORAL MEDICINE/ORAL PATHOLOGY

Oral Medicine/Oral Pathology provide tertiary diagnostic and clinical services to the state of NSW by referral only. Services include:

- oral medicine/oral pathology;
- management of the severely medically-compromised patient requiring oral/dental care and treatment;
- management of conditions including the diagnosis of malignancy and treatment in conjunction with the Head and Neck clinical team;
- the investigation and management of diseases of the salivary glands;
- the diagnosis and management of patients with oral manifestations of auto-immune diseases;
- facial pain.

9.1 Key Referral Information

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card, for example valid health care card or pension card (refer to point 1.4).

9.2 Index of Treatment Needs

Indications for referral are patients with:
- any form of suspicious oral lesion or disease;
- suspected cases of mouth/oral cancer and pre-cancerous conditions;
- complex oro-facial pain whose cause has defied explanation and treatment; and
- extensive or complex medical conditions that are best treated in a hospital environment, for example:
  - haemophiliacs,
  - post organ- and bone marrow-transplant recipients; and
  - patients who have had radiotherapy treatment to the head and neck region.

There are 3 priority categories as identified below:

9.2.1 Priority 1 (to be seen within two (2) working days/48 hours)
- suspected oral malignancy;
- severe, incapacitating (unable to eat or drink) oro-pharyngeal ulceration;
- severe, intractable, incapacitating oro-dental pain unrelieved by narcotic opiate agents;
- active dental/periodontal infection in a seriously immuno-compromised patient (chemotherapy or head and neck radiotherapy recipient, patients on significant immuno-suppressant therapy, especially anti-T-cell agents or cytotoxic drugs).

9.2.2 Priority 2 (to be seen at the next available appointment, or within four (4) weeks)
- significant intractable oro-pharyngeal ulceration or oro-dental pain unrelieved by narcotic analgesics;
- patients with suspected oral malignancy awaiting definitive radical surgery, radiotherapy or chemotherapy;
- prior to head and neck radiotherapy treatment;
- pre-transplant (organ or haematopoietic stem cell) or pre-heart valve replacement dental assessment.

9.2.3 Priority 3
- all other cases.

10. ORTHODONTICS

The criteria for referral of patients for public orthodontic services are as follows:
- orthodontic treatment will not be offered to patients who are not dentally fit, that is, who have active caries, chronic marginal gingivitis or whose oral hygiene is not sound;
- referrals must include details of the malocclusion, as listed in the table of treatment need (Table A), and a recent panoramic radiograph (OPG);
- if the patient is assessed as eligible for, and in need of, public orthodontic care the supervising Dental Officer should refer the patient to a designated Dental Officer for prioritisation of care. Note: A designated Dental Officer is a public dental officer who has sufficient orthodontic knowledge and expertise which includes:
  - the ability to recognise the need for interceptive care;
  - the ability to undertake minor orthodontics; and
  - the ability to prioritise severe cases for referral to specialists.

1.1 Key Referral Information:

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card). (Point 1.4)

- Orthodontic treatment will only be offered to those patients who are dentally fit and who maintain an excellent standard of oral hygiene.
- If a patient does not maintain excellent oral hygiene during treatment and does not respond to an improvement program, treatment may be discontinued.
- Patients must bring a valid health care card or pension card to every visit.
- Any patient with a severe classification is likely to be accepted for treatment.
- Any patient with a moderate classification should be referred and assessed for suitability.
- Any patient with a mild classification will not be accepted for treatment.
- Any patient falling into the 'Other' category may be referred for assessment.
- All patients accepted for orthodontic treatment who are assessed as requiring a combined orthodontic/surgical (orthognathic) treatment must be a self holder or whose parents/guardians are holders of valid Centrelink concession card at the time of Request For Admission for surgery. If the patient under orthognathic treatment is no longer the holder or dependant of a Health Card Holder, then the patient's orthognathic surgery may be treated as private or compensable and the patient or parents/legal guardian will be responsible for payment of all fees raised by the hospital and providers. Such fees may include medication, bed costs, special nursing, surgical plates and screws, anaesthesia fees etc.
- The referring clinician should be able to recognise the need for early interceptive treatments and facilitate these treatments which may prevent more serious orthodontic problems in the future.
- The patient should be at an appropriate stage of development for the proposed orthodontic care.

10.2 Index of Treatment Needs

An internationally recognised system of classifying need, the Index of Orthodontic Treatment Need (IOTN) has been adapted. It is presented in table format for ease of use and understanding by referring clinicians (refer to Table A).

Seven occlusal traits have been listed:
- overjet
- overbite
- crowding
- crossbite
- reverse overjet
- hypodontia
- open bite

For each trait, there is a description of severe, moderate and mild. This will determine whether the patient is accepted for treatment.

Table A: Orthodontic Treatment Needs

MALOCCLUSION	SEVERE (eligible)	MODERATE (Refer for opinion)	MILD (Not eligible)
Overjet	> 7 mm	5 – 7 mm	< 5 mm
Overbite	100% coverage of lower incisor or complete to palate	more than 70% coverage of lower incisor	up to 50% coverage of lower incisor
Crowding	> 9 mm per arch	5 – 9 mm per arch	< 5 mm per arch
Crossbite	anterior/posterior crossbite with: ▪ enamel loss ▪ gingival trauma and/or anterior/posterior crossbite with functional shift	anterior/posterior crossbite of more than 2 teeth and/or unilateral posterior crossbite	anterior/posterior crossbite of 1-2 teeth with no functional shift
Reverse overjet	Presence of reverse overjet	edge-to-edge	
Hypodontia	multiple missing teeth with major orthodontic implications	one tooth missing with moderate orthodontic implications	Hypodontia with no need for orthodontic treatment
Open bite Anterior or Posterior	>4 mm	2 – 4 mm	< 2 mm
Other	Impacted/ectopic teeth other than third molars severe skeletal malocclusions/orthognathic cases facial deformities/congenital abnormalities/cleft lip and palate (CLD)		

2. PAEDIATRIC DENTISTRY

All children and young persons (0-<18yrs) are eligible to be referred for paediatric specialist consultation, for the provision of non-admitted treatment and for admitted services for conditions outlined in 11.2.1 – 11.2.4.

However, only children and young persons who are self holders or whose parents/guardians are holders of a valid Centrelink concession card, are eligible for admitted paediatric dental specialty services for conditions outlined in 11.2.5 and 11.2.6.

Exemption to these eligibility criteria can only be made for patients for teaching purposes and those patients with special clinical needs as authorised by Clinical Directors of Local Health District Oral Health Services or their formally authorised delegate/s. For these cases a service charge may be applicable.

11.1 Key Referral Information

For children in Group 6 (Point 11.2.6 below), attempts should be made to treat them using behaviour management techniques prior to referral. Referrals in this category should document these attempts to demonstrate which techniques have been successful and which have not worked.

11.2 Index of Treatment Needs:

The sub-sections below list conditions for which specialist paediatric dental services are provided at Sydney Children's Hospitals Specialty Network (Randwick and Westmead), Sydney Dental Hospital and Westmead Centre for Oral Health.

11.2.1 *Group 1: Emergency Care*

phone the department directly if necessary for all children and young persons aged 0-17 years, including:

- facial swelling or acute oro-facial infection;
- haemorrhage;
- dento-alveolar trauma.

11.2.2 *Group* 2: *Children/Young persons*

whose medical condition or general health is threatened if dental care is not provided, such as but not limited to:

- congenital/acquired cardiac condition;
- oncology, and/or;
- haematological diseases.

11.2.3 *Group 3: Children/Young persons*

with severe/chronic disease and/or functional disability, or with special health needs, such as:

- intellectually or physically disabled;
- requiring frequent medications.

11.2.4 *Group 4*: *Children/Young persons*

with congenital or acquired malformations of the jaws, face or teeth, orofacial pathology, such as:

- craniofacial malformations, e.g. clefts of lip and/or palate;
- dental anomalies, such as amelogenesis imperfecta, multiple supernumerary teeth;
- dento-alveolar pathology such as cysts, ulcers.

11.2.5 *Group 5: Children 0-5 years*

at high caries risk, such as:

- early childhood caries (either white spot demineralisation or cavitated lesions);
- requiring management under general anaesthesia or sedation.

11.2.6 *Group 6: Children/Young persons*

with behaviour management difficulties, such as:

- children over 6 years of age with extreme dental anxiety requiring management under general anaesthesia or sedation.

3. PERIODONTICS

The criteria for referral of patients for periodontic services are:

- Assessment and management of periodontitis.
  - patients must demonstrate a commitment to good oral hygiene, smoking cessation and attendance at appointments.
- Specialist consultation for reasons other than periodontitis as follows:
  - pre-surgical consultations;
  - management of soft tissue lesions;
  - assessment for crown-lengthening;
  - management of oral manifestations of systemic disease;
  - assistance with treatment planning etc.

12.1 Key Referral Information

Patients with gingivitis only are generally not accepted for treatment in the specialist department.

4. PROSTHODONTICS

Referring practitioners are advised, when practical, to discuss the referral with a specialist before referring their patient. It is essential that the patient has received a course of comprehensive care to ensure no pathology remains and the only remaining treatment need is that for specialist consideration.

If there is found to be outstanding treatment needs other than those specifically addressed in the referral, these will be directed back to the referring clinic, resulting in delayed specialist treatment.

13.1 Key Referral Information

- Patients who have lost their dentures, who are dissatisfied with a recently fabricated denture or who have only one or two teeth missing do not need a specialist prosthodontic referral. These are general denture services which are within the capability and responsibility of Local Health Districts.
- The referring practitioner remains responsible for the oral health and well being of the patient, including pain relief during the waiting period. Provision of temporary restorations is essential to ensure the stability of the remaining dentition while awaiting a specialist appointment.
- Any additional laboratory costs arising from specialist treatment are to be borne by the patient. The patient must be made aware of this prior to the referral.
- Ocular prostheses (prosthetic eyes) are provided by ocular prosthetists and not by maxillofacial prosthodontic specialists.

13.2 Index of Treatment Needs:

Patients will be considered for:

13.2.1 *Fixed dental prosthodontics*

crown and bridge work for dentate and partially dentate patients, for example:

- excessive incisal/occlusal wear;
- coronal restoration of endodontically treated teeth;
- over-closed vertical dimension; and
- cases requiring cast-metal based dentures which are not responsive to local efforts.

13.2.2 *Removable prosthodontics*

in cases identified below:

- a history of serious problems, chronic clinical complaints or dissatisfaction where all generalist efforts have been exhausted, for example:
  - chronic non-retention;
  - chronic denture soreness; and
  - inability to wear an otherwise satisfactory prosthesis.
- A medical condition such as
  - undergoing head and neck radiotherapy;
  - salivary hypofunction/xerostomia;
  - severely atrophic maxillary or mandibular ridges;
  - flabby ridges;
  - severe gag reflex; and
  - significant anatomical defects such as mandibular or maxillary tori or cleft palate.

13.2.3 *Fixed and/or removable prosthodontics*
for complex cases involving
- precision attachments;
- osseo-integrated implants; and
- hybrid therapies.

13.2.4 *Complex cases may include:*
- gross occlusal wear not consistent with the patient's age;
- advanced tooth wear resulting from uncontrolled erosion, attrition, abrasion;
- occlusal collapse, or
- where restorative treatment will require multi-disciplinary management.

13.2.5 *Jaw function and oro-facial pain*
where there is no untreated pathology

13.2.6 *Chronic TMJ dysfunction*
it is essential that the referring practitioner has commenced occlusal splint therapy and advised the patient on other pain relieving actions, e.g moist heat packs when the case is acute.

13.2.7 *Specialist dental prosthetic treatment*
is provided to patients with oro-facial deformities, such as:
- intraoral - dentures, speech appliances or other appliances for alveolar resections, hard or soft palate fenestrations, cleft palate, mandibular resection and deviation, velo-pharyngeal incompetence, glossectomy of deformities resulting from surgical resection, reconstruction and/or radiotherapy;
- maxillo-facial - these mostly involve developmental or acquired facial disfigurement in which plastic surgery is contraindicated and a cosmetic prosthesis is required. Typically these cases involve an auricular, nasal or orbital prosthesis.

5. SPECIAL CARE DENTISTRY

The Referral Centres offer special services to a diverse client group with a range of disabilities and complex additional needs. This includes individuals and groups who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of a number of these factors.

14.1 Key Referral Information

- If the patient is unable to consent for his/her own dental treatment, the treatment plan will need to be discussed and consent for treatment signed by the legal guardian prior to commencement of care. Ability to consent must be noted in the referral and, if the patient does not self-consent, the name and address and contact details of the legal guardian must also be provided.
- A parent/carer/guardian is required to be present at all appointments for those patients who are unable to consent, or have significant physical or communicative disability.

14.2 Index of Treatment Needs

To achieve positive outcomes for the referred patient, the Referral Centres offer special services to address specific medical and/or social needs. These Referral Centres need the commitment of the patient/carer/parent/guardian to aspire to good oral hygiene[11] and attendance of appointments.

[11] Good oral hygiene is achieved by the effective removal of dental plaque through twice daily tooth brushing including interdental areas and using fluoride toothpaste and augmented with antimicrobial agents (eg. mouthwashes). Individuals must be instructed in the most appropriate technique of oral health care that includes professional feedback and reinforcement to prevent relapse and disease progression (Löe, 2000)

14.3 Special Care Dentistry Services

Specialist services are as follows:

- Persons with mental illness/disorder/condition or disability (behavioural, and/or intellectual) who are not suitable for routine dental care or are living in:
  - aged residential care (retirement villages) or nursing homes;
  - hostels, group homes or boarding houses;
  - the community with their families or with help from professional carer.
- Persons who are homeless.
- Persons with serious medical conditions.
- Persons with physical disabilities (unable to walk unattended by carers, or using wheelchairs, walking frames, callipers, scooter or other mobility aid.
- Persons with sensory disabilities of a severity which preclude routine attendance at Public Oral Health Clinics.

6. SHORTENED TERMS

ASA	American Society of Anaesthetists
CJD	Creutzfeldt-Jakob Disease
CLD	Cleft lip and palate
GA	General Anaesthesia
HIV	Human Immunodeficiency Virus
HIV/AIDS	HIV/Acquired Immune Deficiency Syndrome
IOTN	Index of Orthodontic Treatment Needs
OPG	Panoramic Radiograph
POHP	Priority Oral Health Program
SDH	Sydney Dental Hospital
TMJ	Temporomandibular Joint
WCOH	Westmead Centre for Oral Health

7. DEFINITION OF TERMS

Term	Definition
In-patient	Someone who stays overnight or for some time in a hospital for treatment or observation (Collins 2004 pg 198)
Non-admitted	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, such clinical services that are included are; allied health and/or clinical nurse specialist; dental; imaging; medical; obstetrics and gynaecology; paediatrics; pathology; pharmacy; psychiatric; surgical and emergency department (Australian Institute of Health and Welfare 2005)
Dental Caries	A chronic multifactorial life style based oral disease of microbial origin affecting the hard tissues of the tooth, commonly known as dental decay or cavities. Dissolution of the calcification tissues of the tooth by acid produced from ingested refined carbohydrates and micro-organisms in dental plaque. The process by which cavities are formed in teeth by gradual destruction of enamel and dentine. (Barnett, L.V 2000)

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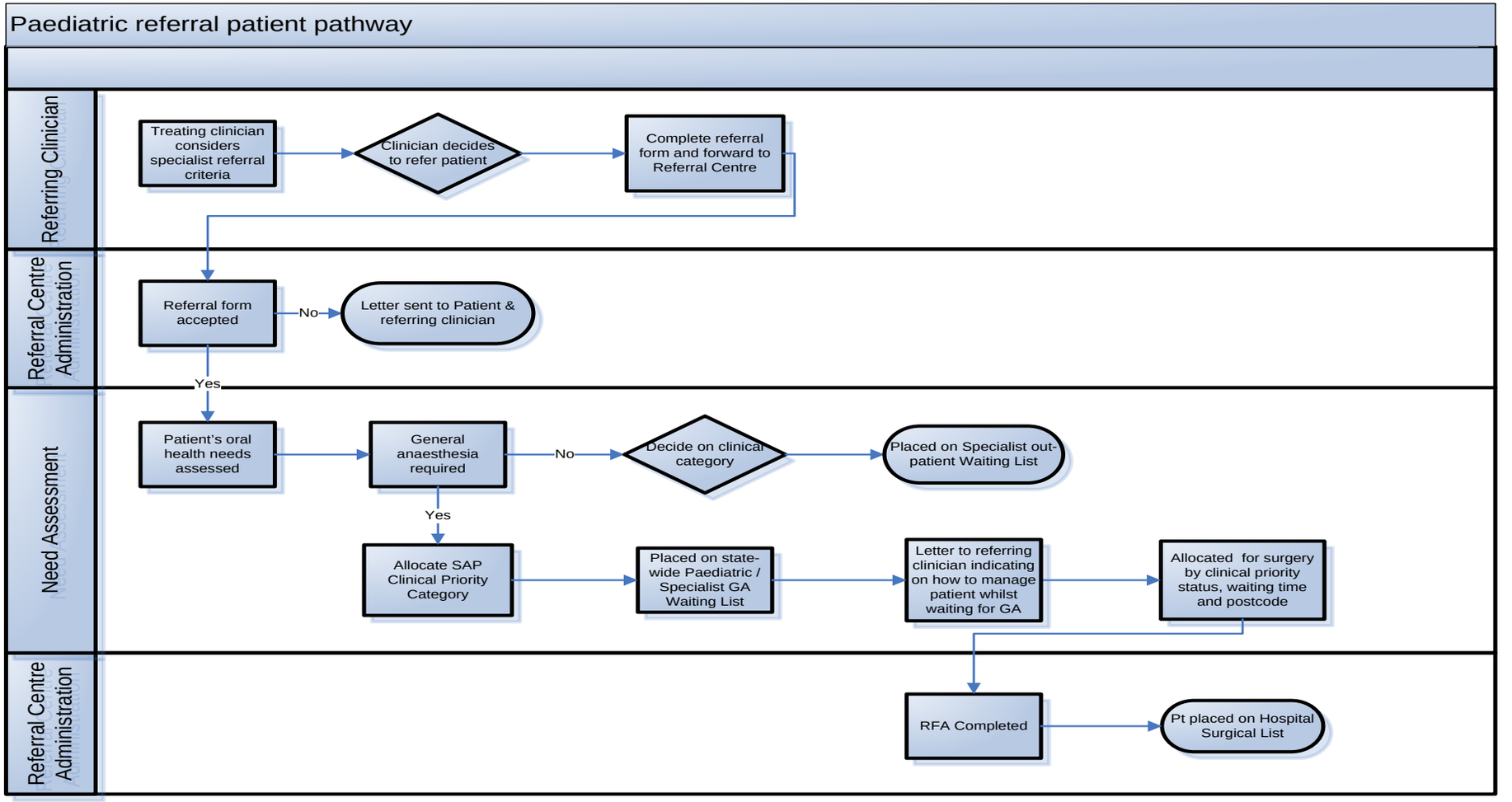
Appendix A - Paediatric Patient - Referral Flowchart (Sample)



DENTAL AMALGAM CLINICAL USE AND DISPOSAL (GL2020_015)

GL2020_015 rescinded GL2011_002

GUIDELINE SUMMARY

This Guideline provides recommendations on the clinical use and the safe disposal of dental amalgam when treating patients in public dental clinics.

It is to be read with *NSW Health Clinical and Related Waste Management for Health Services* (PD2017_026).

KEY PRINCIPLES

NSW Health supports the specific measures outlined in the Minamata convention, by firstly improving oral health through systems and health promotion support, minimising the need for dental restorations. Where dental restorations are needed, current evidence-based approaches are supported, and cost-effective mercury free alternative materials are available to dental practitioners.

This Guideline also provides amalgam disposal practices to support environmental best practice to minimise the release of mercury compounds generated from dental clinics.

CLINICAL USE OF AMALGAM

Existing amalgam restorations remain safe and should not be removed or replaced with alternative restorative materials unless deemed strictly necessary by the dental practitioner. There is no evidence to justify the removal of dental amalgam restorations to relieve other systemic medical conditions or treat medical conditions (other than a proven allergy).

Cost effective, mercury-free alternative materials are available to dental practitioners to support modern evidence-based approaches to restorative care. These alternative materials should be favoured when treating patients who are pregnant, especially in the first trimester, breastfeeding mothers and those patients with severe renal disease and children under the age of 15.

Only pre-encapsulated amalgam is used when dental practitioners deem its necessity based on the specific medical and dental needs of the patient.

If placing or removing dental amalgam, clinical measures to reduce exposure to mercury vapour would include the use of rubber dam, ample water supply and evacuation.

WASTE MANAGEMENT OF DENTAL AMALGAM

The Minamata Convention on Mercury outlines measures to minimize the emission of mercury from dental practice into the environment to protect human health and the environment.

All clinics should be equipped with dental units that have amalgam waste traps that comply with ISO 11143.

Amalgam and amalgam-filled extracted teeth should not be placed in the ‘general’, yellow ‘contaminated’, or ‘sharps’ disposal containers, where contents are often incinerated.

Dental clinics should collect, store and ensure amalgam waste is sent to a licensed mercury waste processing facility for mercury recovery. These facilities recycle the mercury present in all the dental amalgam waste. If necessary, the Environment Protection Authority should be contacted for specific requirements for the disposal of mercury.

The Guideline can be downloaded from
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_015

EMERGENCY DEPARTMENT DENTAL REFERRALS (GL2023_005)

GL2023_005 rescinded GL2010_008

GUIDELINE SUMMARY

This Guideline provides direction on making appropriate dental follow-up referrals from NSW Health hospital Emergency Departments (EDs).

This Guideline is to be read in conjunction with the NSW Health Policy Directive *State Health Forms* (PD2009_072), NSW Health Policy Directive *Eligibility of Persons for Public Oral Health Care in NSW* (PD2017_027) and NSW Health Policy *Priority Oral Health Program (POHP) and Waiting List Management* (PD2017_023).

KEY PRINCIPLES

Dental conditions feature as a common reason for presentation to NSW Emergency Departments (ED). Information on the management of dental emergencies, within EDs can be accessed through the Agency for Clinical Innovation's Emergency Care Institute webpage on *Dental Emergencies*.

At the point of discharge some patients may require further dental care related to their initial presentation at the ED. Without adequate follow-up care, these patients may re-present to the ED.
Commonly this may include patients that have presented with:

- Dental trauma
- Swelling of the face or neck of dental origin
- Swelling in the mouth of dental origin
- Significant bleeding from a dental origin
- Difficulty opening jaw and/or swallowing as a result of a dental infection
- Difficulty breathing due to a swelling of dental origin.

A discharge summary is to be provided to the patient for follow up dental care. The patients discharge summary must include:

- Details about the presenting condition
- Test completed (such as imaging, blood pathology)
- Details about the management of the presentation and any medications administered

Some patients presenting to the ED may be eligible for a referral to NSW public dental clinics.

Patients requiring routine dental care should seek care from their private dental practitioner or at a NSW public dental clinic (eligibility criteria apply). Patients are eligible to access public dental clinics if they meet all section criteria, on the *Dental Referral for Emergency Departments to NSW Public Dental Clinics* form. This includes all children under 18 and adults with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Health Card. This criterion is also outlined in the NSW Health Policy Directive *Eligibility of Persons for Public Oral Health Care in NSW* (PD2017_027).

If a referral to a NSW public dental clinic is required, the state-wide form *Dental Referral for Emergency Departments to NSW Public Dental Clinics* is to be used. This form is to be given to the patient on discharge.

Contact details for public dental clinics are on the form. In most cases the patient will be required to contact the public dental clinics. Vulnerable or priority patients may require staff assistance. The patient is required to bring the form to their dental appointment.

The Guideline can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_005

EARLY CHILDHOOD ORAL HEALTH GUIDELINES FOR CHILD HEALTH PROFESSIONALS, 3rd EDITION (GL2014_020)

GL2014_020 rescinds GL2009_017.

PURPOSE

The Early Childhood Oral Health Guidelines (the Guidelines) aim to improve the health and wellbeing of children in NSW by integrating oral health into general health interventions provided by child health professionals. The Guidelines add value to the NSW Personal Health Record, which includes oral health information for parents and a requirement to "lift the lip" and check for signs of dental disease during Child Health Checks.

KEY PRINCIPLES

The key principles of the Guidelines are that child health professionals should:

1. Advise pregnant women to visit a dentist for a dental examination and restoration of all active decay.
2. Provide preventive interventions to pregnant women and to new parents/caregivers.
3. Lift the lip of children aged 0-5 years to examine the upper front teeth and look for early signs of tooth decay (e.g. white or brown spots that don't brush off) and existing cavities.
4. Assess child's level of risk for oral disease. Provide preventive interventions to new parents/caregivers.
5. Advise parents/caregivers to reduce the frequency of sugar intake by limiting night time on-demand feeding after six months.
6. Advise mothers and carers to avoid transfer of oral bacteria to their child by maintaining good oral health themselves and by not placing food, utensils, dummies or teats into their own mouths and then into their child's mouth.
7. Provide dietary counselling to parents/caregivers that is specific to the child and their family and monitor compliance.
8. Provide oral hygiene and fluoride advice to parents/caregivers.
9. Provide information on teething to new parents/caregivers.
10. Provide an oral health assessment to a child by their first birthday.
11. Refer children at high risk for tooth decay to an Oral Health Call Centre, Early Childhood Oral Health Coordinator or Private Dentist.
12. Advise parents to talk to their children about dental visits in a positive way.
13. Provide oral health education for all child health professionals.

USE OF THE GUIDELINE

The Guidelines provide support material for child health professionals about oral health that complements their existing expertise by:

- Providing accurate oral health information to parents of children aged 0-5 years
- Assessing levels of oral disease risk for children aged 0-5 years
- Making decisions about appropriate referrals to oral health services.

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_020.html

EARLY CHILDHOOD ORAL HEALTH (ECOH) PROGRAM: THE ROLE OF PUBLIC ORAL HEALTH SERVICES (PD2013_037)

PD2013_037 rescinds PD2008_020.

PURPOSE

Oral Health is essential for health and wellbeing and early childhood is the time when most lifetime habits are established. It offers the greatest opportunity for prevention of disease, which, in turn, can contribute to better health in adulthood. This policy sets the framework for Public Oral Health Services in NSW to work collaboratively with key partners to implement the Early Childhood Oral Health Program in order to improve the oral health of the population.

MANDATORY REQUIREMENTS

- All child health professionals receive core oral health training and have access to regular periodic updates in oral health.
- All members of the oral health team are educated and trained to address the issues of children aged 0-5 years and are responsive to the prioritisation process for children who are at risk of Early Childhood Caries (ECC), including siblings.
- Referral information and supporting resources are available and accessible to child health professionals.
- Culturally appropriate oral health information and resources are available to Aboriginal people.
- Child health professionals who refer children receive timely feedback from the treating oral health professional.
- Administrative structures and procedures support the referral and feedback processes.

IMPLEMENTATION

An overview of responsibilities of key parties required in implementing this policy:

Centre for Oral Health Strategy (COHS) NSW:

- Develop, promote and review state-wide resources & training packages.
- Engage with Aboriginal Health personnel and communities in the development of culturally specific resources.
- Promote education of oral health personnel in early childhood oral health.
- Maintain a high level of consultation & liaison with key stakeholders.
- Monitor ECOH Program uptake.
- Monitor oral health outcomes.

LHD Oral Health Managers and Clinical Directors:

- Allocate adequate resources to implement and sustain the ECOH program.
- Support ongoing professional development for oral health staff.
- Prioritise 0-5 year olds and all eligible family members, who are in the ‘high risk’ category.
- Focus actions on higher risk groups, such as Aboriginal communities and others as identified by epidemiological and/or socio-demographic data.
- Ensure that administrative structures and procedures support referral, appointment, treatment and feedback processes where appropriate.
- Provide preventive information, resources and treatment to improve the oral health status of high risk groups.
- Ensure all children referred by a child health professional are enrolled in the Information System for Oral Health (ISOH).

ECOH Coordinators (or delegated Oral Health Professional):

- Train and provide periodic updates for child health professionals, including Aboriginal Health personnel.
- Distribute ECOH resources & relevant supporting information to both child health professionals and public oral health professionals.
- Monitor ECOH program uptake at the LHD level.
- Train oral health teams in ECOH prioritisation and appointment protocol.
- Participate in ECOH professional development sessions.
- Build collaborative LHD partnerships between oral health and general health professionals.
- Provide timely and accurate reports to LHD Management and to COHS.
- Provide timely feedback to referring agents.

Oral Health Clinicians:

- Provide timely feedback to referring professionals/agencies.
- Implement a family centred model of oral health care that recognises eligible family members for dental treatment where one family member has been referred for prevention and early intervention under the ECOH Program.
- Distribute resources and relevant material that support the ECOH program to parents/carers of young children.
- Liaise with and support the ECOH coordinator and participate in ECOH professional development sessions.

Oral Health Intake/Reception:

- Prioritise referrals from the ECOH Program.
- Record all children who enter the oral health service with a referral from a child health professional as a referral during their Priority Oral Health Program (POHP) triage in ISOH.
- When required, liaise with ECOH coordinators, child health professionals and oral health clinicians as required to facilitate a family centred approach to oral health care.

1. BACKGROUND

Early childhood caries (ECC) is a serious dental condition occurring during the preschool years of a child's life when developing primary (baby) teeth are especially vulnerable. ECC can occur as soon as the first tooth erupts. During the first 12 months post-eruption susceptibility of teeth to decay is high.

It can be a devastating condition often requiring hospitalisation and dental treatment under general anaesthesia (GA). The majority of children on GA waiting lists in NSW are under the age of 5 years. In 2010 - 2011, 1,509 children aged between 0-4 years of age received dental treatment under general anaesthesia in NSW[13].

The pain, psychological trauma, health risks, and costs associated with restoration of carious teeth for children affected by ECC can be substantial.

Family circumstances, such as low socio-economic background, increase the risk of ECC. Thus, to be more effective and efficient, a holistic family-oriented approach is necessary.

The evidence strongly shows that ECC is one of the few chronic diseases that, if preventive messages are implemented, can be mostly prevented.

[13] Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at www.healthstatus.nsw.gov.au Accessed (Thursday, 4 April 2013).

Oral health checks are recommended during child health checks at 6-8 months, 12 months, 18 months, and 2, 3 and 4 years of age[14].

2. DEFINITION OF EARLY CHILDHOOD CARIES (ECC)

The disease of ECC is defined as "the presence of 1 or more decayed (non-cavitated or cavitated lesions), missing (due to caries), or filled tooth surfaces" in any primary tooth in infants and preschool children[15]. In children younger than 3 years of age, any sign of smooth-surface caries is indicative of severe early childhood caries. Major contributing factors include prolonged and/or frequent bottle feeding, especially at night.

3. ASSOCIATED DOCUMENTS

This Policy Directive should be read in association with the following documents:

- Early Childhood Oral Health Guidelines for Child Health Professionals, 3rd Edition: GL2014_020.
- Pit and Fissure Sealants: Use of in Oral Health Services in NSW: PD2013_025.
- Oral Health – Eligibility of Persons for Oral Health Care in NSW: PD2009_074.
- Priority Oral Health Program and List Management Protocols: PD2008_056.

It should also be consistent with whole of government policies & plans:

- Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013
- National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes Implementation Plan
- National Partnership Agreement for Oral Health
- Oral Health 2020: A Strategic Framework for Dental Health in NSW
- Department of Health and Aging MBS Primary Care Items: Healthy Kids Check

4. PRINCIPLES

4.1 Oral health is essential for health and well-being and must be integrated into the 'general' health agenda.

4.2 Poor oral health can have a serious impact on quality of life and good oral health in infancy and early childhood contributes to better health in adulthood.

4.3 Dental caries is a multifactorial disease and in early childhood is linked strongly to family behaviours and practices. Oral health services need to prioritise all eligible family members where one child is at high risk.

4.4 Intervening early makes good economic sense. Interventions targeted at young children will have much higher economic returns than later interventions. Policies that focus on the treatment of established problems or conditions are not sustainable.

4.5 Primary teeth are important for normal development, function and health. If children lose their primary teeth too early there can be an adverse effect on self-esteem, eating and the position of the adult teeth.

4.6 Generally, child health professionals[16] have more opportunities to engage with and influence new parents, and to conduct risk assessments, than do oral health professionals.

[14] "My First Health Record" Personal Health Record, NSW Health 2007. SHPN (PHCP) 060174 ISBN 1741870178.
[15] American Academy of Paediatric Dentistry.
[16] Any health professional who works with children, including General Practitioners, Paediatricians, Child & Family Health Nurses, Aboriginal Health Workers, Speech Therapists, Dieticians, Drug and Alcohol Workers, and others as identified.

5. IMPLEMENTATION PLAN

Training

Procedure	Who	When	How
• Provide child health professionals, including Aboriginal Health personnel, with core ECOH Program training and annual oral health updates	ECOH Coordinators	When required	Train the trainer model developed by COHS.
• Provide oral health teams with professional development in early childhood oral health	COHS	In conjunction with ECOH Program roll-out	Regional in-services, supported by DVD
• Provide oral health teams with training in referral and feedback procedures	ECOH Coordinators	Prior to implementation. Include in AHS orientation & training programs	Develop local LHD protocols
• Provide ECOH Program participants with access to supporting state-wide policies, guidelines and resources	COHS	As appropriate	ECOH Policy Directive, evaluation of resources, development of culturally specific resources for Aboriginal and CALD communities

Referral and feedback

Procedure	Who	When	How
• Check the mouth and assess the risk for dental disease in children aged 0-5, following participation in ECOH Program training	Child health professionals	Child Health Checks and other opportunistic interventions	As per ECOH guidelines
• Document findings and refer children at risk of dental disease to oral health services, using either paper-based or electronic referral system		Following identification of risk of dental disease	Use referral template provided in ECOH guidelines
• Prioritise referrals from the ECOH Program	Oral Health Services	First client contact	Through the Priority Oral Health Program (ISOH) referral protocols
• Routinely collect statistics on total number of referrals received	Oral Health Services	Quarterly	Through LHD data collection processes
• Provide timely feedback to referring professionals/agencies	Oral Health Professional	Following the child's appointment	Develop local LHD protocols

Monitoring

Procedure	Who	When	How
• Record all children who enter the oral health service with a referral from a child health professional as a referral during their Priority Oral Health Program (POHP) triage	Oral Health Services	During POHP triage	Tick "Do you have a referral from an NGO, Community Health, GP, DoCS?"
• Monitor ECOH Program uptake • Report to COHS in a timely and uniform manner	Oral Health Managers & ECOH Coordinators	Quarterly	Through LHD data collection processes
• Monitor the number of families participating in the ECOH program	Oral Health Services, COHS	As appropriate	Refer to Waiting list protocol. Participation in population oral health surveys
• Develop an indicator that identifies ECOH referrals	COHS	After general release of ISOH version 7	Through ISOH

6. ADDITIONAL INFORMATION

6.1 Web links

- ECOH Guidelines for Child Health Professionals, 3rd Edition
  http://www.health.nsw.gov.au/policies/gl/2014/GL2014_020.html
- My First Health Record: Personal Health Record
  http://www.health.nsw.gov.au/Kids/Pages/my-personal-health-record.aspx
- Lift the Lip Posters
- Lift the Lip Translations http://www.mhcs.health.nsw.gov.au/topics/Dental_Care.html
- See My Smile brochure, Better Health Centre – Publications Warehouse
- Lift the Lip brochure, Better Health Centre – Publications Warehouse
- NH&MRC Public Statement on the Efficacy and Safety of Fluoridation 2007 www.nhmrc.gov.au
- Online learning*: early childhood oral health: case studies from general practice*
  www.gplearning.com.au
- Oral Health Promotion Clearing House http://www.adelaide.edu.au/oral-health-promotion/programs/

6.2 For information on Oral Health Resources contact:

The Centre for oral Health Strategy (COHS) www.health.nsw.gov.au/cohs/
The Better Health Centre – Publications Warehouse (02) 9887 5450

PRIORITY ORAL HEALTH PROGRAM (POHP) AND WAITING LIST MANAGEMENT (PD2017_023)

PD2017_023 rescinds PD2008_056.

PURPOSE

This policy directive outlines the processes of dental triage, clinical assessment, and waiting list management for NSW residents who access public oral health services.

MANDATORY REQUIREMENTS

Public oral health services managed by NSW Local Health Districts (LHD) and Specialty Networks (SN) must prioritise and manage patient flows according to the processes set out in this Policy Directive.

IMPLEMENTATION

Chief Executives are responsible for:

- Ensuring that this Policy Directive is implemented throughout the Local Health District/Specialty Health Network.
- Supporting the efficient and equitable delivery of oral health services including proactive management of demand.
- Regularly evaluating oral health service performance and ensuring that relevant reporting requirements are met.
- Ensuring that oral health services communicate effectively with patients and carers and treat all clients with respect and dignity.

Oral Health Service Clinical Directors and Service Managers are responsible for:

- Ensuring that clear administrative and clinical procedures are in place to facilitate the implementation of the Policy Directive.
- Conducting quality assurance activities to ensure that the triage, clinical assessment and waiting list management procedures and timeframes outlined in this Policy Directive are adhered to.
- Ensuring that excellent customer service practices are in place to facilitate effective and timely communication with patients. All patients and carers must be treated with respect and dignity.

Oral Health Contact Centre Staff are responsible for:

- Ensuring that excellent customer service practices are in place to facilitate effective and timely communication with patients. All patients and carers must be treated with respect and dignity.
- Ensuring that all patients are triaged in accordance with this Policy Directive.
- Ensuring that patient encounters are documented accurately and appropriately.

Dental Practitioners are responsible for:

- Complying with the procedures and clinical criteria set out in this Policy Directive.
- Prompt and appropriate communication with referring Medical Practitioners regarding the management of a referred patient.
- Contributing to the performance of the oral health service by providing services to patients in an efficient, conscientious manner.
- Providing excellent customer service to patients and carers.
- All patients and carers must be treated with respect and dignity.

Referring Health Practitioners are responsible for:

- Ensuring that adequate demographic and clinical details are provided when referring patients to oral health services.
- Initiating prompt and appropriate communication with oral health services should there be a change in indications for treatment or change in a patient's health with implications for treatment.

Patients and carers should:

- Seek public dental care by telephoning an oral health contact centre for triage.
- Inform the oral health contact centre of any change in patients' oral health complaint.
- Attend pre-treatment appointments as required by the oral health service (such as a clinical assessment appointment) and attend all appointments for treatment.
- Clearly communicate with oral health service staff:
    - Any change of address or other contact details
    - Inability to attend an appointment
    - Any change in decision to undergo a procedure

RELATED NSW MINISTRY OF HEALTH POLICIES

This Policy Directive should be read in conjunction with, but not restricted to:

- Early Childhood Oral Health (ECOH) Program: The Role of Public Oral Health Services (PD2013_037)
- Health Assessment of Children and Young People in Out-of-Home-Care (Clinical Practice Guidelines) (GL2013_010)
- NSW Patient Safety and Clinical Quality Program (PD2005_608)
- Oral Health - Eligibility of Persons for Public Oral Health Care in NSW (PD2016_050)
- Oral Health Fee for Service Scheme (OHFFSS) NSW (PD2016_018)
- Waiting Time and Elective Patient Management Policy (PD2012_011)
- Oral Health Specialist Referral Protocols (PD2011_071)
- Oral Health Referral Form for Medical Emergency Departments (Guidelines) (GL2010_008)
- Oral Health Patient Record Protocol (GL2015_017)

Ministry of Health policies, guidelines and information bulletins are public documents and can be sourced from NSW Health's website: www.health.nsw.gov.au.

Priority Oral Health Program (POHP) and Waiting List Management: Procedures

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1 BACKGROUND

1.1 About This Document

The Priority Oral Health Program and Waiting List Management Policy Directive has been developed to promote clinically appropriate, consistent and equitable management of patient access and waiting lists in NSW public oral health services.

1.2 Introduction

There is no Commonwealth scheme similar to Medicare that provides universal access to dental services. NSW Health provides a public dental system offering a range of services to children as well as adults who meet the eligibility criteria outlined below.

All children under 18 years of age in NSW are eligible for general dental services. To be eligible, adults must hold or be listed as a dependent on one of the following valid Australian Government concession cards:

- Health Care Card,
- Commonwealth Seniors Health Care Card or
- Pensioner Concession Card (includes Centrelink and Department of Veteran Affairs).

These criteria are outlined in more detail in the NSW Health *Eligibility of Persons for Public Oral Health Care in NSW* policy directive (PD2016_050).

Providing oral health care to eligible patients and the effective management of waiting lists is a priority for the Government and NSW Health. Public dental services are provided according to criteria that prioritise emergency situations, as well as patient groups in most need and at highest risk of disease.

Access to public dental services is mostly via an oral health contact centre, through which eligible patients are triaged and given a clinical priority depending on the seriousness of their condition. There is high demand for public dental services and therefore priority is given to the treatment of patients with urgent conditions within clinically appropriate timeframes. Patients with non-urgent conditions may be required to wait on a waiting list for care.

It is recognised that a patient may need to be re-triaged if their condition changes or deteriorates while on a waiting list. At the time of triage, patients and/or carers should be informed of what to do if their condition changes or they become concerned while waiting for care.

Patients and/or carers who are concerned about urgent medical conditions at point of contact should be encouraged to seek appropriate care through a General Practitioner, Aboriginal Medical Service or Hospital Emergency Department.

NSW Health services must actively manage access to oral health services in compliance with the contents of this document.

1.3 Key Definitions

Term	Definition
"must"	Indicates a mandatory action requiring compliance by staff at public health facilities, in accordance with a legislative requirement and/or policy directive.
"should"	Indicates a recommended action that should be followed unless there is a sound reason for taking a different course of action.
Adult	A person 18 years of age or over.
Assessment appointment	An appointment where the treating practitioner diagnoses the patient's clinical condition and may provide treatment to stabilise the condition. The patient may then be assigned to an appropriate waiting list.
Assessment waiting list	A waiting list that patients are placed on after triage until an assessment appointment is made.
Assessment waiting time	Waiting time between the date the patient is placed on the assessment waiting list and the date an offer of care is made and/or the date they attend an assessment appointment.
Child	A person less than 18 years of age.
Comprehensive course of care	An appointment or series of appointments following a comprehensive examination (usually item number 011 or 012) that addresses all of the patient's oral health needs.
Episodic course of care	A limited course of care provided with the intent of only addressing a specific, clinically urgent patient presentation (usually following a limited examination, item number 013).
Failure to Attend (FTA)	A patient has failed to attend a scheduled appointment when they: a) Do not arrive prior to the appointment time; or b) Do not ring to cancel the appointment
Oral health emergency	An oral health emergency is defined as dental trauma or injury; significant bleeding in the mouth; swelling of the face; swelling in the neck or mouth; or acute difficulty opening jaw and/or mouth. Dental pain by itself is not considered an oral health emergency.

Term	Definition
Practitioner	Dental Hygienist, Dental Officer, Dental Therapist, Oral Health Therapist, Dental Prosthetist or Specialist Dentist working in public oral health services.
Recall waiting list	The recall waiting list is only for patients waiting for treatment review of a specific clinical need within a defined timeframe where follow up dental care is required.
Recommended Maximum Waiting Time (RMWT)	A waiting period that oral health services must attempt not to exceed prior to an offer of care or an appointment being made. A RMWT is specified for all assessment and treatment waiting lists.
Specialist services	Services provided by a dental practitioner who is registered with the Dental Board of Australia as a specialist in a recognised oral health speciality.
Specialised services	Services provided by an oral health practitioner who has had specialised training or experience.
Treatment waiting list	A list that patients are placed on to wait for an appointment for a comprehensive course of care.
Treatment waiting time	Waiting time between the date the patient is placed on the treatment waiting list and the date a treatment appointment is made.
Triage	A phone or face-to-face interview using standard questions designed to determine a patient's oral health needs.

2 GENERAL DENTAL AND ORAL HEALTH SERVICES

2.1 Contact and Triage

Triage is the systematic prioritisation of patients according to the urgency of their need for care and is used to allocate oral health assessment and treatment priorities. Triage is an integral feature of the NSW Health system and allows limited resources to be allocated on the basis of clinical need and socioeconomic risk-factors. More information regarding triage can be found in the *Triage of Patients in NSW Emergency Departments* policy directive (PD2013_047).

All patients seeking access to public oral health services must be triaged by telephone, in person or by correspondence via a Local Health District or Specialty Health Network oral health contact centre. The patient is triaged and assigned an assessment priority code and then either wait listed or given an appointment, depending on the priority assigned and service capacity. A patient's triage priority is determined by a number of criteria including clinical condition, acuteness of any symptoms, and socioeconomic factors. The triage process utilises a standardised questionnaire, resulting in a triage code. The triage code will be assigned according to the patient's highest priority condition.

In addition to the telephone triage, patient referrals can be received from medical and allied health practitioners and through Local Health District/Specialty Health Network-specific strategies for priority populations (e.g. Early Childhood Oral Health, Out of Home Care).

2.1.1 Re-Triage Of Patients with Deteriorating Conditions

It is recognised that a patient may need to be re-triaged if their condition changes, deteriorates or additional relevant information is received. The purpose of re-triage is to acknowledge any change in clinical condition of the patient and reassign a new triage category if appropriate. Patients and/or carers should be informed at the time of triage what to do if their condition changes or they become concerned while waiting for care.

2.1.2 Telephone Advice

Oral health contact centre staff cannot provide clinical advice to the public. If the caller is requesting oral health clinical information, a senior dental practitioner may be asked to speak with the caller if available.

If the Triage Officer identifies that a caller requires general medical advice they should direct the caller to phone their General Practitioner or call the National Triage Telephone Advice Line (*Healthdirect Australia*) on 1800 022 222.

If the Triage Officer identifies that the call may be a medical emergency, they should direct the caller to hang up and phone 000 for assistance.

If the Triage Officer identifies that a caller is ringing about a mental health problem, they should direct the caller to phone the NSW Mental Health Line on 1800 011 511.

2.1.3 Rationale For Recommended Maximum Waiting Times

The *Priority Oral Health Program and Waiting List Management* policy directive has been developed to promote clinically appropriate, consistent and equitable management of oral health patients and waiting lists in NSW public oral health services and has been approved by the State Oral Health Executive Committee (SOHE).

Categorisation of both children and adult oral health patients by clinical priority is required to ensure they receive care in a timely and clinically appropriate manner. The priority codes and associated criteria are detailed in sections 2.1.4 Adult Triage Codes and 2.1.5 Child Triage Codes of this document.

The recommended maximum wait times used throughout this document are considered clinically appropriate in consideration of the likelihood of the patient's condition to:

- Deteriorate quickly to the point that it may become an emergency, or
- Impact on other medical conditions, or
- Impact the patient's general health and well-being

If a patient has a condition that has the potential to deteriorate quickly or become an emergency, they will be prioritised for care over a patient whose condition has less potential to become an emergency.

2.1.4 Adult Triage Codes

Priority	Adult Triage Criteria	Recommended Maximum Waiting Time
1*	• Patients with dental trauma or injury • Patients with symptoms of suspected dental origin that may include: o Swelling of the face or neck o Swelling in the mouth o Significant bleeding from the mouth o Difficulty opening jaw and/or swallowing ** Priority 1 patients should be given the earliest possible appointment and concurrently advised to attend an emergency department if they experience an acute deterioration prior to their appointment, or to seek medical attention if otherwise concerned.*	**24 hours**
2	Patients referred from a specialist medical practitioner requiring specific life-saving medical care (e.g. radiotherapy, chemotherapy, organ transplant, heart surgery or urgent assessment for specialist service)	**3 days**
3a**	• Patients with pain of suspected dental origin causing disturbed sleep • Patients who have had an ulcer for 3 weeks or more ***Priority 3a patients should be given an appointment, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.*	**1 week**
3b^	• Patients with pain of suspected dental origin during waking hours *^Priority 3b patients should be given an appointment or waitlisted, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.*	**1 month**
3c	• Patients who have a denture request involving missing upper front teeth that is required because: o There is no existing denture, **OR** o The existing denture causes pain, **OR** o The existing denture falls out while talking • Patients who are pregnant	**3 months**

4. DENTAL CARE **4.71**

Priority	Adult Triage Criteria	Recommended Maximum Waiting Time

4	For adult patients who meet one or more of the criteria below:
	• Has a serious medical condition **AND**:
	  o Takes medication regularly for this medical condition, **OR**
	  o Sees a doctor regularly for this medical condition, **OR**
	  o Has been hospitalised in the last 12 months for this medical condition
	• Has a physical or intellectual disability
	• Uses a wheelchair or is unable to leave home
	• Patient has the following living conditions:
	  o Homeless
	  o Boarding house/refuge/rehabilitation facility
	  o Institution/group home
	  o Care facility (hospice/aged care facility)
	• Arrived as a refugee within the last 12 months
	• Identifies as an Aboriginal and/or Torres Strait Islander
	• Referred from a medical practitioner
	• Referred from an Aged Care Assessment Team (ACAT)
	• Meets the criteria for a LHD-specific referral pathway
		6 months

5	For adult patients requesting a check-up with one of the following concerns: • Extractions • Needs fillings or complains of a broken filling • Broken or chipped tooth • Bleeding or sore gums • Loose teeth • Other denture requests including broken plate or clasp • Ulcers for less than three weeks^^ • Crown and bridge • Scale and clean • Clicking/grating in jaw joint • Halitosis (bad breath) ^^*these patients will be given an appointment or placed on a waitlist and at the same time advised to see their medical practitioner for symptomatic management and to assess for medical causes of mouth ulceration.*	**12 months**
6	For patients who request a check-up without any of the above concerns.	**24 months**

2.1.5 Child Triage Codes

Priority	Child Triage Criteria	Recommended Maximum Waiting Time
1*	• Dental trauma or injury • Symptoms of suspected dental origin that may include: o Swelling of the face or neck o Swelling in the mouth o Difficulty opening jaw and/or swallowing o Significant bleeding from the mouth o Fever and/or refusing food and fluids ** Priority 1 patients should be given the earliest possible appointment and concurrently advised to attend an emergency department if they experience an acute deterioration prior to their appointment, or to seek medical attention if otherwise concerned.*	**24 hours**
2	Referral from a specialist medical practitioner for patients who require specific life-saving medical care (e.g. radiotherapy, chemotherapy, organ transplant, heart surgery or urgent assessment for specialist service)	**3 days**
3a**	• Symptoms of suspected dental origin that may include: o Swelling in the mouth o Pain in the mouth causing disturbed sleep o Ulcers in the mouth ***Priority 3a patients should be given an appointment, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.*	**1 week**
3b^	• Pain in the mouth during waking hours *^Priority 3b patients should be given an appointment or waitlisted, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.*	**1 month**

4. DENTAL CARE 4.73

Priority	Child Triage Criteria	Recommended Maximum Waiting Time
3c	• Children 0-5 years of age • Referral from the Department of Family and Community Services (FACS) or Agency providing services to children under temporary care (includes Out Of Home Care). • Symptoms of suspected dental origin that may include: o Decayed tooth (may need filling or extraction) o Minor bleeding or sore gums o Over-retained primary tooth o Severe crowding affecting speech/eating o Broken or chipped tooth o Broken or chipped filling	**3 months**
4	For child patients who meet one or more of the criteria below: • Has a serious medical condition **AND**: o Takes medication regularly for this medical condition, OR o Sees a doctor regularly for this medical condition, OR o Has been hospitalised in the last 12 months for this medical condition. • Has a physical or intellectual disability. • Uses a wheelchair or is unable to leave home. • Patient reports one of the following living conditions: o Homeless or Out of Home Care o Refuge/rehabilitation facility o Institution/group home • Arrived as a refugee within the last 12 months. • Identifies as an Aboriginal and/or Torres Strait Islander. • Meets the criteria for a LHD-specific referral pathway.	**6 months**
5	• For patients requesting a check-up with one of the following concerns: o Loose teeth o Crowded teeth o Halitosis (bad breath) o Scale and clean • Child has a referral letter from: o Aboriginal Health Services (e.g. LHD AHW) o Aboriginal Community Controlled Health Services o Child and Family Health Nurse o Medical Practitioner o Practice Nurse o Private Dentist o Public Health Service (e.g. Allied Health, Maternity, Public Hospital)	**12 months**
6	For patients who request a check-up without any of the above concerns.	**24 months**

2.2 Clinical Assessment

A clinical assessment is performed by a dental practitioner to confirm the clinical care priority of the patient. When the clinical care requirements of the patient are confirmed by the practitioner, one of the following courses of actions can occur:

a) An episodic course of care is provided, then the course of care is closed.

b) An episodic course of care is provided, then the course of care is closed and the patient is placed on a waiting list for other treatment needs.

c) The patient is placed on a treatment waiting list for their treatment needs.

d) No treatment is required.

2.3 Treatment Pathways

2.3.1 Episodic Care

The scope of episodic care is to provide relief of pain, treatment of infection, or to address dental trauma only.
Episodic care is provided after clinical need has been confirmed at the clinical assessment appointment, either at a public dental clinic or through the Oral Health Fee for Service Scheme (OHFFSS). In some limited circumstances, such as when a dental practitioner is not available to provide a clinical assessment, an OHFFSS voucher may be issued. More information about the OHFFSS can be found in NSW Health Policy Directive PD2016_018.

2.3.2 Comprehensive Care

The scope of comprehensive care is to address all treatment needs of the patient, as appropriate.

All adults should be offered a course of comprehensive care after coming off a treatment waiting list. Where possible, children should receive a full comprehensive course of care after being appointed from triage. LHD/SN’s must use the definitions of the codes and clinical criteria outlined in the tables below.

2.3.3 Adult General Dental Treatment Waiting List Codes

Priority Code	Clinical Categorisation	Criteria	Recommended Maximum Waiting Time
A	Confirmed Medical Priority	The patient has been referred from a medical practitioner who has requested a dental examination preceding treatment for a medical condition. The condition should be of equal significance to: • Head and neck cancer • Other cancers that require radiotherapy, chemotherapy or significant immunosuppression • Transplant surgery • Cardiac surgery • Intravenous antiresorptive therapy	**2 weeks**
B	Pregnancy	The patient presents with poor oral health during pregnancy.	**3 months**
C	Chronic Disease/ Medically Compromised*	• At risk of developing endocarditis • At risk of developing medication-related osteonecrosis of the jaw • Has a significant psychiatric illness (e.g. requiring recent hospitalisation) • Dementia • Degenerative diseases • Has coagulopathy • Is living with HIV • Patient has poorly controlled diabetes • Patient has Special Needs • Significant Salivary hypofunction • Organ transplants / immunosuppressed **Other conditions of equal clinical significance may be considered in consultation with a Clinical Director.*	**6 months**

Priority Code	Clinical Categorisation	Criteria	Recommended Maximum Waiting Time
D	Urgent Denture Needs	The patient is confirmed to have urgent denture needs due to: • No existing denture and missing maxillary anterior teeth • Existing maxillary denture that is displaced whilst speaking • No existing maxillary denture with social impairment, or where lack of denture will result in damage to supporting structures	**9 months**
E	High Treatment Needs	• Three or more teeth present with carious lesions • Periodontal Screening & Recording Code 3 or greater • All other denture needs not included in Code D	**12 months**
F	Low Treatment Needs	• All other assessed treatment needs	**24 months**

2.3.4 Child General Dental Treatment Waiting List Codes

Priority Code	Clinical Categorisation	Criteria	Recommended Maximum Waiting Time
A	Confirmed Medical Priority	Situations where failure to provide dental treatment would delay the commencement or progress of urgent medical treatment.	**2 weeks**
B	Urgent Treatment Needs	• Special need patients who have extensive treatment needs • Dental anomalies are present that require management • Dental anomalies are present in the permanent dentition	**3 months**
C	High Treatment Needs	• Carious lesions and/or periodontal disease are present	**6 months**
D	Low Treatment Needs	• All other assessed treatment needs	**12 months**

3 SPECIALIST / SPECIALISED ORAL HEALTH SERVICES

LHD/SN's may operate specialist and/or specialised child and adult services that are prioritised according to the tables below. Specialist and specialised services are those identified in the *Oral Health Specialist Referral Protocols* Policy Directive (PD2011_071). The clinical priority categories in the tables below align with the Australian National definitions for elective surgery urgency categories.

It is recognised that there may be slight variation in the waiting times for different specialties based on clinical staging.

3.1 Specialist/Specialised Dental Referral Waiting List Codes

Priority	Definition	Recommended Maximum Waiting Time
1	Assessment clinically indicated within 7 days	**7 days**
2	Assessment clinically indicated within 30 days	**30 days**
3	Assessment clinically indicated within 90 days	**90 days**
4	Assessment clinically indicated within 365 days	**365 days**

3.2 Specialist/Specialised Dental Treatment Waiting List Codes

Priority	Definition	Recommended Maximum Waiting Time
X	Procedures clinically indicated within 30 days	**30 days**
Y	Procedures clinically indicated within 90 days	**90 days**
Z	Procedures clinically indicated within 365 days	**365 days**

4 MANAGED CARE PROGRAMS

Managed care programs seek to improve health outcomes for particular patient groups. Adults and children who receive care under managed care programs may be placed on a recall list. Recall lists are only for patients that need review of a specific clinical need within a defined timeframe.

It is recommended that patients who require recall are allocated only by dental practitioners following a course of care, consultation or referral/review.

Local guidelines should be established to ensure a structured approach to managed care.

5 ADMINISTRATIVE PROCESSES

5.1 Movement of Patients between Local Health Districts

When a patient moves to a locality serviced by another LHD/SN:

- The previous LHD/SN oral health service must advise the receiving service of the patient's current waiting list status, if requested; and
- The transferred waiting list status must include the original listing date to avoid disadvantaging the patient.

Due to funding and reporting arrangements, oral health care will normally be provided by the LHD/SN in which a patient lives. However, LHD/SN's may have inter-district arrangements that allow for patients to receive care in a bordering district to facilitate accessibility to an appropriate service.

5.2 Management and Auditing Of Waiting Lists

Managing waiting lists is a key priority for the Government and NSW Health. LHD/SN's should have appropriate staff training programs, protocols and processes in place to ensure a high standard of data quality is maintained within oral health information systems.

Waiting list monitoring should be undertaken on a regular basis (at least monthly).

Measures should be put in place to ensure that documentation provides a clear audit trail that can identify:

- Any changes made to a patient's wait list status and type
- Patients who have completed their treatment and should be removed from the waiting list
- Duplicate list entries
- Whether waiting times are within timeframe

Any one patient should only be waiting on one type of treatment waiting list (the highest priority that they meet the clinical criteria for) at any point in time.

5.3 Missed or Cancelled Appointments.

1.	Type of Non-Attendance	2.	Definition
3. 4.	**Failure to Attend (FTA)**	5. a) b)	A patient has failed to attend a scheduled appointment when they: do not arrive prior to the appointment time; or do not ring to cancel the appointment (Refer to UTA)
6. 7.	**Unable to Attend (UTA)**	8.	A patient or carer has notified the service prior to the appointment time that the patient will not be able to attend for the appointment. The patient's reason for nonattendance should be documented.
9. 10.	**Dental Organisation Cancelled Appointment (DOC)**	11.	The oral health service cancels or reschedules an appointment. An apology and explanation should be given to the patient in these circumstances.

- Local processes should be implemented to minimise/manage non-attendance.
- Patients must be fully informed that a requirement for ongoing care is to inform the oral health service if they are unable to attend their scheduled appointment.
- A patient who has two (2) FTA appointments during a course of care may have their course of care discontinued. The LHD/SN should exercise discretion on a case by case basis to avoid disadvantaging patients in cases of a genuine hardship, misunderstanding and other unavoidable circumstances.
- LHD/SN's should have an active strategy to identify and assist vulnerable persons who regularly fail to attend (FTA) appointments without adequate prior notification, for example people with a mental illness, the frail and aged, and people experiencing homelessness.
- When the patient contacts the oral health contact centre after an FTA they may be required to re-register their oral health needs via a POHP triage. Local LHD/SN policies regarding patients who FTA their appointments should be complied with.

SMOKING CESSATION BRIEF INTERVENTION IN ORAL HEALTH SETTINGS (PD2021_016)

PD2021_016 rescinds PD2021_014 and PD2015_030

POLICY STATEMENT

Tobacco smoking is a leading cause of preventable chronic disease, including periodontitis and oral pharyngeal cancer, and premature death in Australia. Tobacco use is more prevalent in disadvantaged groups who are served in public oral health settings. Dental practitioners and dental assistants in NSW public oral health settings can play a pivotal role in engaging with patients and supporting them to modify their risk practices. Dental practitioners must consider providing brief advice and support to patients, through smoking cessation brief interventions as appropriate to the clinical situation.

SUMMARY OF POLICY REQUIREMENTS

Dental practitioners and dental assistants are expected to be appropriately trained in delivering smoking cessation brief interventions. Mandatory training is available via *My Health Learning*.

All patients aged 14 years and over are to have their use of tobacco or other similar substances assessed and recorded in the oral health record, unless doing so would be clinically inappropriate.

Where the setting is appropriate, all patients who smoke are to be approached in a nonjudgmental way about their smoking and be provided advice to quit. Dental practitioners must record the smoking cessation advice offered in the patient's oral health record.

Consenting patients are to be offered a referral to a smoking cessation support service. Oral health executives must ensure that supporting resources are available. Local health districts and the Ministry of Health are to monitor local smoking cessation brief intervention activities.

Go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2021_016 to view the Smoking Cessation Brief Intervention in Oral Health Settings Policy and Procedures.

ORAL HEALTH: CLEANING, DISINFECTING AND STERILISING (PD2013_024)

PD2013_024 rescinds GL2005_037.

The purpose of this policy directive is to provide minimum standards for cleaning, disinfecting and sterilizing in oral health care settings for the maintenance of a safe and healthy environment for patients, visitors and staff. This policy must be read in conjunction with NSW Health Infection Control Policy PD2007_036 and Hand Hygiene Policy PD2010_058.

MANDATORY REQUIREMENTS

NSW Health is committed to ensuring health and safety for patients in the oral health care setting and providing a healthy working environment for all oral health employees. This includes adopting and maintaining infection prevention processes that minimise the risk of oral health patients and oral health providers acquiring a health-care associated or occupational infection. For this to be achieved NSW Local Health Districts must implement the 'Oral Health: cleaning, disinfecting and sterilizing standard operating procedures', and:

- successfully promote and implement the Oral Health cleaning, disinfecting and sterilizing procedures through annual auditing processes;
- implement facility wide auditing of oral health practices, which is reported to the Local Health District Chief Executives; and
- set the example: Chief Executives, Health Service Executives, Directors of Clinical Governance, Oral Health Managers and Oral Health Clinical Directors implement and sustain infection prevention practices in all patient care activities.

All health care services and health care workers have a common law duty of care to take all reasonable steps to safeguard patients, staff and the general public from infection. The *Work Health and Safety Act 2011*[17] (WH&S) prescribe the employer's duty of care to provide a safe and healthy working environment for all employees and other persons on their premises.

The *WH&S Act* also prescribes responsibilities for managers (who manage WH&S within the areas they are responsible for) and employees (who must cooperate with the employer and not put anyone at risk by their acts or omissions). There is also a requirement for employers to provide the information, instruction, training and supervision necessary to ensure the health and safety of employees at work.

IMPLEMENTATION

The policy directive and standard operating procedures are to be used in the public dental services, as well as providing guidance to private oral health facilities, such as universities, TAFE and private practices. To implement the policy effectively the following roles and responsibilities are required.

Roles and Responsibilities

NSW Ministry of Health

- Ensure the mandatory requirements and standards of this policy are monitored and acted on accordingly.

Chief Executives of Local Health District

- Assign responsibility and personnel to implement the cleaning, disinfecting and sterilization processes identified in Oral Health: cleaning, disinfecting and sterilizing standard operating procedures.

[17] http://www.comcare.gov.au/laws__and__regulations/ohs_act,_regulations__and__code

Oral Health Clinical Directors and Oral Health Managers

- Provide oral health clinicians, patients and visitors with the means to perform infection control processes;
- Provide support to oral health line managers to implement and sustain infection control processes in oral health settings; and
- Manage oral health staff/s who doesn't comply with the policy, in accordance with NSW Health policy directives for staff performance management.

1. BACKGROUND

The Oral Health: cleaning, disinfection and sterilizing standard operating procedures' document has been developed in accordance with the NSW Health Infection Control Policy[18]; Acts and Regulations that define the registration requirements for Dentists, Dental Therapists, Dental Hygienists, Oral Health Therapists, Dental Prosthetists and Dental Technicians[19][20]; available scientific evidence; and consultations with key stakeholders.

The standard operating procedures (SOP) was developed by the Centre for Oral Health Strategy NSW and State Oral Health Executive through a working group consisting of representatives from Department of Health, Local Health Districts and Infection Control Experts. The SOP was reviewed by the NSW Health Healthcare Associated Infections (HAI) Expert Advisory Group and the Clinical Excellence Commission for accuracy.

In this standard the term:
Must – indicates a mandatory action required that must be complied with.
Should – indicates a recommendation action that should be followed unless there are sound reasons for taking a different course of action.

The SOP is to be read in conjunction with the following NSW Health policies and programs:

- Environmental Cleaning[21]
- Hand Hygiene[22]
- Hand Hygiene In Out Patient Care[23]
- HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed[24]
- HIV, Hepatitis B or Hepatitis C – Health Care Workers Infected[25]
- Incident Management[26]
- Infection Control Management of Reportable Incidents[27]
- Infection Control Policy[28]
- Infection Control Policy: Animals as Patients in Health Organisations[29]
- Infection Control Policy: Prevention & Management of Multi-Resistant Organisms (MRO)[30]
- Infection Control Program Quality Monitoring[31]

[18] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html
[19] http://www.legislation.nsw.gov.au/maintop/view/inforce/subordleg+333+2010+cd+0+N
[20] http://www.legislation.nsw.gov.au/sessionalview/sessional/sr/2008-190.pdf
[21] http://www.health.nsw.gov.au/policies/pd/2012/PD2012_061.html
[22] http://www.health.nsw.gov.au/policies/pd/2010/PD2010_058.html
[23] http://www.hha.org.au/home.aspx
[24] http://www.health.nsw.gov.au/policies/pd/2005/PD2005_311.html
[25] http://www.health.nsw.gov.au/policies/PD/2005/PD2005_162.html
[26] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_061.html
[27] http://www.health.nsw.gov.au/policies/PD/2005/PD2005_203.html
[28] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html
[29] http://www.health.nsw.gov.au/policies/pd/2009/PD2009_030.html
[30] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_084.html
[31] http://www.health.nsw.gov.au/policies/PD/2005/PD2005_414.html

- Lookback Policy[32]
- Occupational Assessment, Screening & Vaccination Against Specified Infection Diseases[33]
- Sharps Injuries – Prevention in the NSW Public Health System[34]
- Waste Management Guidelines for Health Care Facilities[35]
- Work Health and Safety: Better Practice Procedures[36]

2. GOAL

The goal of this standard operating procedure document is to identify processes that aim to provide a safe clinical environment that protects the health and wellbeing of all patients who access public dental services and all dental staff.

3. KEY DEFINITIONS

Anti-reflux valve	is a valve that only allows liquid to flow one direction. Previously known as Anti-retraction value.
Cleaning	is the physical removal of soil and organic matter from surfaces and other objects using a detergent and water. Cleaning reduces the numbers of microbes on surfaces and prevents multiplication with the production of many organisms by removing organic matter. A clean dry surface is generally hostile to the reproduction of microorganisms.[37]
Clinical Area	is an area that is made of one or more collocated dental surgeries.
Clinical Waste	is waste which has the potential to cause sharps injury, infection or offence. When packaged and disposed of appropriately there is virtually no public health significance. Clinical waste contains the following types of waste: • sharps; • human tissue (excluding hair, teeth and nails); • bulk body fluids and blood; • visibly blood stained body fluids and visibly blood stained disposable material • and equipment; • laboratory specimens and cultures; • animal tissues, carcasses or other waste arising from laboratory investigation or for medical or veterinary research[38].
Decontamination	is a process that renders equipment, or environmental surfaces safe to handle by cleaning and disinfection or sterilization (PD2007_036).
Disinfection	means the destruction of pathogenic and other kinds of micro-organisms by thermal or chemical means. Disinfection is less lethal than sterilization, because it destroys the majority of recognised pathogenic micro-organisms, but not necessarily all microbial forms (eg bacterial spores). Disinfection does not ensure the degree of safety associated with sterilization processes. (PD2007_036 page iv).

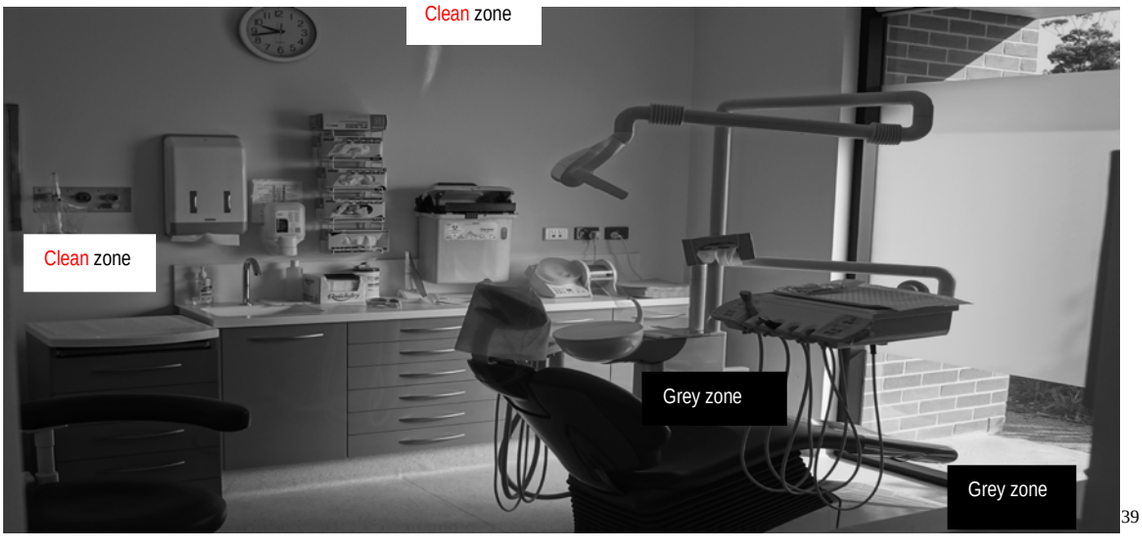
[32] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_075.html
[33] http://www.health.nsw.gov.au/policies/pd/2011/PD2011_005.html
[34] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_052.html
[35] http://www.health.nsw.gov.au/policies/pd/2005/PD2005_132.html
[36] http://www.health.nsw.gov.au/policies/pd/2013/PD2013_005.html
[37] http://www.health.nsw.gov.au/policies/pd/2012/PD2012_061.html
[38] http://www.health.nsw.gov.au/policies/PD/2005/PD2005_132.html

Four-handed dentistry	is the cooperative action of the treating clinician and assistant to significantly enhance overall productivity, efficiency and effectiveness.
NSW Health Services	consists of staff employed in all Local Health Districts, all statutory health corporations, the Ambulance Service of NSW, Institute of Medical Education and Training, Health Technology, Health Support and any declared affiliated health organisations.
Operating Area	is the area set aside as the primary working area includes patient's mouth, bracket table and dental assistant's kit.
Patient	includes (but is not limited to) a person who is accessing medical or health services or who is undergoing any medical or health procedure.
Sharp	is any object capable of inflicting a penetrating injury, which may or may not be contaminated with blood and/or body substances. This includes needles and any other sharp objects or instruments designed to perform penetrating procedures (PD2007_036 page v).
Sterile	is free from all living micro-organisms, usually described as a probability (eg the probability of a surviving microorganism being 1 in 1 million) (PD2007_036 page v).
Sterilization	is the destruction of all living organisms, including spores (PD2007_036 page v)
Surgery Zones	are developed to keep the surgery as clean as possible during the course of treating patients. The zones are clean, grey and dirty.
Technical Procedures	are those procedures carried out by dental technicians within the dental laboratory.

4. DENTAL AND CLINICAL PRACTICE

4.1 Surgery Zones

The surgery zones are designated as clean, grey and dirty and are to be identified in the clinical area (refer to picture below). Clean zones are where no contaminated items enter. The grey zone is centred on the patient's mouth and includes the clinician and assistant work surfaces. Dirty zones are where contaminated instruments are placed to start the cleaning and/or disinfection and/or sterilizing process. Dirty zones are not in the surgery.



[39]

[39] Nepean Blue Mountains dental clinic Penrith taken by J Conquest

4.2 Placement of equipment

Equipment should be positioned as follows:

- primary work surface (grey zone), usually on top of the assistant's cart and on the bracket table, where instruments and equipment of direct relevance to the appointment should be placed;
- when using equipment that cannot be sterilized such as amalgamators and curing lights, barrier film/s and/or disinfection must be carried out as per manufacturer's instructions after each patient;
- all other items that are not involved in the procedure such as the clinical record, patient notes, radiographs, computer key board and mouse must remain in the clean zone. To access these items in the clean zone gloves must be removed and hand hygiene performed;
- if other items, equipment or consumables are required during the procedure they should be retrieved by the assistant by:
  - using transfer forceps that are cleaned and disinfected between patients, or single use only, and stored in the clean zone; or
  - removing gloves and performing hand hygiene before and after retrieving equipment.

Exemptions may occur depending on the design of the dental unit as some equipment may be attached to the unit, such as the curing light and would therefore remain in the grey zone. This equipment must be covered with a barrier film to minimize bacterial/microbial load. Decontamination of this equipment must be carried out as per the manufacturer's instructions.

4.3 Dental practice processes

Clinicians and assistants should be trained in four handed dentistry techniques to improve safety and performance as it is considered to be the ideal way to deliver of care[40] [41].

4.3.1 Pre-plan, pre-set, pre-dispense, reprocessing, dispense

All instruments should be set up and materials dispensed prior to treatment commencing and remain in their sterile pack until the patient is seated in the dental chair. This reduces the need to enter drawers or cupboards during an appointment.

Adherence to the following guidelines is recommended:

- all materials should be pre-dispensed, where appropriate. (Some volatile materials deteriorate quickly in air, so should be prepared for dispensing, but not dispensed.);
- hand hygiene must be performed immediately prior to the procedure commencing and after finishing (refer to 5 moments for hand hygiene[42]), and appropriate personal protective equipment shall be used. Please refer to NSW Health Hand Hygiene[43] and Infection Control Policy – Standard & Additional Precautions for personal protective equipment (PPE) requirements;
- materials that require hand mixing should be mixed on a single sheet of non-porous clean paper; and
- a bib, tray or paper towel should be used to define the work surface. Pre-set/pre-dispensed items should be placed on the primary work surface.

[40] Paul (1980) 'A Manual of Four Handed Dentistry'
[41] Robinson and McLaughin (1996) 'Annals Royal Australasian College of Dental Surgeons'
[42] http://www.hha.org.au/home.aspx
[43] http://www.health.nsw.gov.au/policies/pd/2010/PD2010_058.html

4.4 Methods of Limiting Contamination

4.4.1 Dental dam

The use of dental dam is an effective measure in confining and limiting contamination.

Silicone dams must be used for patients who have a known sensitivity or allergy to latex.

4.4.2 Suctioning

Effective suctioning at the tooth site will markedly reduce contamination from aerosol. This is achieved by:

- using a four-handed technique with a trained dental assistant;
- utilising high speed evacuation suction tips that have a posterior and anterior end. Suction tips must not be reversed during a procedure. If the other end of the tip is required, a new tip must be used; and
- disposable single use low speed suction tips may be pre-bent to increase effectiveness.

Cleaning of suction is guided by the manufacturer's 'Instructions for Use'. Detergents and disinfectants must be registered with the Therapeutic Goods Administration (TGA) and listed on NSW State Contract.

5. DENTAL CLINIC EQUIPMENT

5.1 Chair controls

The chair should be pre-set at the commencement of treatment. Where possible the chair should be foot controlled allowing adjustment at any time, however if the chair is hand controlled then barrier film must be used.

The entire chair including the controls located on the back of the head rest or the side of the chair must be wiped clean with neutral detergent and water and/or detergent wipes at the conclusion of the appointment. Single use barrier film may be used in addition to this procedure, but must not be used instead of this procedure.

5.2 Lights

The patient light should be pre-set at the commencement of treatment. Only the handles of the overhead light should be touched, and these must be covered with barrier film where light sensor controls are not in place. The barrier film must be changed between patients. The light and handles must then be wiped clean with neutral detergent and water at the conclusion of the appointment and between patients (NSW Health Infection Control Policy).

5.3 Mouth rinsing

Spittoons must not be used. If mouth rinsing is required the mouth can be rinsed with a triplex and high-speed suction or a funnel connected to the high speed suction. Funnel attachments must be sterilized between patients or single use only. Following impressions, a two-cup technique may be used by patients to rinse their mouth. The used cups are to be disposed of into general waste whilst their contents can be discarded into a designated dirty sink in a utility/disposal room or by suction.

5.4 Hand Hygiene - Clinical Sinks[44]

'Hand washing should be undertaken in dedicated (clean) sinks preferably fitted with non-touch taps (or done with a non-touch technique) and not in the (contaminated) sinks used for instrument cleaning. If touch taps are used the taps may be turned on and off with a paper towel' (ADA 2008a).

Hands must not be washed in a sink which is used for processes such as:

- instrument cleaning
- disposal of blood, body substances or chemicals
- cleaning of impressions and impression bowls
- flushing of lines
- where bleach or other antiseptic solutions are disposed

5.5 Air, water and suction lines

Air, water and suction lines[45],[46] must be flushed for a minimum of **2 minutes** at the start of the day and for **30 seconds** after each patient.[47]

5.5.1 Air

Triplex heads must be wiped clean with neutral detergent and water and covered with a barrier film after each use.

Triplex tips must be changed after each patient use and sterilized or if disposable these need to be discarded after each use.

5.5.2 Suction

Suction lines should be non-convoluted with a flat bore and not covered with woven fabric. Suction lines should be flushed thoroughly with water after each patient and at the end of the day using neutral detergent or following manufacture's 'Instructions for Use'.

5.5.3 Water

All dental equipment which supplies water to the oral cavity is to be fitted with anti-reflux valves. Routine maintenance of anti-reflux valves is necessary to ensure their effectiveness. Manufacturer's 'Instructions for Use' must be considered to establish an appropriate maintenance routine.

Australian Dental Association Inc. state that 'sterile irrigants such as sterile water or sterile saline as a coolant are required for surgical procedures such as dentoalveolar dental implant placement'.

Water for tooth irrigation during cavity preparation and for ultrasonic scaling should be of no less than potable standards as identified in the Australian Drinking Water Guidelines 2011.[48] When treating immunocompromised patients, it is recommended that water from dental unit waterlines contain less than 200 colony forming units per mL. Bacterial levels can be tested using commercially available test strips or through commercial microbiology laboratories.[49]

[44] http://www.nhmrc.gov.au/node/30290
[45] http://shop.standards.co.nz/scope/ASNZS4187-2003.scope.scope.pdf
[46] http://www.saiglobal.com/PDFTemp/Previews/OSH/AS/AS4000/4800/4815-2006.pdf
[47] http://www.nhmrc.gov.au/node/30290
[48] National Health and Medical Research Council (2011) National Water Quality Management Strategy : Australian Drinking Water Guidelines 6 http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/eh52_aust_drinking_water_guidelines_120323_0.pdf
[49] Wirthlin, M.R., Marshall, G.W., Rowland, R.W. (2003) Formation and decontamination of biofilms in dental unti waterlines, J Periodontal 2003 Nov; 74 (11): 1595-609

5.6 Transportation of Instruments

Where dental care is provided in a location separate to the sterilization, all sterilized instruments and equipment must be transported in metal or rigid plastic (puncture proof) containers with secure lids to prevent damage and/or spillage. There are to be separate dedicated containers for sterile and contaminated instruments/equipment that are clearly labelled and in a different colour to identify its contents.

The labels must be worded 'clean' or 'dirty'. These containers should be cleaned with neutral detergent and water and are to be dedicated for this purpose only. All transport equipment shall be maintained in a clean, dry state, and in good working condition.

Public Dental Services must provide all staff with personal protective equipment to undertake this task.

The motor vehicles used to transport equipment should have adequate means of segregation between 'clean' and 'dirty' instruments.

6. DENTAL PROSTHETICS/LABORATORY

6.1 Clinical Area[50]

6.1.1 Mixing of impressions

For mixing of impressions, a flexible bowl and spatula are used. The flexible bowl and spatula must be cleaned with neutral detergent and water and dried after use.

6.1.2 Cleaning of Impressions/Prosthesis[51]

When taking an impression either single use trays or sterilized metal trays must be used. All impressions must be rinsed clean with neutral detergent and running water to remove all debris. A neutral detergent must be used according to the manufacturer's instructions for the cleaning of impressions and dental prostheses. This process must occur prior to transportation from the clinical area. If a designated sink is not available in the clinical area an alternative location must be provided.

Public Dental Services must consider the DOHA guideline statement; *'Although the efficacy of disinfection of dental materials is still undetermined, standard precautions must be applied whenever people handle dental material. The most important step is the thorough cleaning of material that has contacted oral tissue (e.g. impressions). Thorough rinsing with tepid running water, followed by the application of a neutral detergent and further rinsing, should continue until all visible contamination is removed'*[52].

6.1.3 Transportation of Dental Prosthesis Impressions

Transportation to the laboratory of any items is to be placed in a designated container with a lid or single use sealable plastic bag. Such containers and lids or bags must be single use or cleaned and decontaminated before and after use. The container/s or bag/s must be marked identifying the disinfecting procedure for the impression or dental prostheses that has been undertaken.

[50] http://www.nhmrc.gov.au/node/30290
[51] http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm
[52] http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm

6.1.4 Polishing

For all items and appliances it is recommended that:

- fresh pumice must be used to polish each patient's dental prostheses and must be discarded after use;
- the pumice tray must be cleaned after each use;[53]
- denture polishing brushes and denture mops should be cleaned as per the manufacturer's 'Instructions for Use', and
- detergents and disinfectants must be registered with the Therapeutic Goods Administration (TGA) and listed on NSW State Contract.

6.1.5 Minor Adjustments

Where possible, denture adjustments are to be done in the laboratory. Dentures and dental prostheses are to be cleaned with a neutral detergent and water before extra oral adjustments.[54] Minor adjustments may be performed at the chair side in the surgery over a bin. Reusable burs used for adjustments must be cleaned and sterilised after use in accordance with manufacture's 'Instructions for Use'. Single use burs must be discarded at the chair-side in the sharps container.

6.1.6 Return to the Clinic[55]

Dental prostheses and appliances must be cleaned with neutral detergent and water before leaving the laboratory for patient areas.

Items must be transferred in sealed containers or in single use sealable plastic bags with appropriate identification. If disposable containers are not used and reusable containers are used, they must be cleaned between uses.

6.2 Radiographs

Between patients the head of the x-ray tube must be wiped down with neutral detergent and water after each use. Single use barriers must be used on parts that come into contact with non-intact skin or mucous membrane. All parts including lead aprons must be thoroughly cleaned with neutral detergent and water after each use and stored dry.[56]

Radiographic films should be covered by single use barrier envelopes or be single use films, which are wiped over with neutral detergent prior to processing.[57]

6.3 Extra-Oral Radiological Equipment

Single use barrier film must be used for extra-oral radiological equipment,[58] such as bite piece for OPG, chin rests, head frames, cephalostat earpieces and extra-oral cassettes and are to be thoroughly cleaned with neutral detergent and water after each use.

6.4 Use of Covers or Sheaths on Radiological Equipment

Single use barrier film designed to protect the equipment must be disposed of between patients. Barrier film use does not negate the need to clean the equipment after each patient.[59] Manufacture's 'Instructions for Use' must be followed.

[53] http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm
[54] http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm
[55] http://www.nhmrc.gov.au/node/30290
[56] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html
[57] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html
[58] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html
[59] http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

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GROWTH ASSESSMENT AND DIETARY ADVICE IN PUBLIC ORAL HEALTH SERVICES (GL2019_001)

PURPOSE

This document introduces routine measurement of height and weight of patients in public oral health services, as part of addressing the NSW Premier's priority on Tackling Childhood Obesity to reduce childhood overweight and obesity by 5% by 2025.

This document complements the NSW Health Guideline *Growth Assessment in Children and Weight Status Assessment in Adults* (GL2017_021). It provides specific directions on the implementation of growth assessment and dietary advice for children in public oral health services.

KEY PRINCIPLES

A strategic direction under the NSW Premier's priority on Tackling Childhood Obesity is the routine collection of height and weight across NSW Health Services. Routine weight status assessment and management by public oral health services, including the provision of brief advice and referral pathways to healthy lifestyle programs, is important for inter-professional collaboration to address the issue of childhood obesity.

This Guideline provides the recommended approach for public oral health services to implement routine growth assessment and advice into clinical care. This includes:

- Professional development for staff (Section 2);
- Processes for growth and dietary assessments (Section 3);
- Provision of brief intervention for children above a healthy weight (Section 4.1);
- Provision of dietary and physical activity advice to address both oral health and obesity risk (Section 4.2), and;
- Referral pathways and processes for children identified as being outside of a healthy weight status (Section 5).

Successful implementation of this Guideline will require oral health service to establish partnerships with other key health services in their Local Health District, such as Health Promotion, to obtain additional support for staff and patients.

USE OF THE GUIDELINE

Public oral health staff should be aware of the recommended professional development (Section 2), and the processes for:

- Measuring and recording height and weight of patients (Section 3);
- Providing an appropriate brief intervention (Section 4); and
- Providing referrals to other health services (Section 5).

Public oral health service managers and clinical directors should support staff in completing recommended professional development, and in the implementation of the measurement of height and weight, brief interventions, and referrals as part of standard clinical practice.

The Growth Assessment and Dietary Advice in Public Oral Health Services guideline can be downloaded from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_001

TELEDENTISTRY (GL2020_019)

GUIDELINE SUMMARY

This Guideline provides a framework for the use of teledentistry-enabled models of care by NSW Health Districts. Specifically, this Guideline is designed to provide information for live patient – provider teledentistry interactions and store-and-forward episodes and to establish standard item codes for teledentistry services.

KEY PRINCIPLES

- Provide a framework for teledentistry utilisation in NSW public dental services for:
  - Live patient and provider teledentistry services
  - Store and forward teledentistry services
- Establish standard item codes for teledentistry services
- Establish a consistent approach to recording and reporting of teledentistry episodes

USE OF THE GUIDELINE

This Guideline is intended for use by NSW Health public dental and medical organisations which provide teledentistry services.

- Support public dental services to use teledentistry to improve access to oral healthcare
- Clinicians should follow these guidelines when providing teledentistry-enabled services
- Standardise the use of item codes for recording teledentistry utilisation
- Dental clinicians should use the described, standard teledentistry item codes when providing treatment
- Teledentistry services should be monitored, evaluated and improved

The Teledentistry guideline can be downloaded from:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_019

No content remains in this chapter

Final amendment 338 – July 2021 removed obsolete content

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

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EMERGENCY DEPARTMENT PATIENTS AWAITING CARE (PD2018_010)

PD2018_010 rescinds PD2010_075.

PURPOSE

The purpose of this Policy is to outline the mandatory requirements and procedures for emergency department (ED) staff for patients, their families and carers immediately following the triage process and while awaiting the commencement of clinical care and medical assessment in the ED.

Although this Policy seeks to provide guidance on the clinical safety and care of patients while they are waiting; of equal importance is the outcome of patient satisfaction related to the waiting environment. Factors identified by patients, families and carers related to poorer waiting experience include lack of communication in general whilst waiting, uncertainty about waiting times and lack of information about the functions of the ED. Communication and early symptom management have been identified as key measures to prevent patients from leaving without being seen following triage1; which is an important monitoring measure of quality in the ED environment. Medical, nursing, clerical, allied health and other ED support staff all have a role in ensuring clear communication for patients and their families.

This Policy does not seek to outline the triage process – please refer to NSW Health policy PD2013_047 Triage of Patients in NSW Emergency Departments for information on triage in NSW.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy and support the mandatory requirements detailed here:

- This Policy applies to all adult and paediatric patients, following triage in the ED waiting for clinical care to commence and/or medical assessment, regardless of their location.
- In addition to the parameters of this Policy; people brought to the ED involuntarily for the purpose of initial health assessment, care and treatment, will be cared for in accordance with the relevant legislative framework for example The Mental Health Act 2007 (NSW) or the Crimes (Administration of Sentences) Act 1999.
- Undifferentiated patients can be at risk of deterioration – for those located in the waiting room, lack of supervision adds to this risk. Ensuring the safety of patients in the waiting room is the responsibility of the senior medical and nursing staff in charge of the shift.
- The ED waiting room should be a pleasant, safe environment where patients, families and carers can be comfortable. When designing or redesigning ED waiting rooms, emphasis should be on ensuring that adequate signage, a culturally appropriate setting and access to toilets and refreshments are accommodated.
- Regular communication with waiting patients is essential, particularly in relation to ED processes and waiting times. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified.
- Patients waiting for clinical care to commence and those accompanying them may become frustrated, particularly in the absence of regular communication. Local practices that focus on taking action to recognise and respond to escalating behaviour are safer, for both patients and staff, than those that rely solely on managing behaviour that has already become aggressive or violent.
- NSW Health has a zero tolerance policy[2] to violence and aggression where, as far as reasonably practicable, action will be taken to prevent and mitigate aggressive behaviour and violence. Appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour, while ensuring clinical services continue to be provided.

[1] Ibanez, G. Guerin L. Simon N. Which improvements could prevent the departure of left-without-being-seen patients? *Emerg Med J 2011, 28: 945-947*

[2] NSW Health Policy 2015 Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach (available at http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2015_001)

- Clinical care of waiting patients may commence according to locally endorsed and statewide clinical pathways whilst the patient is in the waiting room or other area of ED awaiting medical assessment. Regular reassessment of the patient's clinical condition should occur, particularly if the waiting time exceeds the allotted triage category maximum waiting time. Documentation of all assessments and clinical care commenced must be entered into the patient's health care record.
- During triage and any interaction with ED staff, patients and families/carers should be encouraged to speak up if they feel their condition is deteriorating whilst waiting for examination, this is especially true in departments where constant patient observation is not possible in the waiting room. Where a patient's deterioration in condition has been detected by ED staff, established local clinical emergency response system processes should be followed.
- ED clinicians retain responsibility for the overall clinical management of patients transported to ED via Ambulance; this occurs as soon as the patient enters the ED. In recognition of occasions of Transfer of Care delays between Ambulance and ED staff, this Policy outlines a shared care responsibility for the care of patients.
- Local processes should be in place to monitor numbers of patients who 'Did not Wait' for treatment following triage, including rates for Aboriginal and non-Aboriginal patients. Strategies to address issues identified should be implemented and evaluated.

IMPLEMENTATION

Local Health District Chief Executives are responsible for:

i. Assigning responsibility, personnel and resources to implement this policy.
ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for patients awaiting care. This should include nomination of an executive sponsor to support staff responsible for implementation of this policy.
iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management, and clinical staff.

Emergency Department Patients Awaiting Care Procedures

1. BACKGROUND

1.1 About this document

This Procedure document supports and further explains the mandatory requirements of the Emergency Department Patients Awaiting Care policy statement through the following components:

- The waiting room environment; including safety.
- Procedure for managing waiting patients; including communication, assessment and escalation of care.
- Guidance on patients who arrive with other services staff such as NSW Police, NSW Ambulance and custodial officers.
- Patients who decide not to wait for treatment.

This procedure applies to all patients, following triage in the emergency department (ED) awaiting clinical care to commence and/or medical assessment, regardless of their location.

Key definitions

Key Definitions are only included in this section where there may be multiple uses for terminology used and so detailed here to provide clarification on the use in this document.

Absconding Patient	For the purposes of this document, an absconding patient refers to an involuntary patient detained under the Mental Health Act 2007 or the Mental Health Forensic Provisions Act, who leaves an Emergency Department, without permission, or a voluntary patient who leaves an Emergency Department who is considered at risk.
Did Not Wait	Refers to a patient who decides not to wait for clinical care to commence or medical assessment following triage in the emergency department
Medical assessment	For the purposes of this document, medical assessment also indicates assessment by a Nurse Practitioner
Transfer of Care	Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to an emergency department clinician. Transfer of Care is deemed complete when clinical handover has occurred, the patient has been offloaded from the ambulance stretcher and the care of the paramedics is no longer required.

2. THE WAITING ROOM ENVIRONMENT

2.1 Waiting room design

Waiting rooms are areas specifically for patients, families and carers before and after clinical care. Waiting rooms that are not comfortable have been demonstrated to play a key role in patients leaving the ED before treatment[3]. In light of this, specific attention should be given to the design of the waiting room including making modifications and improvements. Waiting areas should not be cluttered with posters and unnecessary signs as this creates confusion for those visiting the ED.

The waiting room should be well lit with access to natural light if possible.

If able to be accommodated; EDs and waiting rooms should be designed with unobstructed views of the entrances and exits. An open plan design allows staff to visually monitor the movements within and outside the waiting room as well as changes in patients' conditions. Similarly waiting room and triage staff should be visible to patients and relatives in the waiting room, which then allows patients to interact with staff when they have concerns and updates. An open visual environment allows staff to quickly assess the waiting area at any given time. Reception and triage areas should have convex mirrors or CCTV in place to ensure reception and triage staff can see all parts of the waiting room.

The use of different coloured seating or different areas of seating as a visual cue indicating where the patient is in the triage process may be used. Chairs should be comfortable, easy to clean and robust. Consideration should be given to multimedia activities that can provide some distraction in the waiting room including the use of televisions and videos. Consideration should also be given to provision of a mobile device charging station.

For further guidance on waiting room design and NSW requirements please see Chapter 15 of Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies. Additionally, information is available in the Australasian Health Facility Guidelines – Emergency Unit document.

[3] Ibanez, G. Guerin L. Simon N. Which improvements could prevent the departure of left-without-being-seen patients? Emerg Med J 2011, 28: 945-947

2.1.1 Wayfinding

Clearly visible wayfinding solutions directing patients, families and carers to the various areas within the ED must be used. Wayfinding plays a major role in the coordination of safety, process and patient flow in the ED[4].

Wayfinding solutions should be in culturally specific languages of the cultural groups that predominately access the hospital's services. It should include the use of universal pictorial symbols and also consider the use of braille symbols.

2.1.2 Access to toilets and refreshments

EDs should make provision for adequate access to toilets and refreshments within or in close proximity to the ED. Facilities for people with a disability, parents with babies and young children should also be factored into the design and location of the toilets and refreshments. Larger EDs should consider access to cafes and vending machines thereby providing 24 hour access to refreshments. Smaller EDs may have access to vending machines or other means of providing refreshments.

The NSW Health Framework 'Healthy food and drink in NSW Health facilities for staff and visitors' provides best practice guidelines to increase the availability of healthy options to make the healthy choice an easy choice for our staff and visitors. It provides guidance on appropriate options in vending machines (e.g. no sugary drinks and including everyday snacks such as dried fruit or lightly salted nuts).

The positioning of both toilets and refreshments is important and the design should not impede the flow and movement within the waiting room.

2.1.3 Considerations for Aboriginal patients

Section 4.1 acknowledges the higher rates of Aboriginal patients who choose not to wait for treatment in ED when compared to non-Aboriginal patients. An important contributor to this issue is Aboriginal patients feeling safe to stay and wait. The use of local Aboriginal art in ED waiting rooms can provide links to culture and community; advice should be sought on appropriate art from the local Aboriginal community. If available in the hospital, relatives may access the designated Aboriginal waiting room for families and carers. If no room exists, a culturally appropriate space within the local hospital should be identified.

Patients identifying[5] as Aboriginal people should be provided with information regarding access to Aboriginal Health Workers that may be available. Access to any of these services may include referral pathways for patients that present out of business hours.

2.1.4 Cultural and age appropriate considerations

EDs should seek to cater for all community specific needs; this will be based on the demographic of the local population and will include information in languages other than English that relate to the local community's needs.

Ideally there should be a dedicated waiting area for children that is easily observable by staff, and where possible with age appropriate play equipment. Where there is not a separate waiting area, there should be processes in place that, where possible, children can be fast tracked out of the waiting room area. Art that specifically caters to the engagement of children should be considered.

[4] NSW Health publication 2008 Practical steps to improving Emergency Department signage (available at http://internal.health.nsw.gov.au/pubs/2008/pdf/ed_signage.pdf)

[5] NSW Health policy PD2012_042 Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_042.pdf)

2.2 Waiting room personal safety

2.2.1 Organisational safety factors

Procedures to identify and manage risks in the clinical environment must be developed and implemented, in consultation with staff and other duty holders. For more information see NSW Health Protecting People and Property - Policy and Standards for Security Risk Management in NSW Health Agencies.

The occurrence of an incident of aggressive behaviour is to be reported and reviewed with the required timeline in accordance with the PD2014_004 Incident Management Policy and local management procedures.

2.2.2 Environmental safety factors

Factors for consideration when assessing potential risks in ED waiting rooms include:

- Areas of first contact should be designed to prevent unauthorised entry and provide security and protection for staff members, patients and visitors while still allowing good communication.
- Main public entry access doors must be able to be secured and fitted with Closed Circuit Television (CCTV) cameras and intercom systems for after-hours access and be able to be secured remotely.
- Procedures and physical design/layout must reflect the specific risks identified for that ED environment, ensuring effective and safe access and egress from the ED.
- Consideration should be given to any objects or furniture that may be used to cause injury. Objects like this should be fixed appropriately e.g. television screens and brochure stands.
- Consideration should be given to the installation of physical barriers to aggression such as security screens for triage and clerical staff and must be appropriate to the environment, i.e. provide protection for staff but not reduce the ability for patients or their carers to clearly communicate with staff.
- Triage, reception, and interview rooms must include duress alarms, fixed and/or mobile alarms as appropriate. All staff working in EDs must have and wear a mobile duress alarm.
- Triage, reception and interview rooms must have two doors to allow for appropriate access and exit and where possible have doors that swing outwards.
- Access to clinical areas from the waiting room must be controlled, e.g. doors are secured by swipe card access, with entry by permission of clinicians.

When patients presenting to an ED are considered to be at risk, or who have a particular security need, a risk assessment to identify and address the identified security risks must be undertaken. These patients may include (but are not limited to):

- victims of sexual assault[6]
- victims of domestic violence[7]
- patients affected by the use of drugs or alcohol
- patients with mental illness or mental disorder
- patients in custody
- patients who are confused or cognitively impaired
- patients with developmental disability
- children at risk of harm[8]. 298(16/03/18)

[6] NSW Health Policy PD 2005_607 Sexual Assault Services Policy and Procedure Manual (Adults) (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_607.pdf)

[7] NSW Health Policy PD2006_084 - Identifying and Responding to Domestic Violence, Section 12.1 Emergency Departments (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2006_084.pdf)

2.2.3 Response to escalation

Where patients, or their carers/guardians, present a known risk to the health and safety of staff or others, a patient alert (or file flag) should be added to the health care record. Where a patient alert is added there must be an up to date management plan documented in the health care record to ensure those staff managing the presenting individual can do so in a safe and appropriate manner. Information on current individuals with patient alerts must be highlighted during clinical handover.

Staff should use de-escalation techniques to prevent and address escalating behaviour. Where de-escalation is not successful or a staff member continues to feel unsafe, the following actions should occur:

- Use of personal space and environmental awareness to keep safe.
- Calling for back up from colleagues, including from more senior staff.
- Activating duress alarms to alert the duress (code black) response.
- Scanning the environment for dangerous items.
- Identifying exits.
- Activating the process for calling the police where a matter involves a weapon or continues to escalate.

Where a duress alarm is activated summoning the organised response, the duress response team must be multi-disciplinary and led by clinicians with assistance by security staff if necessary. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.

2.2.4 Education and Training

Staff working in or moving through ED waiting rooms must maintain awareness of personal safety at all times. All staff are responsible for engendering a workplace health and safety culture. Staff working within the ED setting are to be provided with training, consistent with the standards set out in PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations, to ensure they are equipped to de-escalate or manage violent/aggressive behaviour. This training must include team based training.

3 CARING FOR WAITING PATIENTS

3.1 Customer Service Approach for frontline ED staff

Frontline ED staff includes reception, triage, nursing, medical, porters and allied health staff who interact with patients at all stages of their journey. These staff are often the first contact patients and their families/carers will have with the health system and hospital; a specific focus on patient experience, customer service and welcoming, caring communication is an important part of their role.

Education resources such as online learning, videos and locally delivered resources which allow for simulation training should be provided (at state and local level) and will support the maintenance of a high standard of interaction with all patients by staff.

Utilising a customer service approach in ED reception areas will also assist in minimising common issues in ED such as patients who “Did Not Wait” for treatment, escalating behaviour and patient dissatisfaction with their ED experience. Review of these types of incidents in NSW EDs is often traced back to unclear or perceived uncaring interactions with staff at the beginning of the patient’s journey.

Local investment in real time opportunities for patients, families and carers to provide feedback on their ED experience should be considered. 298(16/03/18)

[8] NSW Health Policy PD2013_007_Child Wellbeing and Child Protection Policies and Procedures for NSW Health (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf

3.2 Communication with waiting patients and families/carers

Patients and families/carers should have access to information outlining the ED process, including information brochures and/or audio visual information. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified[9].

Patients from culturally and linguistically diverse backgrounds and patients with a disability should be provided with specific information regarding their ED stay including access to Social Workers and interpreters.

Patients and families/carers should be provided with regular, ongoing communication regarding changes to waiting times and their management. In many cultures, family members have a specific role or responsibility to carry out on behalf of the family member in the ED and these needs should be understood and accommodated where possible by ED staff. Patients may be informed of alternatives to ED care for their condition for example, general practitioner and medical centres if clinically appropriate.

Patients must be encouraged to speak with the triage/waiting room nurse prior to leaving the ED prior to medical assessment.

All communication should be documented in the patients' health care record.

3.3 Assessment of waiting patients following triage

Clinical care may commence whilst the patient is in the waiting room. Patients may be identified by the triage nurse as appropriate for initiation of care according to locally endorsed and statewide clinical pathways.

Regular reassessment of patients should occur, particularly if they wait longer than the allotted triage category time. This may include regular visual observation and haemodynamic observations where appropriate.

Documentation of the initiation of care and patient assessment must be completed in the patient health care record.

ED processes should facilitate early contact with senior medical and nursing decision makers to ensure that relevant tests are ordered and treatment commenced as soon as possible after arrival.

The waiting room nurse or Clinical Initiatives Nurse (CIN) (where these roles exist) should be responsible for the regular reassessment and initiation of care of waiting room patients. The CIN may function under the direction of the triage nurse or according to local policies. Where there is no CIN or waiting room nurse, local processes must be in place to ensure safety of patients in the waiting room.

High risk patients should be positioned in a highly visual area of the waiting room and moved to an appropriate clinical area as soon as possible. This may include patients at risk of harm to themselves/others or at risk of absconding. Vulnerable patients including children or elderly patients or those unable to self advocate in the waiting environment must to be allocated to an area of the ED where appropriate supervision by ED staff is available.

Staff should be trained on how to identify patients at risk of highly contagious infectious diseases and to quickly isolate patients and/or provide masks and other personal protective equipment to prevent the spread of disease.

[9] NSW Health Policy PD2017_001 Responding to Needs of People with Disability During Hospitalisation (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_001.pdf)

3.4 Escalation of care for waiting patients

Recognition of a patient's deterioration may occur through patients, families, carers and ED staff who assess the patient following triage.

Deterioration in condition may be recognised through:

- Physiological abnormality including falling or trending 'outside of the flags' on the standard patient observation chart.
- New or progressive clinical symptoms that require more urgent medical review.
- Deterioration in mental state.
- Escalation in behaviour.
- Patient, family or caregiver concern.

Any waiting patient whose condition deteriorates should be managed in accordance with the local clinical emergency response system processes[10] including notification to senior ED clinical staff and documentation in the health care record.

Patients and families/carers should be informed of how to contact a staff member should they feel that the patient's condition is deteriorating whilst waiting for care to commence.

Should a patient or visitor who deteriorates in the waiting room need assistance to a more appropriate location manual handling must be in accordance with Work Health and Safety safe working practices.

3.5 Patients arriving with other services staff

3.5.1 Patients who arrive by ambulance

The ED is responsible for the overall clinical management of any patient transported by ambulance as soon as the patient enters the department[11]. The following principles apply for these patients:

- Local strategies should be in place to support early offload of ambulances.
- Local systems should be implemented to monitor the number of patients in the ambulance bay to assist in quality care delivery, safety and patient flow.
- Clinical care should commence in accordance with locally endorsed or statewide clinical pathways as appropriate.
- Following triage, patients suitable to be transferred into the waiting room are to be offloaded and appropriate clinical handover undertaken.
- Patients remaining on an ambulance stretcher for longer than 30 minutes or who have escalating care requirements are to be managed according to local clinical emergency response system processes.
- If a delay in Transfer of Care of the patient between paramedics and ED clinicians occurs, a shared care responsibility exists for monitoring and communicating changes in the patient's clinical condition, between Ambulance and ED staff. The triage nurse should inform the Paramedic of an appropriate staff member to contact should the patient deteriorate whilst on the stretcher.

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[10] NSW Health Policy PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating (available http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_049.pdf)

[11] ACEM Statement of Responsibility for Care in Emergency Departments (2012) http://www.acem.org.au/getattachment/1e5b1137-43b5-4304-af42-de4c00884d01/Statement-on-Responsibility-for-Care-in-Emergency.aspx

- A joint risk assessment should be undertaken by ED clinical staff and paramedics for patients with mental health issues who have been voluntarily brought to the ED but for whom presenting paramedics have safety concerns.
- All care is to be documented in the patient's health care record.

3.5.2 Patients who arrive with Police

For people presenting in Police custody or detained under the Mental Health Act/ Mental Health Forensic Provisions Act, Police are to provide a comprehensive verbal handover to the triage nurse or assessment clinician. The handover discussion should focus on:

- Facilitating the effective and safe management of the person.
- Maintaining the safety of staff, other patients and visitors.
- Include a risk assessment of the likelihood of the person's behaviour escalating to become a safety issue; particularly once any mechanical restraints are removed and/or police withdraw.

These processes will assist with expediting handover of patients to ED staff from Police at the earliest opportunity.

Presenting police are to clearly communicate with clinical staff whether to notify police prior to the person being discharged from the ED. ED staff are to ensure this information is conveyed to staff as part of safe clinical handover between shifts and upon ward transfers.

People brought to the ED under the Mental Health Act by Police are not to be handed over to NSW Health security staff only. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.

3.5.3 Patients who arrive with custodial officers

Patients arriving from custody should be assessed and managed in the same manner as other patients. If a private section of the ED is available, they should wait there with custodial officers. ED staff can contact Justice Health & Forensic Mental Health Network (JH&FMHN) clinicians if required, especially for those custodial patients requiring ongoing nursing care on discharge, as many custodial sites do not have 24 hour nursing care. Patients transferred from an adult correctional or juvenile justice centre will have a letter with them titled 'Information for Hospital Staff: Healthcare for People in Custody' including contact phone numbers.

4 PATIENTS WHO DECIDE NOT TO WAIT FOR TREATMENT

The term "did not wait" (DNW) or equivalent is used to describe patients who leave whilst awaiting clinical care or medical assessment to commence. These patients have been triaged and may or may not have had initial nursing assessments and observations as part of the triage process. DNW patients represent an important subset of the ED patient population in relation to quality of care for both access to and the process of ED care delivery[12].

Signage must be prominently placed in ED waiting areas advising patients to notify the triage staff if they leave the ED whilst awaiting clinical care to commence or medical assessment.

ED clinical staff should discuss the safety implications of leaving without being medically assessed with the patient and family/carers. Communication of safety implications should be in line with guidance in Section 3.1 Communication with waiting patients and families/carers. A senior clinician must be notified of any concerns about patient's safety. Documentation of conversations with the patient, family/carers and senior clinician is to be recorded in the patient's health care record. 298(16/03/18)

[12] EMERGENCY MEDICINE — RESEARCH The Medical Journal of Australia ISSN: 0025-729X 3/17 December 2007 187 11/ 12 626-629 ©The Medical Journal of Australia 2007 www.mja.com.au

Notification to a senior ED clinician and documentation should also be undertaken if the triage nurse is concerned for patients who choose to leave without notifying staff.

Health practitioners should be mindful of their obligations with regard to Section 27 of the Children and Young Persons (Care and Protection) Act 1998, which requires mandatory reporting by health care workers where there are reasonable grounds to suspect a child is at risk of significant harm.

Health practitioners should also be mindful of whether the Mental Health Act provisions may be applied to the patient. Involuntary patients detained under the Mental Health Act who have absconded are able to be apprehended and returned to the ED in accordance with the Act. Notification of incidents should be as per PD2014_004 Incident Management Policy

4.1 Monitoring of rates of patients who 'Did not Wait'

EDs should maintain a local auditing system to monitor trends in rates of DNW. Review of data should also be undertaken by Aboriginal and non-Aboriginal patients as there is significant evidence in the literature of higher rates of DNW among Aboriginal patients presenting to ED[13] [14]. Addressing this issue is in line with the Australian Commission on Safety and Quality in Healthcare's guidance on Improving care for Aboriginal and Torres Strait Islander People.

Locally designed strategies to manage identified reasons for patients who DNW should be implemented with outcomes reviewed. Consideration may be given to follow up of patients who DNW who are considered to have high risk issues or are from a vulnerable patient group.

5 LIST OF RELATED DOCUMENTS

- PD2012_022 Maternity - Management of Early Pregnancy Complications (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_022.pdf)
- PD2010_034 Children and Adolescents- Guide for care in Acute care settings (available at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_033.pdf)
- PD2015_004 Principles for Safe Management of Disturbed and /or Aggressive Behaviour and the Use of Restraint (available at http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015_004)

[13] Tropea J, Sundararajan V, Gorelik A, Kennedy M, Cameron P, Brand CA. Patients who leave without being seen in emergency departments: an analysis of predictive factors and outcomes, Acad Emerg Med. 2012 Apr;19(4):439-47

[14] Wright, L. 2009 "They just don't like to wait"—A comparative study of Aboriginal and non-Aboriginal people who did not wait for treatment or discharged against medical advice from rural emergency departments: Part 1 AENJ, vol 12 (3) 78-85

EMERGENCY DEPARTMENT - NOTIFICATION OF SPECIALIST OR VMO REGARDING PATIENTS ADMITTED THROUGH THE ED (GL2011_003)

GL2011_003 rescinds GL2005_026.

PURPOSE

The purpose of these guidelines is to provide advice on the development of hospital mechanisms for the notification of Specialists or Visiting Medical Officers of patients admitted through the Emergency Department.

KEY PRINCIPLES

Mechanisms should be in place for the appropriate Visiting Medical Officer or Staff Specialist to be notified of each hospital admission through the emergency department. The notification should be made by the rostered medical officer attending to the patient in the emergency department, prior to the end of his or her shift. In hospitals with specialty registrars, this notification can be made to the appropriate registrar.

All relevant medical practitioners should be educated regarding the need for compliance with the above guideline.

USE OF THE GUIDELINE

Following the recommendation of the State Coroner, these guidelines should be incorporated into written hospital policy in relation to the notification of admitting Visiting Medical Officers or Staff Specialists regarding patients admitting through the emergency department.

The Guideline can be downloaded at http://www.health.nsw.gov.au/policies/gl/2011/GL2011_003.html

TRIAGE IN NSW EMERGENCY DEPARTMENTS (PD2013_047)

PD2013_047 rescinds PD2008_009.

PURPOSE

The purpose of this policy is to outline the key components of triage of patients presenting to Emergency Departments in NSW hospitals including the role, key responsibilities and the processes that support efficient and safe triage.

This policy does not seek to outline the clinical components of this process; clinical information related to triage is as indicated by the Australasian College for Emergency Medicine's (ACEM) policy[15] and guideline[16] on triage and the College of Emergency Nursing Australasia (CENA) Position Statements on Triage.[17,18]

This policy should be read in conjunction with NSW Health Policy **PD2010_075 *Emergency Department Patients Awaiting Care***

MANDATORY REQUIREMENTS

- Triage is an essential function of an Emergency Department (ED). Triage (or an alternative local 'sorting' process by a senior ED clinician) should be the first interaction a patient has in the ED.
- ED and hospital processes must support the ability of triage to be carried out within five minutes or less so as not to delay other patients awaiting triage. This includes limiting the responsibilities and additional tasks required of the Triage Nurse, where appropriate, so that focus can remain on timely triage of patients as they enter the ED.
- The triage process encompasses a brief clinical assessment of the patient on arrival to the ED to determine the priority for clinical care. Assignment of triage category reflects the clinical urgency of the patient's condition.
- The patient's level of urgency is indicated using the Australasian Triage Scale (ATS) and the Triage Nurse determines (in consultation with relevant ED and Ambulance staff if required) the most appropriate place for the patient to commence or wait for further treatment.
- It is recognised that triage is a dynamic process and may require that the patient be re-triaged if their condition changes or deteriorates prior to being seen by a treating clinician.
- The physical location and environment of triage must ensure the safety of staff and patients and accommodate privacy for the assessment of patients.
- The process of Triage involves the application of high-level patient assessment skills and knowledge to determine the patient's degree of urgency to see a treating clinician – it is for this reason that triage in NSW EDs should be carried out by Registered Nurses. It is not appropriate for clerical/administrative staff to undertake triage. In Hospitals with ED role delineation level 1 & 2, there may be occasional circumstances where an Enrolled Nurse is the first point of contact for a patient arriving in the ED. Contingencies for this occurring are described in section 2.5 - Triage Education.

15 ACEM Policy on the Australasian Triage Scale **http://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx**
16 ACEM Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments **https://www.acem.org.au/getattachment/d19d5ad3-e1f4-4e4f-bf83-7e09cae27d76/G24-Implementation-of-the-Australasian-Triage-Scal.aspx**
17 CENA Position Statement: Triage Nurse http://www.cena.org.au/wp-content/uploads/2014/10/CENA_Position_Statement_Triage_Nurse.pdf
18 CENA Position Statement: Triage and the Australasian Triage Scale http://www.cena.org.au/wp-content/uploads/2014/10/2012_06_14_CENA_-_Position_Statement_Triage.pdf

- Registered Nurses undertaking the triage role must demonstrate and maintain clinical expertise in emergency nursing and have appropriate training in the triage role; the requirements of which will be determined locally. Please see section 2.5 Triage Education for further information on 'expertise in emergency nursing.

IMPLEMENTATION

Local Health District and Specialty Health Networks are responsible for:

i. Assigning responsibility, personnel and resources to implement this policy.
ii. Establishing mechanisms to ensure that the essential criteria are applied, achieved and sustained as usual processes for triage; this should include nomination of an executive sponsor.
iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with responsible executive, Clinical Governance unit, ED senior management, and senior clinical staff.
iv. Providing opportunity for Registered Nurses to complete local triage education programs; ensure adequate supervision for Registered Nurses learning the triage role and demonstrate local processes for the ongoing evaluation of triage practice.

1. BACKGROUND

1.1 About this document

Triage is an essential function of an Emergency Department (ED) and must be the first interaction a patient has in the ED. This Procedure Document supports and further explains the mandatory requirements of the *Triage in NSW Emergency Departments Policy* through the following components:

- The purpose and role of Triage.
- Use of the Australasian Triage Scale.
- Re-triage of patients with deteriorating conditions.
- Triage location and safety requirements.
- Triage education.
- Triage of Ambulance patients.
- Telephone advice.
- Mass Casualty Disaster and Triage.

1.2 Key definitions

For the purpose of the Policy Statement and this Procedures Document, the following definitions apply:

Acuity:
Acuity is a synonym for urgency, and they can be used interchangeably. An acuity-based description should answer the question: "This patient should wait for assessment and treatment by a treating clinician no longer than….".

Australasian Triage Scale (ATS):
The Australasian Triage Scale (ATS) is a 5-point scale that is designed for use in hospital-based emergency services throughout Australia and New Zealand. It is used to help sort patients by clinical urgency.

Competency:
Competency refers to the consistent application of knowledge and skill to the standard of performance required in the workplace. It is also the ability to consistently perform work activities; applying skills and knowledge; to agreed standards over a range of contexts and conditions.[19]

Complexity:
Complexity relates to the difficulty of the presenting problem and the resources involved in finding a solution to the problem. A low ATS category with a highly complex problem may consume more resources and workload than a high urgency but low complexity presentation.

Emergency Triage Education Kit (ETEK):
The Emergency Triage Education Kit (ETEK) is a teaching resource that aims to provide a consistent approach to the educational preparation of Australian emergency clinicians for the triage role. In particular the ETEK has been designed to promote the correct use of the ATS. The ETEK can be accessed via: **http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents**

Re-triage:
The process of re-triage involves an assessment of the waiting patient who has not been assessed by a clinician responsible for care within the time frame allocated by the initial triage category. The purpose of re-triage is to identify and escalate the care of a patient whose condition is deteriorating, reassign an appropriate triage category and prioritise clinical resources to manage the patient.

Streaming:
Streaming is a predetermined method of allocating patients to a particular treatment cohort during the triage process based on specific criteria. Such criteria may include urgency or complexity, age or presenting problem. Streaming may include allocation to a specific area within the ED, a specific set of resources (eg. medical and nursing teams) or to a patient service external to the ED (eg. specialty clinic). The practice of streaming patient presentations from the point of triage into appropriate care areas is shown to result in improvements in waiting times and ED length of stay.

Transfer of Care:
Transfer of Care in this policy refers to the NSW Health key performance indicator of the percentage of patients arriving by ambulance whose care is transferred from paramedics to ED staff within 30 minutes of arrival. Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to a hospital clinician.

Triage:
Triage is the process of assessment of a patient on arrival to the ED to determine the priority for medical care based on the clinical urgency of the patient's presenting condition. Triage enables prioritisation of limited resources to obtain the maximum clinical utility for all patients presenting to the ED. The triage nurse applies an Australasian Triage Scale category in response to the question: "This patient should wait for assessment and treatment by a treating clinician no longer than….".

1.3 Legal and legislative framework

Duty of Care

By engaging with a patient as they present to the ED, the Triage Nurse enters into a health professional-patient relationship. The Triage Nurse shares the responsibility of the hospital to ensure that patients who present to the ED are offered an appropriate assessment of their urgency of treatment requirements.

[19] http://www.hwa.gov.au/sites/uploads/national-competency-report-final-20120410.pdf.

All nurses should have an understanding of basic legal principles, which include consent, the elements of negligence, definition and sources of the standards of care, and how policies and guidelines can influence practice to maximise patient safety. There is an expectation that the Nurse performing the role of triage will have adequate experience, training and supervision to perform the role. The employing institution also has a responsibility to ensure that triage staff are adequately prepared to perform the role.

Patients who 'Did Not Wait' for treatment following Triage

Patients may choose to leave the hospital without being seen by the treating clinician in the ED; if the patient is competent, the Triage Nurse cannot prevent them from leaving. However, the Triage Nurse has a responsibility to advise the patient of the consequences of such a decision, and appropriate documentation recording this event should be completed (see 'Documentation' section below). Issues must be escalated to the appropriate senior ED clinician in charge of the department as required.

Patients who have a cognitive impairment (e.g. from drug use, alcohol use, a head injury, mental illness, delirium or patients at risk of suicide or with self-harm ideation) are at risk from adverse events in such situations. The Triage Nurse must therefore consider their duty of care in such cases. The Triage Nurse must be aware of and fulfil his or her responsibilities with these patients and abide by any local policies or protocols. For the purposes of triage, a rapid re-triage and/or escalation to senior ED staff may be indicated.

Documentation

Medical records are a method of communication for health care team members and are a contemporaneous record of events. They must be accurate, clear and succinct. It is also expected that the records will be easily accessible and able to be understood[20].

Minimum information that is required to be recorded for any triage episode include the following:
- Date and time of triage assessment.
- Name of the Triage Nurse.
- Presenting problem.
- Relevant clinical assessment findings and limited relevant history.
- Initial triage category allocated.
- Area the patient is allocated or streamed to within the ED.
- Diagnostic, first aid or treatment initiated at triage.
- Type of visit code.

Any change in the patient's condition prior to being seen by the treating clinician must be documented clearly. If re-triage is required; documentation should include:
- The time of re-triage.
- Reason for the re-triage.
- Information about escalation of the patient's change in condition to relevant senior ED staff.

Documentation regarding patients that choose to leave the ED without treatment should detail as much information as is available, including the following:
- Information given to the patient or carer regarding the need to stay for treatment.
- Advice given regarding alternative or ongoing care.

[20] NSW Health Policy 2012_069 Health Care Records – Documentation and Management available **http://www.health.nsw.gov.au/policies/pd/2012/PD2012_069.html**

- The name and position of the clinician that concerns were escalated to.
- The patient's condition on departure.
- The time that the patient left.
- Any action that was taken subsequent to the patient leaving.
- Any other relevant information.

2. COMPONENTS OF THE TRIAGE PROCESS

2.1 The Purpose and role of Triage

Triage is a critical component in the delivery of emergency care, and is the first point of contact and assessment in the patient's ED journey.[21] The purpose and role of triage is to first identify patients with life-threatening or emergency conditions and initiate appropriate interventions (eg. emergency first aid as per local protocols), then second, allocate the patient to an appropriate area or stream within the ED.

ED and Hospital processes must support the ability of triage to be carried out within five minutes so as not to delay other patients awaiting triage. This includes limiting the responsibilities and additional tasks required of the Triage Nurse, where appropriate, so that focus can remain on timely triage of patients as they enter the ED.

Triage is used to determine the patient's clinical urgency; it is not an indicator of complexity of the patient's condition and should not be used as a substitute for this.

Triage involves rapid patient assessment, interpretation of the clinical history and physiological assessment, while objectively discriminating between the ATS categories of urgency. Triage decision-making is inherently complex, made under conditions of uncertainty and with limited or obscure information.

Assessment of clinical urgency is achieved by observation of general appearance, collection of a focused history to identify presenting problem and clinical risk and collections and interpretation of physiological data using a primary survey approach.

It is the responsibility of the Triage Nurse to escalate and engage further assistance from senior ED clinical staff where appropriate.

It is recognised that the triage process relates to managing the queue of patients who present for treatment. Currently this is done consistently by Triage Nurses, however EDs may choose to implement strategies to manage the queue according to local needs (for example, decision making clinicians seeing patients immediately on arrival to the ED).

It is important that the Triage Nurse is competent in identifying and promoting cultural safety for patients that are triaged including access to interpreter services, notification of Aboriginal Liaison Officers where appropriate and is able to access culturally appropriate information regarding triage and the waiting room for patients.

Use of the Australasian Triage Scale

In all NSW EDs, emergency nurses perform the triage role using the ATS. The ATS is a five-point scale used to prioritise patients. An ATS category from one to five is allocated according to the maximum time the Triage Nurse determines the patient can wait for emergency care.

[21] Hodge, A., et al., *A review of the quality assurance processes for the Australasian Triage Scale (ATS) and implications for future practice.* Australasian Emergency Nursing Journal, 2013. **16**(1): p. 21-29.

The Triage Nurse applies an ATS category in response to the question *"this patient should wait for assessment and treatment by a treating clinician no longer than..."*.

ATS Category	Treatment Acuity (maximum waiting time)	Performance Indicator Threshold*
ATS 1	**Immediate**	**100%**
ATS 2	**10 minutes**	**80%**
ATS 3	**30 minutes**	**75%**
ATS 4	**60 minutes**	**70%**
ATS 5	**120 minutes**	**70%**

**Performance Indicator Threshold represents the percentage of patients assigned ATS Category 1 through to 5 who commence clinical assessment and treatment within the relevant waiting time from their time of arrival.*[22]

2.3 Re-triage of patients with deteriorating conditions

It is recognised that triage is a dynamic process and may require that the patient be re-triaged if their condition changes, deteriorates or additional relevant information is received prior to being seen by a treating clinician.

Such relevant information may be received via a source such as: interpreters, Drs letter, family members, past medical records etc.

The process of re-triage involves an assessment of the waiting patient who has not been reviewed by a clinician responsible for care. The purpose of re-triage is to acknowledge any change in clinical condition of a patient and assign a relevant triage category. A patient may be assessed as requiring a higher acuity triage category (due to deterioration).

Documentation is to occur detailing the assessment, application of a new triage category, and necessary discussions or escalation of the patient's condition to a senior ED clinician (Registered Nurse, Medical Officer, Team Leader).

Patients and/or carers should be informed at the time of triage what to do if their condition changes or they become concerned while waiting for care and how the triage system works to prioritise care.

All waiting patients should be regularly assessed by either the Triage Nurse or Clinical Initiatives Nurse (CIN) if available; particularly if the waiting time exceeds the allotted triage category maximum waiting time.

2.4 Triage location and safety requirements

The triage environment must provide safety for the public, the Triage Nurse, staff and patients of the ED. The triage environment must take into account the potential risk of aggressive behaviour of patients or their relatives.

[22] ACEM Policy on the Australasian Triage Scale **http://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx**

The environment:

- Must be immediately visible and well sign posted.
- Must allow for clear visibility of the waiting room by the Triage Nurse.
- Must have access to an area for patient examination and provision of first aid.
- Must be designed to maximize the safety of the Triage Nurse, staff and patients (eg. duress alarms, egress routes for staff exiting the triage room and access to security personnel).
- Should enable and facilitate patient privacy (a private consultation room is recommended for patient examination).

2.5 Triage education

It is recognised that triage should be completed by *specifically trained and experienced RNs*[23] as:

> *… clinical decisions made by triage nurses require complex cognitive process. The Triage Nurse must demonstrate the capacity for critical thinking in environments where available data is limited, incomplete or ambiguous.*[24]

The Registered Nurse must demonstrate clinical expertise in emergency nursing prior to commencing triage education and training.

The LHD will determine the baseline level of clinical expertise expected of a prospective Triage Nurse; however, new graduate (transitional) nurses should not be eligible to undertake a triage education program. The following is recommended as baseline clinical expertise:[25]

- One-two years full time ED nursing experience (this does not include the New Graduate year).
- Successful completion of the NSW Health '*Transition to Practice, Emergency Nursing Program'* or equivalent transitional program.
- Completion of the Clinical Excellence Commission (CEC)[26]
  - Between the Flags program
  - D.E.T.E.C.T.
  - D.E.T.E.C.T. junior
- Advanced Life Support accreditation
- NSW Health Paediatric Clinical Practice Guidelines e-learning package.[27]

Local decision making should be applied by ED Nursing Managers, Clinical Nurse Consultants and Nurse Educators on readiness of nurses to undertake the triage role where appropriate. Local systems should be in place for Recognition of Prior Learning to ascertain an equivalent level of the development of clinical expertise.

It is the responsibility of the LHD Executive, the Medical Director of the ED (or equivalent), the Nurse Manager of the ED (or equivalent) and LHD Nursing Education service to ensure an adequately resourced, locally relevant, comprehensive triage training and assessment program. It is recommended that the program should encompass the following elements:

- It should be based on the *Emergency Triage Education Kit*[28] (ETEK).
- It should not teach ETEK in isolation, but use it as part of a training and competency based triage program.

[23] **Australasian College for Emergency Medicine (2006) *Policy on the Australasian Triage Scale***
[24] **College of Emergency Nursing Australasia (2009) *Position Statement Triage Nurse***
[25] **Health Policy Priorities Principle Committee (2011) *Australian Triage Process Review***
[26] **Clinical Excellence Commission (2013) *Between the Flags***
[27] **NSW Ministry of Health (2010) Paediatric Clinical Practice Guidelines e-learning package**
[28] **Australian Department of Health and Aging (2009) *Emergency Triage Education Training Kit***

- It should include information about local procedures, processes and nuances.
- It should provide supernumerary support during practical triage training.
- It should ensure that novice triage nurses have access to senior medical and nursing staff for support as they learn the triage role (either in person or via appropriate telecommunications).

At the completion of a triage training program, the Triage Nurse must be able to demonstrate knowledge and/or competence as follows:[29]

- Recall the science and practice of triage.
- Outline the Australian health care system.
- Describe the role of the Triage Nurse.
- Apply the ATS.
- Relate the legislative requirements and considerations.
- Discuss epidemiology and population health.
- Demonstrate effective communication skills including use of electronic medical record systems where appropriate.
- Application of the primary and secondary surveys.
- Apply and synthesize an assessment and triage decision making process by the following presentation types:
  - Trauma.
  - Medical and surgical emergencies.
  - Older persons emergencies and delirium identification.
  - Paediatric emergencies.
  - Obstetric and gynaecological emergencies.
  - Mental health emergencies and the *Mental Health Act 2007*.
  - Rural and isolated triage practice.
  - Environmental emergencies.
- Discuss quality and safety in health care and apply it to triage decision making.
- Discuss cultural safety issues and ensure cultural competence of triage staf.f

It is recognised that in hospitals with ED role delineation level 1 & 2, there may be occasional circumstances when an Enrolled Nurse is the first point of contact for a patient arriving in the ED.

For these contingencies, hospitals must:

1. Have clear processes established in order to rapidly notify a registered nurse of the patient's arrival.
2. Note that Registered Nurses are responsible for formal triaging in all circumstances.
3. Establish training for those Enrolled Nurses likely to encounter these circumstances so that they are equipped to identify high acuity patients.

Ongoing evaluation of performance, updates of clinical practice and professional development must be in place to ensure currency of knowledge and practice for the role of Triage Nurse.

2.6 Triage of Ambulance patients

Patients arriving to the ED via ambulance will be assessed and triaged as per normal ED triage procedures.

Some LHDs may have local protocols in place for rapid triage/triage bypass of specific clinical groups (e.g. ST Elevation Myocardial Infarction, Trauma, Sepsis and Stroke). LHDs are required to ensure that all triage staff are aware of local protocol agreements relating to the triage of specific clinical groups within their ED.

[29] Adapted from **College of Emergency Nursing Australasia (2009) *Position Statement Triage Nurse***

Following triage assessment, the Triage Nurse will determine the most appropriate location within the ED to facilitate transfer of care of patients presenting by ambulance and release of paramedics from care of the patient. This will include allocation of patients to defined clinical areas within the ED or transfer to the waiting room where appropriate, particularly low acuity and low complexity patients for whom staying on the ambulance stretcher is not necessary.

To facilitate Transfer of Care, a clinical handover using a structured approach such as 'IMIST AMBO', must occur between the treating Paramedic and accepting ED clinician. Transfer of Care is deemed complete only when this clinical handover has occurred and the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

In the event, that the patient is unable to be offloaded from the ambulance stretcher to an appropriate location within the ED, joint care and monitoring of the patient by ED staff and paramedics will continue until the patient can be offloaded. Transfer of Care should occur as soon as possible.

2.7 Telephone advice

It is not the role or responsibility of the Triage Nurse to provide clinical telephone advice to the public, carers and non-health professionals who may telephone the ED in an attempt to seek emergency and other medical advice.

If the Triage Nurse identifies that a caller is requiring general medical advice they should direct the caller to phone the National Triage Telephone Advice Line (*healthdirect Australia*) on 1800 022 222. If the Triage Nurse identifies that the call may be of an emergency nature, the Triage Nurse should direct the caller to hang up and phone 000 for assistance. If the Triage Nurse identifies that a caller is ringing about a mental health problem, they should direct the caller to phone the NSW Mental Health Line on 1800 011 51.

2.8 Mass Casualty Disaster and Triage

This procedure document outlines the process for ED triage under 'usual' circumstances.

Mass casualty triage, while similar, is distinct from the triage process that has been described in this document. During mass casualty incidents, or 'disasters' the triage process may change. This decision will be made by a hospital disaster controller, or their delegate.[30]

LIST OF RELATED DOCUMENTS

1. Australasian College for Emergency Medicine policy on the Australasian Triage Scale available: **http://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx**
2. Australasian College for Emergency Medicine guidelines on the implementation of the Australasian Triage Scale in Emergency Departments available: **https://www.acem.org.au/getattachment/d19d5ad3-e1f4-4e4f-bf83-7e09cae27d76/G24-Implementation-of-the-Australasian-Triage-Scal.aspx**
3. College of Emergency Nursing Australasia position statement: Triage Nurse available: **http://www.cena.org.au/wp-content/uploads/2014/10/2012_06_14_CENA_-_Position_Statement_Triage.pdf**
4. College of Emergency Nursing Australasia Position Statement: Triage and the Australasian Triage Scale **http://www.cena.org.au/wp-content/uploads/2014/10/2012_06_14_CENA_-_Position_Statement_Triage.pdf**

[30] **http://www.health.nsw.gov.au/policies/gl/2010/GL2010_011.html**

5. Australian Triage Process Review report available: **http://www.ecinsw.com.au/sites/default/files/field/file/Australian%20Triage%20Process%20Review.pdf**
6. Emergency Triage Education Kit available: **http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents**
7. Emergency Department Triage Method available: **http://www.ecinsw.com.au/sites/default/files/field/file/Triage%20Method-Oct%202010-2.pdf**
8. NSW Health Emergency Department Models of Care July 2012 available: **http://www.health.nsw.gov.au/Performance/Publications/ed-model-of-care-2012.pdf**
9. PD2015_001: Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach **http://www.health.nsw.gov.au/policies/PD/2015/PD2015_001.html**
10. NSW Health Policy PD2007_036 Infection Control Policy available: **http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html**

DIRECT ADMISSION TO INPATIENT WARDS FROM EMERGENCY DEPARTMENT
(PD2009_055)

PURPOSE

Timely and efficient handover of clinical care of admitted patients from the Emergency Department medical staff to in-patient medical staff is essential for the safe and effective care of each patient and for maintaining the effective operation of the Emergency Department. An essential component of this transition of responsibility for the clinical care of the patient is timely confirmation of acceptance of the clinical handover by the relevant inpatient clinical team.

This policy directive seeks to avoid delays in the admission of patients from the Emergency Department through the application of a clear local protocol in each hospital. As smaller rural hospital Emergency Departments do not have full time separate Emergency Department medical staff and are supported by general practitioners who also care for admitted patients, this policy directive applies to public hospitals with Emergency Departments designated as level 3 or above.

The key benefit of the development and use of a local protocol is that it provides a prior written agreement developed locally by clinicians setting out which clinical unit/team accepts which patients.

Application of this policy directive will enable a timely and clinically appropriate direct admission of a patient from the Emergency Department where an inpatient clinical team has not confirmed acceptance of the admission of the patient under that team within two hours of the clinical decision that the patient requires admission to the hospital.

MANDATORY REQUIREMENTS

Each hospital must have in place by 31 October 2009 an agreed written local protocol that sets out a decision framework for the transfer of care of a patient requiring admission from the Emergency Department to an inpatient clinical team/unit.

The key components of the local protocol are set out in – *Key Components Local Protocol – Admission Decision Framework*. Where a hospital already has a local protocol, the protocol should be reviewed to ensure that it complies with this policy directive.

The local protocol should be reviewed on a six monthly basis and also updated when the clinical service mix of the hospital materially changes.

IMPLEMENTATION

Chief Executives are to ensure a written local protocol as described in this policy and its associated documents is in place for all hospitals designated level 3 or above with Emergency Departments.

Local protocols should be developed by a local hospital executive lead governance group with input from Emergency Department senior medical staff, clinical units/teams and the Medical Staff Council. This consultative process will ensure that gaps in the draft framework are identified and addressed and that the requisite clinical engagement and commitment occurs.

KEY COMPONENTS LOCAL PROTOCOL – ADMISSION DECISION FRAMEWORK

1. A comprehensive list of clinical conditions for which the hospital is able to provide inpatient care and the clinical team/unit that primarily provides inpatient care for each listed clinical condition. This list will be based on the clinical team/unit skill set.

2. The senior medical staff who are appointed and credentialed to accept admissions in each clinical team/unit listed.

3. If a hospital does not have the facilities or skills to admit certain patients, this should also be clearly stated and an appropriate networked hospital identified which will accept such patients.

4. A clearly set out admission process for patients presenting with co-morbidities, undifferentiated illness or conditions involving more than one clinical discipline (eg. the protocol may set out that a joint admission should occur).

5. An agreed mechanism for ongoing review, improvement and further development of the protocol as issues arise (e.g. a periodic standing agenda item for local clinical unit and medical staff council meetings)

6. A clearly defined dispute resolution process for dealing with unforeseen circumstances with these circumstances then informing the ongoing review and improvement process. The dispute resolution process must NOT delay the admission of a patient from the Emergency Department and transfer of care to an inpatient clinical team in accordance with the protocol.

7. A clear written outline of the agreed admission decision process for patients in the Emergency Department requiring admission to the hospital. The process should comply with the following principles.

Emergency Department inpatient admission process principles

8. Following assessment in the Emergency Department, a senior doctor in the Emergency Department will:
   a. decide if the patient requires admission;
   b. determine the condition(s) necessitating admission;
   c. apply the agreed local protocol to determine the clinical team under whose care the patient will be admitted;
   d. request the clinical team to accept the admission.

9. In situations where there is not agreed acceptance of the admission by the inpatient consultant or team, discussion should take place at the most senior clinical level possible, preferably consultant level, based on the agreed local protocol.

10. If the appropriate admitting team for the patient is unable to be determined by the above steps in the required time frame, then the most senior medical officer who has seen the patient will make the admission decision. In the emergency department the specialist emergency physician would be the most senior medical officer. If an emergency physician is not on duty, another senior medical officer (specialist, registrar or CMO) who has seen the patient will make the decision.

11. A reasonable time for conclusion of this decision-making process would be no more than 2 hours from the time of the clinical decision that the patient requires admission.

- This process must result in a clear decision to admit the patient under a specific consultant or clinical team. The decision-maker must then notify the admitting team. The admitting team will accept the patient once this decision is made. An inpatient consultant who remains unwilling to accept the patient after all these steps have been followed may elect to see the patient and having done so, take personal responsibility for discussing with, and arranging admission under, another consultant.

- Occasions requiring the most senior doctor to make a contested decision to admit the patient under a specific consultant or clinical team must be the subject of a subsequent review at the local hospital level to determine whether further refinement of the local protocol is required, as part of the ongoing review, improvement and further development of the local protocol.

- Should the patient subsequently require transfer to another clinical unit after admission from the Emergency Department under the local protocol, the clinical team on call will arrange this. The local protocol should include prior agreement about processes to expedite the transfer of such patients between units where

This checklist can be used to review the implementation of this policy directive.

Assessed by:		**Date of Assessment:**		
Requirement:	**Assessment:**			
	Not commenced	**In development**	**Partial compliance**	**Full compliance**
IMPLEMENTATION REQUIREMENTS				
1. Comprehensive list of clinical conditions and inpatient teams primarily responsible for these conditions by October 31st 2009	❑	❑	❑	❑
	Comments: ❑ Not applicable			
2. Written Emergency Department admission decision process in place	❑	❑	❑	❑
	Comments: ❑ Not applicable			
3. Regular review process for the local protocol in place	❑	❑	❑	❑
	Comments: ❑ Not applicable			
4. Clearly defined dispute resolution process in place	❑	❑	❑	❑
	Comments: ❑ Not applicable			

NSW RURAL ADULT EMERGENCY CLINICAL GUIDELINES (GL2022_004)

GL2022_004 rescinds GL2020_004

GUIDELINE SUMMARY

This Guideline is provided to assist early appropriate clinical management of acute and lifethreatening conditions, and to relieve pain and discomfort, for patients at hospitals where medical officers are not immediately available.

KEY PRINCIPLES

The Guidelines reflects evidence based best clinical practice and expert consensus opinion to standardise initial clinical management of specific adult conditions.

A graduated clinical response is required, dependant on:

- Severity of the presenting emergency condition e.g. the clinical response to patients with mild to moderately severe asthma is different to that of a patient with immediately life-threatening asthma.
- Level of training and expertise of the nursing staff who initiate the management of the patient i.e. Registered Nurses with advanced clinical training will practice more advanced interventions.
- Legal requirements for Nurses who initiate treatment and administer medications based on medication standing orders.
- Need for flexibility to respond to input from senior clinical staff and medical officers to accommodate local circumstances

Alignment with the principles outlined in the First Line Emergency Care Course (FLECC) for Registered Nurses. These nurses have advanced knowledge and skills; and have been deemed competent to carry out these advanced roles using contemporary assessment and ongoing credentialing processes.

The Guidelines can be used by any First Line Emergency Care Course (FLECC) credentialed nurse in the following settings:

- Emergency Department in the absence of a medical officer
- In inpatient areas where a medical officer is not immediately available for patients who fall into the “Clinical Review” or “Rapid Response” criteria of the NSW “Between the Flags” program. Implementation is to occur in conjunction with the activation of the local clinical emergency response system (CERS).

When a Registered Nurse who is recognised as a First Line Emergency Care Course credentialed nurse uses these Guidelines, the designated Medical Officer will be notified immediately.

Medication standing orders contained and utilised in the Guideline will be reviewed and authorised by the designated medical officer as soon as possible (within 24 hours) and the medical officer will countersign the record of administration on the patients’ medication chart.

Enrolled Nurses and Registered Nurses who are not First Line Emergency Care Course credentialed can use these Guidelines to inform assessment and management, however are not permitted to undertake shaded interventions that require First Line Emergency Care Course credentialing unless formal previous recognition of prior learning has been granted.

These Guidelines can be commenced on any adult patient who meets the clinical severity prompt criteria on any specific condition within the guidelines.

In circumstances where the patient meets more than one guideline the most life-threatening condition must take priority and the most appropriate corresponding guideline commenced.

The Guidelines can be downloaded from:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_004

RESPONDING TO SEXUAL ASSAULT (ADULT AND CHILD) POLICY AND PROCEDURES (PD2020_006)

PD2020_006 rescinds PD2005_614 and PD2005_607

PURPOSE

This Policy Directive provides policy and practice guidance to NSW Health services in responding to children, young people and adults who have, or may have, been sexually assaulted and their families, carers and significant others. It details the functions and governance of NSW Health Sexual Assault Services and clarifies the responsibilities of other NSW Health services in responding to sexual assault.

SUMMARY OF MANDATORY REQUIREMENTS

This Policy requires that Local Health Districts (districts) and Speciality Health Networks (networks):

- Prioritise the health, safety and wellbeing of people who have experienced sexual assault (adult and child).
- Provide an integrated response to sexual assault within a public health approach.
- Adhere to the identified principles of intervention for responding to sexual assault.
- Comply with key reporting requirements related to sexual assault.
- Follow identified procedures and protocols for responding to sexual assault in Emergency Departments.
- Deliver services in ways that increase health, safety and wellbeing and minimise harm. This includes services seeking to prevent re-traumatisation and to ameliorate the impact of sexual assault on the person who has experienced it and their families/significant others.
- Deliver services in a way that is culturally safe and responds sensitively to people's needs, including the experiences of identified population groups with specific vulnerabilities and additional barriers to accessing services.
- Collaborate with interagency partners at local and district levels in responding to sexual assault.
- Ensure every district has at a minimum one Level 4 (or Level 6) Sexual Assault Service (SAS) within their geographic boundaries which provides 24 hour integrated psychosocial, medical and forensic crisis responses for both adults and children as well as the full range of other identified elements of the SAS service model. For a SAS to qualify as a Level 4 as per the NSW Health ***Guide to the Role Delineation of Clinical Services*** it will meet the identified minimum requirements.
- Apply the clinical processes, practices and management requirements for SASs set out in the Responding to Sexual Assault (adult and child) Policy and Procedures, including information sharing and records requirements.
- Comply with the NSW Health **Violence, Abuse and Neglect (VAN) Service Standards**.

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- establishing mechanisms to ensure the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are applied, achieved and sustained;
- ensuring NSW Health staff understand and are aware of their obligations in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures* and related policies and procedures;
- ensuring resources are available to deliver and meet the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures*;

- ensuring that NSW Health staff are trained to operationalise and implement the *Responding to Sexual Assault (adult and child) Policy and Procedures*;
- communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures*; and
- ensuring NSW Health staff are advised that compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures* is part of their patient / client care responsibilities.

Managers of NSW Health SAS and other NSW Health services specified in the *Responding to Sexual Assault (adult and child) Policy and Procedures* are responsible for:

- ensuring the requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are disseminated and implemented in their service; and
- monitoring implementation and compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures*.

NSW Health workers are responsible for:

- Implementing and complying with the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures.*

For the complete *Responding to Sexual Assault (Adult and Child) Policy and Procedures* document go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2020_006

DOMESTIC VIOLENCE - IDENTIFYING AND RESPONDING (PD2006_084)

The *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) http://internal.health.nsw.gov.au/pubs/p/pdf/procedures_dom_violence.pdf provides a framework for informing domestic violence responses for staff in hospitals and community health services. This document's child protection focus has been improved by amendments as detailed below.

It is important to note the inclusion of the following additional text in *section 3.1 Identification of domestic violence* (page 9), procedures section after the paragraph commencing "*Ask about safety*":

"*Ask about child safety:*

- *Do you have children? (If so) have they been hurt or witnessed violence?*
- *Who is/are your child/ren with now? Where are they?*
- *Are you worried about your child/ren's safety?*

Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm."

Procedures in *Section 3.2.2, Counselling interventions with victims* (page 13) have also been amended by deleting and replacing dot point six under "*Assess safety*" with the following text:

"*Are there children involved? Who is/are your child/ren with now? Are they safe? Was/were your child/ren nearby when your partner was violent to you?" Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm (refer to Section 4.5 – Children and domestic violence)"*

It is recommended that any hard copies of the document *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) in circulation also be amended accordingly.

Living with domestic violence has a serious impact on short- and long-term psychological, emotional and physical health of victims and their children. The aim is to help reduce the incidence of domestic violence through the provision of primary and secondary prevention health care services, and to minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches including ongoing treatment and follow-up counselling.

The term "domestic violence" is used to refer to abuse and violence between adults who are partners or former partners. NSW Health has existing policies and strategies that address other forms of violence that are commonly experienced. Health workers may find this policy can provide guidance in responding to situations where similar dynamics occur, in particular the section on legal responses for domestic violence.

The policy and procedures were developed by the NSW Department of Health in consultation with Area Health Services, interagency partners and non-government organisations.

A core component of the policy is routine screening for domestic violence, which is to be implemented for women attending antenatal and early childhood health services and women aged 16 years and over attending mental health and alcohol and other drugs services in accordance with the policy. *Routine screening for domestic violence in NSW Health: an implementation package* provides the screening protocol, guide for managers and the learning program:
http://www.health.nsw.gov.au/publications/Publications/Domestic_Violence_Screening.pdf

DOMESTIC VIOLENCE – MEN'S BEHAVIOUR CHANGE PROGRAMS (IB2014_003)

PURPOSE

To provide information about Men's Domestic Violence Behaviour Change Programs.
This information should be read in conjunction with the *Policy and Procedures for Identifying and Responding to Domestic Violence* PD2006_084. Where the information differs, the information in this bulletin applies.

The Policy and Procedures for Identifying and Responding to Domestic Violence are being reviewed in 2013 and the advice in this Information Bulletin will be incorporated into any new Policy Directive.

KEY INFORMATION

In NSW, there are a range of men's domestic violence behaviour change programs, provided by Government and non-government services. These are provided in custodial settings, by welfare groups and by counselling services, and are a valuable service to men seeking to change their abusive behaviour.

The NSW Government has introduced minimum standards for men's domestic and family violence behaviour change programs. The standards will significantly improve the safety of victims of domestic violence and assist those attending programs to stop the violent behaviour. The minimum standards aim to reflect good practice, and foster programs that are safe and effective in changing behaviour.

The standards apply to all group programs for male perpetrators of domestic and family violence in NSW. This includes programs run by government agencies, including NSW Health agencies. It also includes programs run by non-government agencies.

NSW Health responsibilities

The minimum standards are NSW Government policy, and the Director General has signed a formal agreement with the Department of Attorney General and Justice to implement the minimum standards. To comply:

- NSW Health staff should only refer patients/clients to complying programs listed at **http://www.domesticviolence.lawlink.nsw.gov.au/**;
- Where any NSW Health agency provides funding to Men's Behaviour Change Programs, any new or revised funding agreement should require compliance with the minimum standards;
- Where any NSW Health agency provides funding to relevant community services, new or revised funding agreements should include a clause requiring those NGO staff to refer clients/patients only to programs complying with the Minimum Standards. These services may include Aboriginal Medical Services, Women's Health Centres, multicultural services, Family Planning services, Lifeline, mental health & drug and alcohol services, health services for the homeless, youth services, and victim support services;
- NSW Health staff with concerns or complaints about programs, should report this directly to the Domestic and Family Violence Unit, Crime Prevention Division, Department of Attorney General and Justice at **http://www.domesticviolence.lawlink.nsw.gov.au/** or 02 8688 3277.

The Principles and Minimum Standards

1. **Principle**: The safety of women and children must be given the highest priority.
   - 1.1. **Standard**: Program providers will develop and operate from written procedures that address risks to women and children.
   - 1.2. **Standard**: Program providers will ensure that current partners of program participants are provided with support prior to and during the program.
   - 1.3. **Standard:** Partner support workers will prepare women for the participation of their partners in the behaviour change group program.
   - 1.4. **Standard:** Partner support workers will complete individual risk assessments and safety plans.
   - 1.5. **Standard:** The contact worker is to disclose to women any new expressed or perceived threat to their safety.

1.6. **Standard:** Where women and children express an interest in having ongoing contact from a partner support worker, additional contact will occur for the duration of the program.
1.7. **Standard:** Group facilitators and partner support workers will have approach knowledge and training about the impact of domestic and family violence on women and children.
1.8. **Standard:** Partner support workers must have relevant knowledge, training and experience to enable them to support and advocate for women and children.

2. **Principle:** Victim safety and offender accountability are best achieved through an integrated, systemic response that ensure that all relevant agencies work together.
2.1. **Standard:** To ensure program transparency, accountability and integration program providers will develop a formal relationship with relevant local agencies.

3. **Principle:** Challenging domestic and family violence requires a sustained commitment to professional and evidence-based practice.
3.1. **Standard:** Group facilitators must have relevant knowledge and training.
3.2. **Standard:** All programs will have a minimum of two group facilitators.
3.3. **Standard:** Group facilitators must undertake supervision.
3.4. **Standard:** Program providers will develop policies to ensure that group facilitators undertake ongoing professional development.
3.5. **Standard:** Behaviour Change Group Programs will have a duration of at least 24 hours over 12 weeks.
3.6. **Standard:** Program providers will complete an operational review of each program focussing on process and content.
3.7. **Standard:** Program providers will evaluate the impact of programs on the behaviour and attitude of group participants.
3.8. **Standard:** Program providers will contribute to an evidence base for behaviour change programs.

4. **Principle:** Perpetrators of domestic and family violence must be held accountable for their behaviour.
4.1. **Standard:** Programs must be grounded in an evidence-based theory of change.
4.2. **Standard:** Program providers will document and implement thorough participant assessment procedures.
4.3. **Standard:** Program provider will have procedures for engaging participants which challenge them to acknowledge their abusive behaviour.
4.4. **Standard:** Program content will include explicit information about the impact of domestic and family violence on women and children and women's disproportionate experience of domestic violence.
4.5. **Standard:** Program content will include information on different forms of domestic and family violence and provide opportunities for participants to come to an understanding about the nature of their offending behaviour.
4.6. **Standard:** Program providers will develop procedures for non-attendance of mandated participants.
4.7. **Standard:** Program providers will have procedures for group facilitators to prevent their implicit or explicit collusion with participants' attitude that support violence against women.
4.8. **Standard:** Program providers will offer appropriate referrals to meet participants' additional needs.
4.9. **Standard:** Program providers must comply with the requirements of a referring agency for a report on the participant's completion of a program.

5. **Principle:** Programs should respond to the diverse needs of the participants and partners.
5.1. **Standard:** Program facilitators must undertake training to ensure culturally competent practice.
5.2. **Standard:** Programs addressing other forms of family violence will be specific to the participant's needs.

Further information can be found at **http://www.domesticviolence.lawlink.nsw.gov.au/**.

To view the Minimum Standards for Men's Domestic Violence Behaviour Change Programs on the Attorney General and Justice website go to **http://www.domesticviolence.lawlink.nsw.gov.au/agdbasev7wr/_assets/domesticviolence/m422001l2/dfv_behaviour_change_program_standards_april_2012.pdf**

200(30/01/14)

DOMESTIC AND FAMILY VIOLENCE MIGRATION REGULATIONS: RELEVANCE FOR HEALTH WORKERS (IB2018_017)

PURPOSE

This Information Bulletin outlines the special provisions relating to domestic and family violence (DFV) contained in the *Migration Regulations 1994* (the provisions) of the *Migration Act 1958.* It also describes support which can be offered to victims of DFV, in addition to clinical services, by certain professional experts within NSW Health.

This Information Bulletin expands on issues raised in the NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence 2006*, regarding clients from culturally and linguistically diverse backgrounds affected by DFV, who hold certain temporary visas.

KEY INFORMATION

The provisions ensure that persons in Australia on certain temporary visas do not feel compelled to remain in abusive relationships in order to stay in Australia.

The provisions are usually invoked by persons on temporary partner visas or prospective marriage visas, who are in the process of applying for a permanent partner visa. The provisions allow these persons to remain in Australia and apply for permanent residence, even though, as a result of DFV and a relationship breakdown, they do not meet the ordinary requirements to obtain a permanent partner visa.

The provisions can also be invoked by persons on certain skilled stream visas in some circumstances.

Victims of DFV seeking to invoke the provisions must substantiate their claims by proving their relationship was genuine until it ended and that DFV took place during the relationship in Australia.

If the victim's claim of DFV has not been heard by a court, that person can provide the following as evidence that DFV took place during their relationship:

- a statutory declaration (form number 1410 for DFV claims first made on or after 24 November 2012, or form number 1040 for claims made on or after 15 October 2007); and
- two items of evidence from **professional experts**.

The *Migration Regulations 1994 - Specification of Evidentiary Requirements - IMMI 12/116* (IMMI 12/116) provides information on acceptable items of evidence from **professional experts**. Victims of DVF must present at least two of the types of evidence listed in IMMI 12/116 in support of their claim. They cannot present two items of evidence of the same type.

NSW Health workers categorised as **professional experts** include registered medical practitioners, nurses or psychologists and members or eligible members of the Australian Association of Social Workers. Professional experts within NSW Health may provide a statement in a statutory declaration or an official letter with relevant supporting documents in their professional capacity, including a medical report, hospital report or a discharge summary. Their evidence must include:

- details of the violence, identifying all individuals involved;
- evidence or reasons for any opinion or assessment;
- details about their professional relationship with the victim; and
- information regarding services and support offered or provided to the victim.

Professional experts within NSW Health should proactively follow up by asking about the safety of the victim - if they are safe to go home, if they need assistance to go home or a safe place as per the NSW Health policy on *Identifying and Responding to Domestic Violence* PD2006_084.

Professional experts within NSW Health should also identify if children are involved in the violence by asking victims directly. If so, questions should be asked about this - if children have been hurt or witnessed violence, where and who are the children with, and if victims are worried about the children's safety.

Professional experts within NSW Health are also required to follow mandatory reporting protocols if they suspect that a child is at risk of significant harm.

The NSW Mandatory Reporting Guide should be used as part of this assessment and reports to the Child Protection Helpline should be made where indicated.

REFERENCES

1. NSW Ministry of Health. 2006. ***Domestic Violence - Identifying and Responding***. [ONLINE] Available at: **http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2006_084**

2. Australian Department of Home Affairs. 2016. ***Statutory Declaration - Form: 1410***. [ONLINE] Available at: **https://www.homeaffairs.gov.au/forms/documents/1410.pdf**

3. Australian Department of Home Affairs. 2016. ***Statutory Declaration - Form: 1040***. [ONLINE] Available at: **https://www.homeaffairs.gov.au/forms/documents/1040.pdf**

4. Minister for Immigration and Citizenship. 2012. ***Migration Regulations 1994 - Specification of Evidentiary Requirements - IMMI 12/116.*** [ONLINE] Available at: **https://www.legislation.gov.au/Details/F2012L022377**

5. Australian Medical Association. 2016. ***Supporting Patients Experiencing Family Violence***. [ONLINE] Available at: **https://ama.com.au/article/ama-family-violence-resource**

6. Childstory Reporter. 2016. ***Mandatory Reporter Guide***. [ONLINE] Available at: **https://reporter.childstory.nsw.gov.au/s/mrg**

NEW SOUTH WALES HEALTH SERVICES FUNCTIONAL AREA SUPPORTING PLAN (NSW HEALTHPLAN) (PD2014_012)

PURPOSE

NSW HEALTHPLAN details the health emergency management arrangements to ensure that health resources in NSW are effectively and efficiently coordinated in the event of emergencies through prevention, preparation, response and recovery.

MANDATORY REQUIREMENTS

NSW HEALTHPLAN is the NSW Health Services Functional Area Supporting Plan to the NSW State Emergency Plan (EMPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

The plan outlines the agreed roles and functions of the eight key contributing health services (Medical Services, Ambulance Services, Mental Health Services, Public Health Services, Health Communications, HealthShare NSW, NSW Health Pathology and The Sydney Children's Hospital Network), which constitute a whole of health response incorporating an all-hazard approach.

NSW Health is designated as the Combat Agency for all health emergencies within NSW under the NSW State Emergency Plan (EMPLAN).

The principal position holder for health emergency management is the State Health Services Functional Area Coordinator (State HSFAC) who is contactable on a 24 hour basis.

The policy directive *Emergency Management Arrangements for NSW Health* PD2012_067 outlines the mandatory requirements, governance and operational arrangements for the Local Health Districts and the Health Service Functional Area Coordinators.

IMPLEMENTATION

New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) will replace NSW HEALTHPLAN PD2009_008 (v3.5 December 2009).

An e-learning package has been developed and distributed to the Local Health Districts to support the release of this policy and an online learning package is available through Interaction Pulse for NSW Ambulance.

PD2014_012 can be downloaded at **http://www.health.nsw.gov.au/policies/pd/2014/PD2014_012.html**

MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN (GL2018_017)

GL2018_017 rescinds GL2010_011, PD2009_080 and PD2009_048

PURPOSE

The attached plan is the NSW Health Major Incident Medical Services Supporting Plan supporting the NSW Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

The purpose of the NSW MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN (NSW MEDPLAN) is to enable medical service resources to be varied from business as usual arrangements and effectively and efficiently coordinate the resources in the event of major incidents requiring a significant and coordinated medical response.

The NSW MEDPLAN details the arrangements to be adopted by NSW Health in order to coordinate all of the hospitals and medical services resources available in NSW (both government and non-government) to the State HSFAC and State Medical Controller for the response and recovery from the impact and effects of a major incident.

The arrangements in this plan will also provide guidance for the preparation of the Local Health District/Network medical services arrangements and procedures of the LHD HEALTHPLAN.

KEY PRINCIPLES

The following principles underpin the NSW MEDPLAN:

1. The Plan shall be read in conjunction with NSW HEALTHPLAN.
2. The provisions defined in the NSWHEALTHPLAN (Part 3) for prevention and preparation responsibilities in a health emergency for NSW Medical services apply.
3. The provisions of the NSW MEDPLAN should not inhibit the LHD instigating a local response, if required.

The plan assigns responsibility to the State Medical Services Controller for hospitals and medical services once the NSW MEDPLAN has been activated by the State Health Services Functional Area Coordinator (HSFAC) such that:

a. the management of multiple casualties and potential casualties is centrally coordinated (both government and non-government)
b. definitive care is provided as rapidly as possible. This may require deployment to the incident, receiving hospitals or other emergency centres.

The plan identifies recommended actions under four phases: Prevention, Preparation, Response and Recovery. Actions under the Prevention and Preparation phases are identified in the NSW HEALTHPLAN and are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases (Parts Three and Four) are recommended to be carried out once the NSW MEDPLAN has been activated by the State Health Services Functional Area Coordinator (State HSFAC).

The primary role for medical services in the response phase will be to manage multiple casualties and potential casualties using central coordination to ensure the provision of definitive care as rapidly as possible.

USE OF THE GUIDELINE

The NSW MEDPLAN:

a. Covers the governance structure for standby, response and recovery for major incident management [Part Three – Four].
b. Addresses the coordination of all hospitals and medical services in NSW (both government and non-government) for response to and recovery from major incidents [Annex One].
c. Assigns responsibility to the State Medical Services Controller for the statewide coordination of hospitals and medical services so that the management of multiple casualties is centrally coordinated. This ensures that definitive care is provided as rapidly as possible.
d. May require deployment of Scene Medical Commander(s) and Emergency Medical Teams either to assist hospitals overwhelmed by casualties or to the incident.
e. Represents the first hours of a major incident and not a protracted event.

Responsibilities of key parties are detailed in Part Two of the NSW MEDPLAN. Action Cards for specific position holders are listed in Annex Three with specific actions.

Details for the Concept of Operations for LHDs are listed in Annex Four. The plan should be communicated to those with roles and responsibilities under this plan and the HEALTHPLAN.

Reporting and Governance of this Plan and key parties are outlined in Annex One.

To download the complete Major Incident Medical Services Supporting Plan Guideline please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_017

MASS CASUALTY TRIAGE PACK – SMART TRIAGE PACK (PD2017_037)

PD2017_037 rescinds PD2011_044

PURPOSE

This policy specifies the use of Mass Casualty Triage Pack - SMART Triage Pack in a mass casualty situation to denote the priority for treatment under the Medical Service Supporting Plan (GL2010_011).

MANDATORY REQUIREMENTS

This policy sets the requirements for the use of the SMART Triage Packs for mass casualty triage, documentation in the field and when patients are immediately transported to hospital. The SMART Triage Tags form part of the patient's health record.

In Local Health Districts, the SMART Triage Packs form part of the Health Response Team Medical Equipment list requirement (PD2009_080). NSW Ambulance carries SMART Triage Packs across all ambulance vehicles for use in mass casualty incident.

IMPLEMENTATION

This policy replaces PD2011_044 Mass Casualty Triage Pack – SMART Triage Pack which was implemented across Local Health Districts and Ambulance Services of NSW in 2011.

SMART Triage Packs are included in the HealthShare NSW catalogue.

Local Health Districts

Local Health Districts are responsible for:

- Ensuring that the policy is brought to the attention of staff who are responsible for maintenance, storing, management and use of the SMART Triage Packs.
- Ensuring staff are appropriately trained in the use of the Kits.
- Ensuring Health Response Team Kits within the Local Health District are stocked with two (2) SMART Triage Packs.

NSW Ambulance

NSW Ambulance is responsible for:

- Ensuring that the policy is brought to the attention of staff who are responsible for maintenance, storing, management and use of the SMART Triage Packs.
- Ensuring staff are appropriately trained in the use of the Kits.
- Replacing and maintaining the stock of SMART Triage Pack items in NSW Ambulance fleet.

NSW Health Emergency Management Unit

NSW Health Emergency Management Unit is responsible for:

- Reviewing and updating this policy every three (3) years or earlier if any request is made to NSW Health Emergency Management Unit following a mass casualty incident or operation.
- E-learning package for Mass Casualty Triage Training.

Mass Casualty Triage & SMART Triage Packs - Procedures

1. BACKGROUND

1.1 Triage Process

Triage was first introduced in a military context as a system of sorting the casualties for medical treatment in the field. In recent decades, the triage concept has been adopted and implemented in the disaster medical management and emergency departments.

In the context of medical management in a mass casualty situation, the aims of triage are not only to deliver the right patient to the right place for optimal treatment, but also to 'do the greatest good for greatest number' with medical resources which should not be diverted to treating an irrecoverable condition.

1.2 Australian Standard Mass Casualty Triage Tags

In 2010, the SMART Triage Tags were approved as an Australian standard mass casualty triage label by the Council of Ambulance Authorities (CAA) following consultation with jurisdictional Health Departments.

The SMART Triage Tags provide a standard tool for mass casualty triage process in a mass casualty incident. The tags provide a national consistent approach to mass casualty triage across Australia[31].

The SMART Triage Tags meet world's best practice and have been tested and evaluated for Australian conditions.

2. SMART Triage Pack

2.1 Personal SMART Triage Pack

The personal SMART Triage Pack (Red colour for Ambulance Services and Green colour for Health Response Teams) consists of:

- SMART Triage Tags
- Triage Sieve and Casualty Count Chart
- Paediatric SMART Tape
- CBR Tag
- Light stick and pencils

Photo source: SMART TAG™

Health Response Team Kits are to have two (2) SMART Triage Packs per kit.

[31] 1 Aitken, P. & Fitzgerald, G., (2012) Disaster triage: Evidence, consistency and standard practice. Emergency Medicine Australasia 2012 24,222-224.

2.2 Commander Triage Pack

The Commander Triage Pack, located in ambulance supervisor vehicles, includes:

- Incident Control Boards – detachable and Velcro to the Commander pack
- Document holders for maps and plans
- SMART Triage Tags
- Dispatch panels for holding the Transport tags
- Internal pockets for additional equipment

2.3 SMART Triage Tag

The SMART Triage Tag is a variable triage tag that enables field documentation. The tag is durable, waterproof and can be written on when wet.

Each Mass Triage Tag has an individual barcode and unique identifier number. The unique identifier number shall be recorded in all patient documentation. Each SMART Triage Tag also has a plastic bag with main pocket for Triage Tag and a small front pocket when using a CBR (Chemical, Biological & Radiation) Tag.

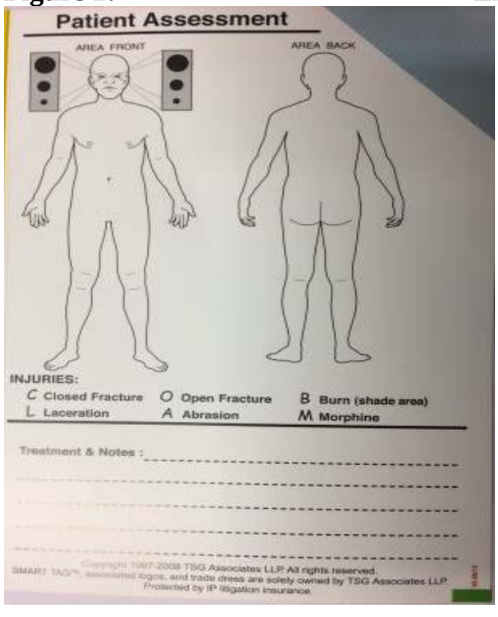
Figure 1:

The SMART Triage Tag has a prominent priority numbering and matching colour system on the tag (Figure 1). A separate Black colour triage tag is used for deceased persons (Figure 1).

The blue colour corner (Figure 2) of the SMART Triage Tag is referred to as the Fourth Priority or Expectant. The Expectant priority refers to a patient whose condition is so severe that they cannot survive despite the best available care. The Expectant category will only be used in NSW following a major or catastrophic event where the number and criticality of patient(s) significantly diverts medical resources from the salvageable patient who may then be compromised.

The authorisation to implement this category can only be given by the State Health Services Functional Area Coordinator (HSFAC) following clinical discussions with the Medical Supervisor on site as outlined in NSW Ambulance Major Incident Response Plan (NSW AMPLAN).

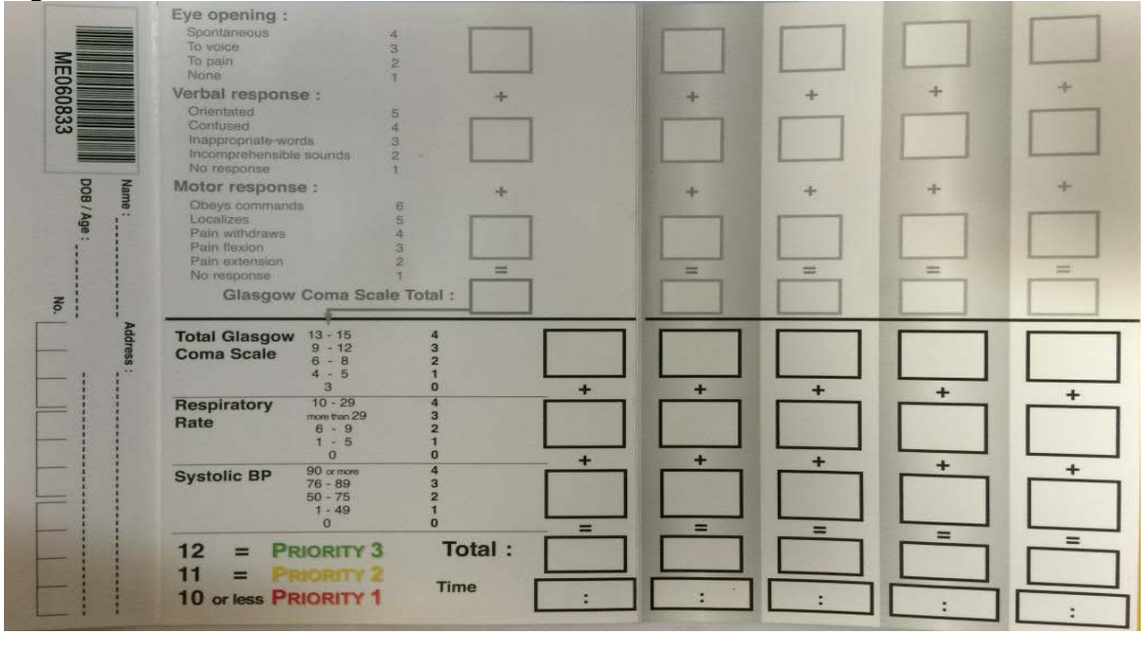
Figure 2: Expectant (Blue) category corner



The SMART Tag provides documentation for recording patient changes in condition. The tag can be refolded to display a different priority without losing the important patient information already recorded on the tag.

Time should be recorded on the tag using 24 hour time (00:00-23:59).

Figure 3:

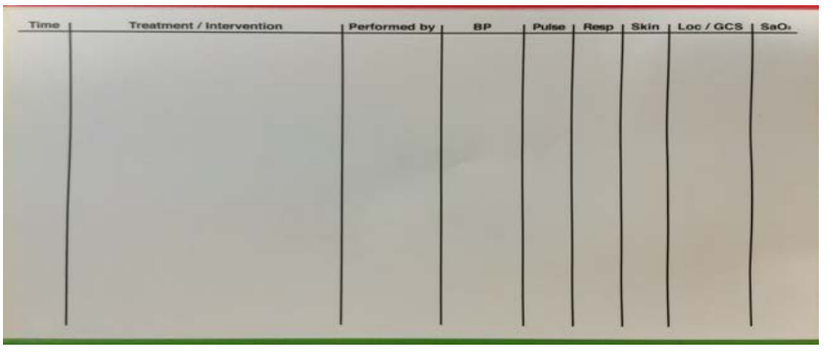


Before the patient is transferred to definitive health care facility, the Ambulance Loading Point Officer will complete and remove the transport tag (at the side of the SMART Triage Tag) for records (Figure 4). This documentation enables the tracking and accounting of the casualty's movement and destination.

Figure 4:

The SMART Triage Tag will remain attached to the patient who is then transferred to the definitive care destination.

The card allows further patient information to be recorded as necessary:

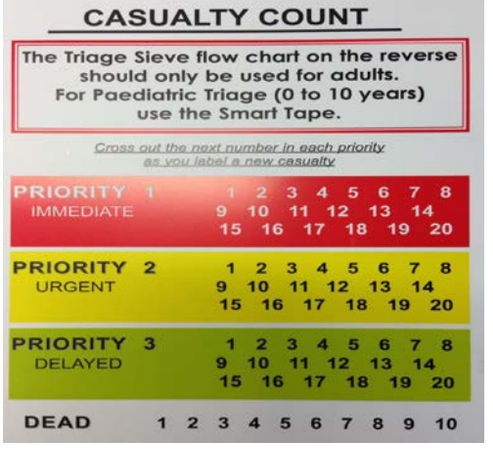


2.4 Casualty Count Chart

A double sided card with the casualty count chart (Figure 5) and adult triage sieve process is attached to the SMART Triage Pack with an elastic band. The chart provides a quick reference of the triage sieve process and a casualty count record is a document than can be used by to track the number of casualties and the clinical acuity.

The care is made from the same durable material as the SMART Triage tags.

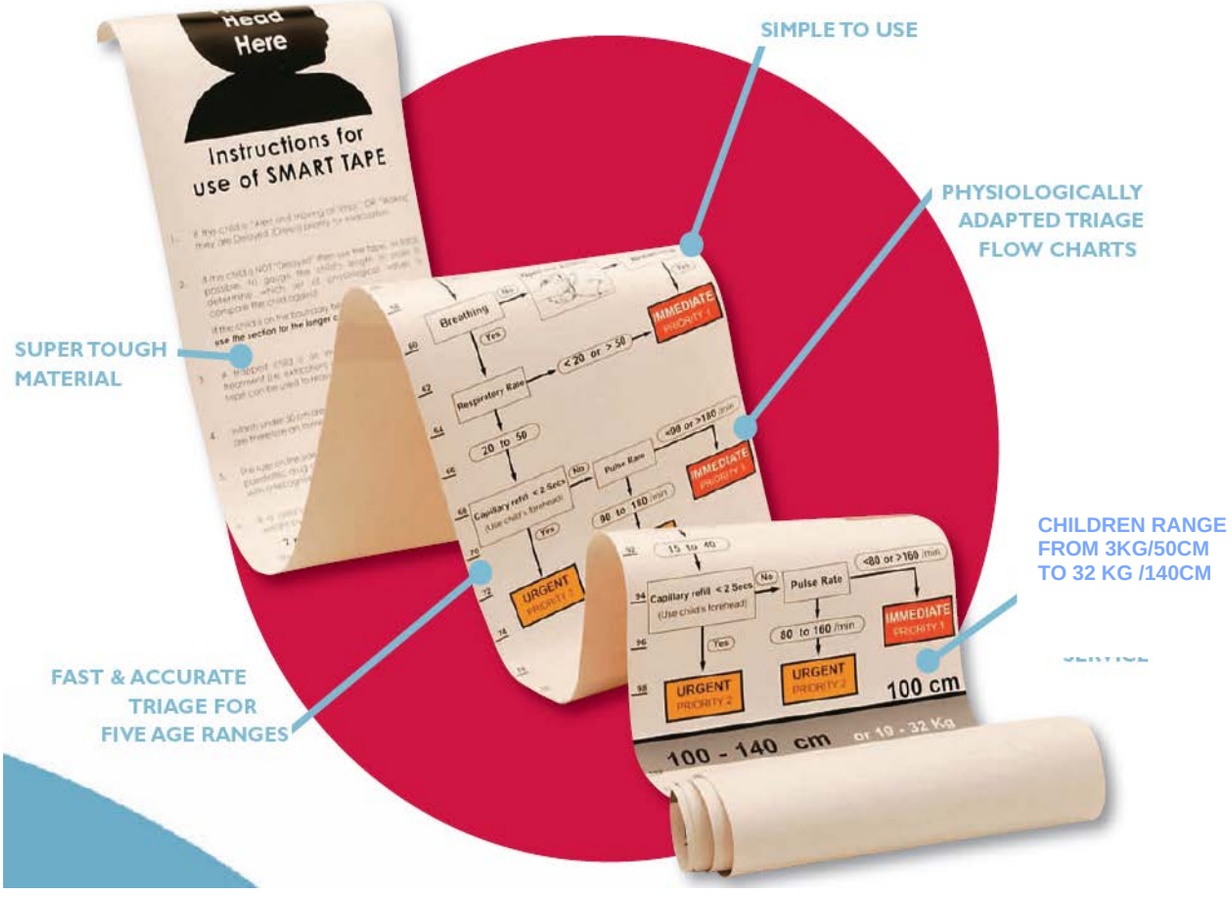
Figure 5:



2.5 Paediatric SMART Tape

The durable Paediatric SMART Tape is an evidence based system[33] [34]and is to be used as a non-biased triage decision for children from 3kg/50cm to 32kg/140cm[35]. The Paediatric SMART Tape allows a triage sieve to be performed on any child less than 32kg. The use of this tool has been incorporated into the existing Health and Ambulance training programs.

If resources or time do not permit, the adult triage sieve can be used for paediatrics, however this may result in the over triage of a paediatric casualty.



2.6 CBR Tag[36]

The Chemical Biological and Radiological (CBR) Tag provides a form to record the details for contaminated casualties from an incident involving chemical, biological, radiological or infectious agents. The CBR Tag allows recording of particular agents, decontamination and any use of auto-injectors.

The CBR Tag DOES NOT replace the SMART Triage Tag and does not have the unique identifier barcode and number. The CBR Tag must be used in conjunction with the SMART Triage Tag.

[33] Hodgetts, T., J. Maconochie, C. & Smart, C (1998). Paediatric triage tape. Pre-hospital Immediate Care 2:155-159.
[34] Wallis, LA & Carley, S (2006) Validation of the Paediatric Triage Tape, Emergency Medicine Journal. Jan: 23 (1):47-50.
[35] Sandell, J. M. & Charman, S.C (2009). Can age-based estimates of weight be safely used when resuscitating children? Emergency Medicine Journal 2009;26;43-47.
[36] The term 'WMD" used in the SMART Triage Pack or Education Pack, should be referred as "CBR". "WMD' is a term used in USA but not in Australia. In Australia, the term "CBR" is used instead.

The unique identifier number of the victim's SMART Triage Tag is required to be documented on the CBR Tag. The completed CBR Tag is to be inserted in the front clear plastic pocket of the SMART Triage Tag.

Photo source: SMART TAG™

3. Training

The SMART Triage Pack has been incorporated in the Major Incident Medical Management and Support (MIMMS) course and Ambulance training programs.

An e-learning package has been developed for all staff within NSW Health and NSW Ambulance and is available on My Health Learning. The course code for Mass Casualty Triage Training is 122605241.

NSW Health and NSW Ambulance have trainers that can provide education in th SMART Triage System.

4. Ordering Requirement and Details

SMART Triage items can be ordered through the HealthShare NSW catalogue with the following details (as sock items):

HIMF Number	Description
710779	DISASTER TRIAGE TAG, **SMART TRIAGE** TAG
710789	DISASTER TRIAGE TAG, **CBRN/HAZMAT** TAG
710787	DISASTER TRIAGE TAG, **DECEASED** TAG –
710782	DISASTER TRIAGE TAG, SMART CASUALTY CARD, SIEVES (Pack5) – **Triage Sieve Algorithm / Casualty Count Card**
710783	DISASTER TRIAGE TAG, SMART TAPE, CHILD - **Paediatric Triage Tape**
710780	DISASTER TRIAGE TAG, RE-SUPPLY FOR SMART TRIAGE KIT - **Contents only – no bag**
788136	DISASTER PACK, ***EMPTY***, SMART TRIAGE, RED - **Empty bag – for re-issue if contaminated** ***Note: LHDs will need to order replacement green bags directly from Midmed**
710790	DISASTER PACK, SMART TRIAGE KIT, RED - **Full kit with contents** ***Note: LHDs will need to order replacement green bags directly from Midmed**

* For Replacement of the Green bags by LHDs, non-stock orders are to be quoted and ordered with the Supplier: MIDMED PTY LTD - 1300 643 633 www.midmed.com.au

CLOSED HEAD INJURY IN ADULTS – INITIAL MANAGEMENT (PD2012_013)

PD2012_013 rescinds PD2008_008.

PURPOSE

The purpose of this policy is to advise that the *Initial Management of Closed Head Injury in Adults* clinical practice guideline has been updated to reflect the latest evidence based practice for the management of adults with a closed head injury. The guideline provides clinicians with practical evidence based recommendations to assist in the initial management of adults with mild, moderate and severe head injury.

The policy is to ensure that all Local Health Districts have protocols in place based on the key principles of the guideline.

The clinical practice guideline was prepared for the Ministry of Health by an expert clinical reference group under the auspice of the NSW Institute of Trauma and Injury Management.

MANDATORY REQUIREMENTS

This policy requires all health services to have local guidelines/protocols based on the clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage patients with a closed head injury.

The clinical practice guideline reflects what is currently regarded as a safe and appropriate approach to the acute management of head injury. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. The document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. **It does not replace the need for the application of clinical judgement to each individual presentation.**

IMPLEMENTATION

Chief Executives must ensure:

- Local protocols are developed based on the *Initial Management of Closed Head Injury in Adults* clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage patients with a closed head injury.
- Ensure that all staff treating patients with a head injury are educated in the use of the locally developed protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating patients of the revised protocols.

1. BACKGROUND

1.1 About this document

The NSW Institute of Trauma and Injury Management (ITIM) has updated the *Initial Management of Closed Head Injury in Adults* clinical practice guideline to reflect the latest evidence based practice for the management of adults with a closed head injury.

The guideline is intended for use by clinicians in all facilities which provide initial care to the mild, moderate and severely head injured patient. The practical evidence based recommendations are regarded as a safe and appropriate approach to the acute management of adults with closed head injury. However, as with any clinical guideline the document should be used as a guide, rather than as a complete authoritative statement of procedures.

Each LHD must have clear and readily available protocols incorporating the following principles.

1.2 Key definitions

Must – indicates a mandatory action that must be complied with.

Should – indicates a recommended action that should be followed unless there are sound clinical reasons for taking a different course of action.

Mild head injury – a patient with an initial GCS score of 14-15 on arrival at hospital following acute blunt head trauma with or without a definite history of loss of consciousness or post traumatic amnesia.

Moderate head injury – a patient with an initial GCS score of 9-13 on arrival at hospital following acute blunt head trauma.

Severe head injury – a patient with an initial GCS score of 3-8 on arrival at hospital following acute blunt head trauma.

Post traumatic amnesia – period of time during which a person is unable to lay down new memories following an injury.

Post concussion syndrome – a set of symptoms which are commonly experienced following blunt acute head trauma. The symptoms may include headaches; dizziness; fatigue; memory impairment; poor concentration; mood swings; behavioural changes; sleep disturbances and social dysfunction.

2. KEY PRINCIPLES

2.1 Mild closed head injury

Patients with mild closed head injury (initial Glasgow Coma Scale 14-15) should be risk stratified into high and low risk groups based on the presence or absence of specified clinical risk factors.

Patients with a mild head injury should be assessed by a process of structured clinical assessment involving a combination of :

- Initial clinical history and examination.
- Serial clinical observations.
- CT scanning if clinically assessed as being at increased risk of clinically significant lesions requiring acute neurosurgical intervention or prolonged observation in hospital.

Patients with persistent acute clinical symptoms (including post traumatic amnesia, disorientation, confusion, drowsiness, dizziness, nausea, vomiting, headache) at four hours post injury require prolonged clinical observation; and a CT scan should be performed (if not already done) to exclude a structural lesion.

Where CT scanning is unavailable patients with high risk mild head injury will require either admission for prolonged observation or early transfer of CT scanning depending on clinical assessment of risk.

If a patient with mild head injury deteriorates, the priorities are exclusion of other injuries, supportive care of the ABCDEs and early CT scan to identify a neurosurgically significant lesion. If a neurosurgically significant lesion is identified, further management should be discussed with a neurosurgical service.

Mild head injury patients can be safely discharged for home observation after an initial period of in-hospital observation if they meet specified clinical, social and discharge advice criteria.

All patients with mild head injury must be given both verbal and written discharge advice covering signs and symptoms of acute deterioration, when to seek urgent medical attention, lifestyle advice to assist recovery, information about typical post concussion symptoms and reasons for seeking further medical follow up.

2.2 Moderate head injury

Patients who present initially with moderate head injuries should all have an early CT scan and close clinical observation. They should be admitted to hospital for at least 24 hours observation unless they rapidly return to normal, have a normal CT scan and absence of other clinical risk factors.

The majority of patients who suffer moderate head injuries will have some degree of cognitive behavioural social sequelae and should be considered for routine follow up with a brain injury rehabilitation service or a neurologist.

2.3 Severe head injury

Resuscitation with adequate oxygenation and fluid resuscitation and the treatment of other immediately life threatening injuries should be the priority for patients with severe head injury followed by the CT identification of focal intracranial lesions requiring acute neurosurgical intervention. Early intubation to prevent hypoxaemia and facilitate management is recommended.

A neurosurgical service must be consulted about further management of patients with severe head injury as soon as practical after the initial primary survey and resuscitation.

Patients with closed head injury assessed at hospitals without CT scanning facilities should be transferred to the nearest appropriate hospital if there is significant risk of intracranial injury. Transfer of patients to a hospital with CT scanning facilities but without neurosurgical services should be avoided wherever possible.

2.4 Analgesia

Most headaches associated with isolated mild head injury will respond to simple analgesia such as paracetamol. If paracetamol is ineffective as a sole agent then stronger analgesia such a oral opioids or parenteral opioids should not be prescribed to patients with isolated mild head injury unless the need for an initial or repeat CT scan to exclude clinically important intracranial lesions has been considered and a senior clinician has been consulted.

Most moderate head injury patients and nearly all severe head injury patients will require titrated intravenous analgesia and sedation for associated injuries, clinical management or intubation. These patients will all require close clinical observation in a high dependency area following initial clinical assessment and CT scanning.

2.5 Anti-convulsants

Post traumatic seizures are a recognised complication of closed head injuries with incidence depending largely on severity of injury. Acute post traumatic seizures occurring in hospital require systematic reassessment of the ABCDEs to exclude systemic causes and termination with benzodiazepines if required. Underlying structural lesions should be excluded with CT scan and then the need for prophylactic anti-convulsants considered.

Prophylactic anti-convulsants are not indicated for patients with uncomplicated mild head injury. Prophylactic anti-convulsants, such as phenytoin, should be considered in patients with complicated mild head injury or moderate to severe head injury who have specific risk factors that put them at increased risk of seizures. Clinical judgement is required and neurosurgical consultation is advisable.

3. LIST OF ATTACHMENTS

1. Initial Management of Closed Head Injury in Adults (2nd Ed)
   Available as a single document at:
   http://www.itim.nsw.gov.au/images/3/3d/Closed_Head_Injury_CPG_2nd_Ed_Full_document.pdf

2. Initial Management of Closed Head Injury in Adults (2nd Ed) Summary Document
   Available as a single document at:
   http://www.itim.nsw.gov.au/images/d/d0/Closed_Head_Injury_CPG_2nd_Ed_Summary_document.pdf

3. Algorithm: Initial Management of Adult Closed Head Injury
   Available as a single document at:
   http://www.itim.nsw.gov.au/images/8/83/Closed_Head_Injury_CPG_2nd_Ed_Algorithm_1.pdf

4. Algorithm: Initial Management of Adult Mild Closed Head Injury
   Available as a single document at:
   http://www.itim.nsw.gov.au/images/7/74/Closed_Head_Injury_CPG_2nd_Ed_Algorithm_2.pdf

5. **Implementation Checklist**

NSW PAEDIATRIC CLINICAL CARE AND INTER-HOSPITAL TRANSFER ARRANGEMENTS (PD2023_019)

PD2023_019 replaced PD2005_157

POLICY STATEMENT

NSW Health is committed to providing the right care, in the right place, at the right time and as close to home as possible. Many infants, children and adolescents will be able to receive the clinical care they need at a local service. If their needs are outside a service's capability and capacity to deliver the required care, an inter-hospital transfer must be arranged.

SUMMARY OF POLICY REQUIREMENTS

To provide appropriate clinical care and inter-hospital transfers for paediatric patients, NSW Health services must operate at their designated service capability level within agreed local health service arrangements and in partnership with transport and retrieval services. NSW Health services may also have local arrangements in place for paediatric inter-hospital transfers with specialist health services and retrieval services in bordering jurisdictions.

NSW Health organisations are to develop local guidance in line with this Policy Directive. This guidance must outline local arrangements for services (including Multipurpose Services) to follow when accessing clinical consultation to support care delivered locally as well as care involving inter-hospital transfer. Inter-hospital transfer processes are to include escalation of care to higher-level services and return transfer close to home when medically appropriate.

All services must work together to provide a network of care for NSW paediatric patients. Within local arrangements, higher-level services are responsible for providing lower-level services with support, advice and management of paediatric patients, including patients requiring inter-hospital transfer.

As supra-Local Health District services, Level 5 and 6 neonatal and Level 6 paediatric services must provide services for paediatric patients located within NSW and the ACT.

When an inter-hospital transfer is being considered, clinical decision-making must primarily match the paediatric patient's condition to the most appropriate service and consider:

- service capability and capacity of referring and receiving services
- capability and capacity of transport and retrieval services
- providing care as close to home as possible
- child and adolescent and family needs and preferences
- logistics such as weather and modes of transport.

Transfer decisions are to be made through discussion between responsible clinicians at the referring and receiving services. The Newborn and paediatric Emergency Transport Service (NETS) must be involved when an immediate response for transfer is needed and when clinical escort decisions require additional specialist clinical advice. NETS will facilitate care plan decision-making for these transfers through hosting conference calls with all clinical decision-makers.

Retrieval teams are responsible for the clinical care of a patient from the time of handover from the referring treating team until the patient is handed over to the destination service.

If an infant, child or adolescent in a hospital close to the border with an adjoining state requires a cross-border inter-hospital transfer, NETS will arrange transport or retrieval via NETS or NSW Ambulance or request the relevant jurisdiction's retrieval service to respond.

If a bordering jurisdiction's retrieval team is conducting the transfer, NETS will maintain contact with the referring treating team and provide clinical leadership until NETS confirms that the bordering retrieval team has taken over direct patient care. On handover, governance of the transport process moves to the bordering jurisdiction's transport/ retrieval service.

Management of urgency and risk are shared responsibilities of all parties involved in the transfer.

When transfer to higher-level care is required, the patient is to be appropriately transported within the medically agreed time frame to the nearest service that can provide the needed care. Treating teams at higher-level services are responsible for accepting referrals or finding an appropriate alternative if they do not have capacity to provide the needed care.

For return transfers, destination planning (identification of most appropriate service and bed-finding) is led by referring services and must be assisted by higher-level services if required.

Local health districts and the Sydney Children's Hospitals Network will optimise access to appropriate care close to home through services operating at their designated service capability level and actively managing patient flow.
Infants, children, adolescents and their families/carers are to be provided with timely, culturally appropriate and accessible information about clinical care, decisions and the transfer process.

A family member/ carer must be supported to travel with their child during an inter-hospital transfer wherever possible and appropriate, in consultation with the transport/ retrieval service.

Infants, children, adolescents and their families/ carers are to be offered relevant services and supports including through Aboriginal health workers, Aboriginal Maternal and Infant Health Service (AMIHS) staff, interpreters, cultural and diversity supports, social workers and other services as required.

The NSW Paediatric Clinical Care and Inter-Hospital Transfer Arrangements policy is available at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_019

DEPARTURE OF EMERGENCY DEPARTMENT PATIENTS (PD2014_025)

PD2014_025 rescinds PD2005_082.

PURPOSE

For the purpose of this policy, **'Departure from Emergency Department'** refers to patients leaving the Emergency Department (ED) whether they are to be discharged, admitted or transferred to another facility.

This policy outlines the principles for implementing a standardised approach to determining whether a patient is ready for departure from NSW EDs once the ED phase of their care is complete. These principles are to be implemented by NSW Public Health Organisations.

For information on patients awaiting care or commencement of clinical treatment please see **PD2013_047** ***'Triage of Patients in NSW Emergency Departments'*** and **PD2010_075** ***'Emergency Department Patients Awaiting Care'***.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations must:

- Ensure that local processes are in place which comply with this policy and support the four principles of readiness for departure from ED described here.
- Confirm that processes are in place in each ED to ensure that all patients are ready for departure from ED upon completion of the ED phase of their treatment and have been authorised as ready to depart. Readiness for departure from ED encompasses the following four principles:
  - The patient is safe for departure from a clinical and functional perspective.
  - The patient has had appropriate risk assessments undertaken prior to departure.
  - Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible.
  - Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred. Patients should be given post-discharge care instructions in plain language which is relevant to the individual and provides information that adequately describes follow up treatment. Communication must be undertaken with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED, particularly if there is a requirement for them to provide patient care or a request to follow up outstanding care requirements.
- Ensure all staff are aware of the 'Departure of Emergency Department Patients' policy and their responsibilities in relation to managing the departure from ED of patients.
- Ensure that the **Adult and Paediatric ED Observation charts** 'Departure and Discharge from ED' checklists are utilised to support implementation of this policy as per NSW Health policy **PD2013_049** ***'Recognition and Management of Patients who are Clinically Deteriorating'***. If the ED charts specifically are not used, that alternate local processes must be in place which demonstrate all information on the checklist being collected for patients.
- Ensure that local evaluation of compliance with this policy is undertaken. This should include internal review of incidents related to departure of patients from ED and review of consistency of use of the Adult and Paediatric ED Observation chart 'Departure and Discharge from ED' checklists (or equivalent local process).

IMPLEMENTATION

Local Health District and Specialty Health Network Chief Executives are responsible for:

- Assigning responsibility, personnel and resources to implement this policy.
- Establishing mechanisms to ensure that the mandatory requirements are applied, achieved and sustained as usual processes for departure of patients from ED; this should include nomination of an executive sponsor.
- Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management and other relevant staff.
- Ensuring that hospital and ED processes support the minimisation of delays for patients departing the ED, including limiting delays which may occur as a result of the requirement to complete the ED departure process.

a. BACKGROUND

1.1 About this document

For the purpose of this policy, 'Departure from Emergency Department' refers to patients leaving the Emergency Department whether it is to be discharged, admitted or transferred to another facility.

This policy directive and procedure replaces PD2005_082 *'Discharge Policy for Emergency Department at risk patients'*, which was developed in recognition that patients being discharged from Emergency Departments (ED) may be at risk of re-presentation or adverse events. The Special Commission of Inquiry, Acute Care Services in NSW Public Hospitals also recommended in 2008 that a checklist be implemented in NSW EDs to communicate the needs of a patient being admitted to an inpatient unit.

This policy and procedure seeks to encompass both of these elements by detailing a standardised approach for all patients who depart the ED. It describes the principles required to minimise the risk of adverse events for patients who have completed the ED phase of their treatment and have been authorised as ready to depart the ED.

In accordance with NSW Health policy **PD2013_049 *'Recognition and Management of Patients who are Clinically Deteriorating'*** this policy requires use of the NSW Health Standard Adult and Paediatric ED Observation Charts including the checklist for staff to complete for patients prior to leaving ED. If the charts are not used, alternative local processes must demonstrate that the information contained in the checklists is being collected.

This policy is also consistent with the Australian Charter of Healthcare Rights for patients described in NSW Health Policy **PD2011_022 *Your Health Rights and Responsibilities.***

1.2 Key definitions

At Risk	Refers to a patient who has been assessed as having an identified risk which is recognised to contribute to adverse events or readmissions upon leaving the ED.
Clinical Handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.
Emergency Department Departure	(ED Departure) refers to the transfer of responsibility and accountability for a patient's care upon leaving the ED. The patient may be admitted to an inpatient ward, be transferred to another facility or be discharged back to the community and their usual place of residence.
Left at Own Risk	Refers to any person who leaves the ED after treatment has commenced, against advice. The patient's health Care Record will reflect that the patient has been seen by Doctor/Nurse/Nurse Practitioner and will have a diagnosis.
Person Responsible	Refers to someone who has legal authority to make decisions on behalf of someone else who does not have the capacity to consent for themselves. A 'person responsible' is not necessarily the patient's next of kin. A 'person responsible' is either: • a **guardian** (including an enduring guardian) who has the function of consenting to medical, or dental treatment. or, if there is no guardian: • the most recent **spouse** or **de facto spouse** with whom the person has a close, continuing relationship. 'de facto spouse' includes same sex partners. or, if there is no spouse or de facto spouse: • an **unpaid carer** who is now providing support to the person or provided this support before the person entered residential care. or, if there is no carer: • a **relative** or **friend** who has a close personal relationship with the person. • The **NSW Civil & Administrative Tribunal**, **Guardianship Division** ***Note:*** *The above information has been provided by the NSW Civil & Administrative Tribunal,* ***Guardianship Division*** In accordance with **PD2005_406 *Consent to Medical Treatment – Patient Information*:** • A child aged 14 years and above may consent to their own treatment provided they adequately understand and appreciate the nature and consequences of the operation, procedure or treatment
Ready for Departure	Refers to a patient who has been authorised by senior ED staff as safe to depart the ED in accordance with the principles of this policy.
Risk Assessment	An activity that identifies risks, estimates their probability and the likely impact of their occurrence particularly in relation to adverse outcomes.

b. PROCEDURE FOR DETERMINING READINESS FOR DEPARTURE OF EMERGENCY DEPARTMENT PATIENTS

2.1 The four principles for determining readiness for departure of Emergency Department patients

Determination of a patient being ready for departure is a multidisciplinary process with ultimate responsibility resting with the senior ED medical officer and nurse in charge of shift of the ED or their delegates. Readiness for departure from ED encompasses the following principles:

1. The patient is safe for departure from a clinical and functional perspective.
2. The patient has had appropriate risk assessments undertaken prior to departure.

3. Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible.
4. Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred; as well as communication with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED.

2.2.1 Clinically and functionally safe for departure

When deeming a patient clinically safe for departure the following aspects must be met:

- The patient will be 'between the flags' with respect to recorded observations or there will be documented alterations to calling criteria on the relevant NSW Standard Observation Chart where this is appropriate for the patient. Patients who are leaving the ED for higher level care (e.g. Intensive Care Unit) are often unstable and may not be 'between the flags' – this should not delay departure from ED.
- All appropriate diagnostic tests will be completed or there is a documented plan of who is responsible to follow up outstanding tests and results. A management plan is documented including a provisional or definitive diagnosis and this is communicated to relevant health professionals.
- The patient is departing for a location that has a level of supervision or clinical care consistent with their clinical condition and risk assessment.

2.1.2 Risk assessment

There are many health risk assessment tools and guidelines available to clinicians – not all are suitable to be undertaken in the ED. Appropriate risk assessment should be undertaken at the discretion of the treating clinician and according to patient clinical need and local procedures.

In addition to clinical risk identification; mental health, social and cultural aspects that are likely to impact on the patient's readiness for departure from the ED must be considered.

If a patient is determined to be at risk; documentation and a corresponding risk mitigation process should be enacted.

Possible risks include, but are not limited to:

- Level of supervision required for discharge.
- Availability and accessibility of competent supervision if required.
- Competency to access transport or the provision of own transport.
- Ability to comply with discharge instructions including access to other health providers e.g. GPs and pharmacies.
- Need for specialist care within an inpatient unit or the requirement for inter-hospital transfer.
- Patients with undifferentiated diagnoses.
- Evolving or rapidly progressing disease processes.
- Indication for additional resources including equipment and personnel that is not currently available.
- Unsafe home environment/circumstances e.g. departure of elderly patients to home at night, known domestic violence situations.
- Complex social situation/circumstances where significant allied health intervention is required e.g. **homelessness**.

2.1.3 Risk mitigation

Not all risks can be mitigated in the ED, however every effort should be made to identify and manage potential risks during assessment and treatment in the ED. Referral to appropriate services to manage identified risks should occur as early as possible, this may include Mental Health Services, Aboriginal Liaison Officers or Allied Health services.

Departure from the ED must not take place if significant risk has been identified and these risks cannot be managed after ED Departure, or if the patient requires the supervision of a responsible adult for appropriate ED Departure and this cannot be ensured. A local facility protocol should identify the process to be undertaken in this situation (e.g. transfer to inpatient unit if appropriate).

2.1.4 Communication of the Patient's care needs

The communication of information to patients, carers and other health professionals about the ongoing care needs of the patient is essential to ensuring continuity of care.

PD2009_060 *'Clinical Handover – Standard Key Principles'* clearly states the requirements for the transfer of information, accountability and responsibility for a patient or group of patients between clinicians. The elements relevant to the clinical handover should be addressed as per the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists.

Patients departing the ED for inpatient wards
Patients departing the ED for inpatient wards should have a clinical handover process completed with the relevant ward staff which details the patient's plan of care and any outstanding tests and actions that require follow up.

Documentation is to be complete as per **PD2012_069 *Health Care Records - Documentation and Management*** as well as other relevant information to ensure ongoing care of the patient pending review of the inpatient team (e.g. interim orders for analgesia and other medications charted, progress notes completed).

Patients departing the ED for another facility
Patients departing ED for another facility must have communication managed as per **PD2011_031 *'Inter-facility Transfer Process for Adults Requiring Specialist Care'*** and **PD2010_031 *'Children and Adolescents – Inter-Facility Transfers'***

Communication for the Transfer of Critically ill patients is as per **PD2010_021 *'Critical Care Tertiary Referral Networks & Transfer of Care (Adults)'*** and **PD2010_030 *'Critical Care Tertiary Referral Networks (Paediatrics)'***

Patients departing the ED for home or usual place of residence
Patients departing the ED for home or their usual place of residence require adequate instruction to ensure the patient (and/or family/carer where appropriate) is aware of ongoing care requirements.

Not every patient requires a formally written discharge letter; however information should be given to the patient which adequately describes follow up treatment. This may be verbal instruction, patient fact sheets with information about their condition or details of who to call or follow up with regarding their treatment and any referrals made to other services.

The method of information given should be at the discretion of the treating clinician and take into account the patient's understanding of information and any cultural, language and social requirements to assist with understanding of information. Documentation in the patient's Health Care Record of the method used is appropriate, e.g. if verbal instruction only is given or a copy of the discharge letter.

Efforts should be made to contact Residential Aged Care Facility staff to notify them of the resident's return to the facility.

Discharge letter

If further care by another health professional is required, then a discharge letter is appropriate. The letter should include information about the ED treatment, details of test results carried out in the ED or results which require follow up, any changes to medications and any other relevant information required to ensure continuity of the patient's care. A copy of the letter should remain in the patient's Health Care Record.

Authorisation to depart ED

All patients leaving the ED require authorisation that they are ready to depart the ED. This is the responsibility of senior medical and nursing staff in the ED (or their delegate) and should be indicated on the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists (or documented as per equivalent local process).

In EDs where there is no senior medical staff on site, delegation of authorisation to depart the ED will be according to locally agreed to and communicated processes.

c. PATIENTS WHO 'LEFT AT OWN RISK'

A competent adult patient has the right to refuse medical treatment for themselves or their children/dependents. A person is incapable of giving consent if they are not "competent'. There is no single legal test or definition of competency. However, in order to be competent to consent to or refuse treatment, a patient must be able to comprehend and retain treatment information and consider the information in order to reach a decision.

The **Guardianship Act 1987** provides methods for obtaining consent to treat those persons who are incapable of giving consent. A designated Person Responsible may substitute if the patient is unable to given consent.

All reasonable measures must be undertaken to manage the patient who expresses the wish to leave the ED against medical advice.

This includes ensuring the patient:

- Is counselled by appropriate staff against leaving against medical advice. All attempts to convince the patient to stay should be documented in the patient's Health Care Record.
- Has had the potential consequences of leaving the ED explained in plain language which is relevant to the individual (by the senior doctor/nursing staff or their delegate) including the use of interpreters/Aboriginal Liaison Officer if necessary. This must be explicitly documented in the patient's Health Care Record.
- Is competent to make the decision to leave.
- Is given advice on follow up options.
- Is given the option to return.
- Is encouraged to call to inform a friend or relative, or allow the ED staff to do so where appropriate.
- If appropriate has consulted with an Aboriginal Liaison Officer to ensure culturally appropriate treatment options.

Should a patient be found to have left the ED without the knowledge of staff and there are concerns for the patient's or other's safety, actions taken will be in consideration of both the patient's level of competence to make the decision as well as the risk (clinical or otherwise) to the patient/others.

Section 2.5.2 of **PD2012_060 *Transfer of Care from Mental Health Inpatient Services*** provides specific detail on Procedures for locating missing patients which can be applied to the ED setting, particularly for patients being detained under the *Mental Health Act 2007*.

Attachment 1: Adult ED Observation Chart 'Departure and Discharge from ED' checklists.

NSW Health

Facility: _____

ADULT EMERGENCY DEPARTMENT OBSERVATION CHART

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE

PROVISIONAL DIAGNOSIS:

Admitting Consultant name:
Delegate name (If applicable):
Accepted Care of patient
Date:
Time:

Clinical Plan explained to patient /carer Yes ☐
Clinical Plan documented in progress notes Yes ☐
Admission completed by:
ED Medical Officer name:
ED Medical Officer signature:

ED to WARD DEPARTURE CHECKLIST

NURSING

Verified that all documentation is complete
- Admission/Transfer forms/eMR ☐
- Medications charted Yes ☐ N/A ☐
- Analgesia charted Yes ☐ N/A ☐
- IV Fluids charted Yes ☐ N/A ☐
- Fluid Balance up to date ☐
- Progress notes up to date ☐
- Risk assessments completed ☐

Diet: Eat & Drink ☐ Nil By Mouth ☐ IVT ☐ NG ☐

Infection status:

Precautions / Isolation required Yes ☐

Specify: Contact Precautions / Respiratory

Patient belongings sent to ward Yes ☐ N/A ☐

Medication sent to ward Yes ☐ N/A ☐

Ward accepting care:
Ward Nurse accepting care:
ED Nurse Transferring name:
ED Nurse transferring sign:

MEDICAL

Medical Handover given Yes ☐ No ☐
Outstanding results and actions handed over:

1.
2.
3.
4.
5.

Medical Officer Accepting Care name:

ED Medical Officer providing handover
Name:
Sign:
Date:
Time:

AUTHORISATION FOR DEPARTURE FROM ED TO WARD

NURSING

Observations within the last hour Yes ☐

Is the patient 'Between the Flags' Yes ☐ No ☐

If not, clinical reason and plan is documented and signed ☐

Alterations to calling criteria charted Yes ☐ No ☐ N/A ☐

Altered frequency for observations charted Yes ☐ No ☐ N/A ☐

Authorised as safe for transfer Yes ☐
NUM/ Senior ED Nurse name:
NUM/Senior ED Nurse sign:
Date: **Time:**

MEDICAL AUTHORISATION

Authorised as safe for transfer Yes ☐
ED Medical Officer name:
ED Medical Officer sign:
Date: **Time:**

AUTHORISATION FOR DISCHARGE FROM ED TO HOME

NURSING

Cannula / ID Band removed Yes ☐
Discharge / Referral Letter Yes ☐
Discharge Prescription Yes ☐
Fact Sheet Yes ☐
Clothes / Belongings Yes ☐

Authorised as safe for discharge Yes ☐
NUM/ Senior ED nurse name:
NUM/Senior ED nurse sign:
Date: **Time:**

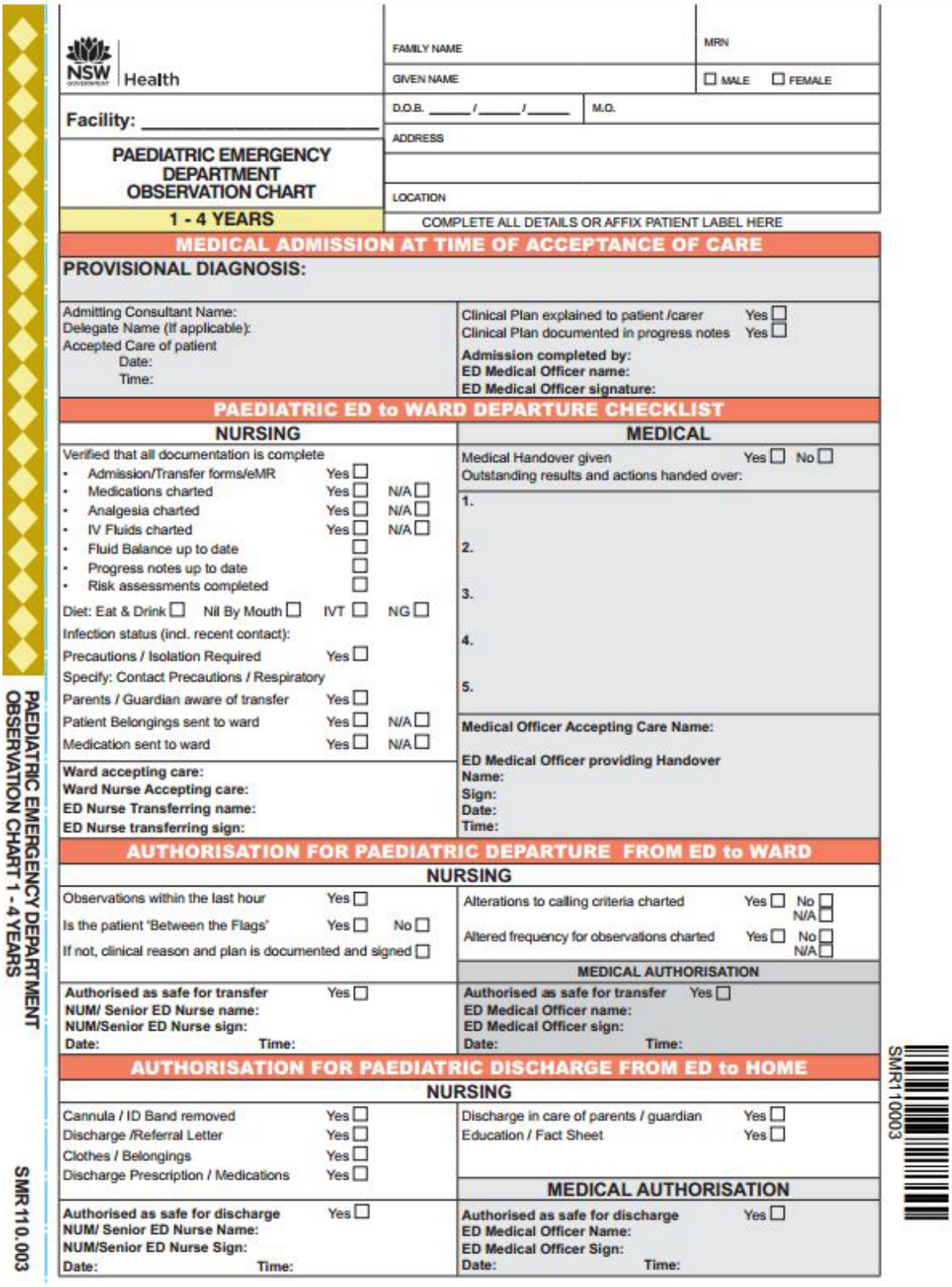
ELDERLY:
Does the patient live alone Yes ☐ No ☐
Time of discharge appropriate Yes ☐ No ☐
NOK/person responsible aware? Yes ☐ No ☐
Nursing Home / Hostel aware? Yes ☐ No ☐

MEDICAL AUTHORISATION

Authorised as safe for discharge Yes ☐
ED Medical Officer Name:
ED Medical Officer Sign:
Date: **Time:**

ADULT EMERGENCY DEPARTMENT OBSERVATION CHART SMR040.010

Attachment 2: Paediatric ED Observation Chart 'Departure and Discharge from ED' checklists



NSW Health

Facility: _____

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART

1 - 4 YEARS

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE

PROVISIONAL DIAGNOSIS:

Admitting Consultant Name:
Delegate Name (If applicable):
Accepted Care of patient
Date:
Time:

Clinical Plan explained to patient /carer Yes ☐
Clinical Plan documented in progress notes Yes ☐
Admission completed by:
ED Medical Officer name:
ED Medical Officer signature:

PAEDIATRIC ED to WARD DEPARTURE CHECKLIST

NURSING

Verified that all documentation is complete
- Admission/Transfer forms/eMR Yes ☐
- Medications charted Yes ☐ N/A ☐
- Analgesia charted Yes ☐ N/A ☐
- IV Fluids charted Yes ☐ N/A ☐
- Fluid Balance up to date ☐
- Progress notes up to date ☐
- Risk assessments completed ☐

Diet: Eat & Drink ☐ Nil By Mouth ☐ IVT ☐ NG ☐
Infection status (incl. recent contact):
Precautions / Isolation Required Yes ☐
Specify: Contact Precautions / Respiratory
Parents / Guardian aware of transfer Yes ☐
Patient Belongings sent to ward Yes ☐ N/A ☐
Medication sent to ward Yes ☐ N/A ☐

Ward accepting care:
Ward Nurse Accepting care:
ED Nurse Transferring name:
ED Nurse transferring sign:

MEDICAL

Medical Handover given Yes ☐ No ☐
Outstanding results and actions handed over:
1.
2.
3.
4.
5.

Medical Officer Accepting Care Name:

ED Medical Officer providing Handover
Name:
Sign:
Date:
Time:

AUTHORISATION FOR PAEDIATRIC DEPARTURE FROM ED to WARD

NURSING

Observations within the last hour Yes ☐
Is the patient 'Between the Flags' Yes ☐ No ☐
If not, clinical reason and plan is documented and signed ☐

Alterations to calling criteria charted Yes ☐ No ☐ N/A ☐
Altered frequency for observations charted Yes ☐ No ☐ N/A ☐

MEDICAL AUTHORISATION

Authorised as safe for transfer Yes ☐
NUM/ Senior ED Nurse name:
NUM/Senior ED Nurse sign:
Date: **Time:**

Authorised as safe for transfer Yes ☐
ED Medical Officer name:
ED Medical Officer sign:
Date: **Time:**

AUTHORISATION FOR PAEDIATRIC DISCHARGE FROM ED to HOME

NURSING

Cannula / ID Band removed Yes ☐
Discharge /Referral Letter Yes ☐
Clothes / Belongings Yes ☐
Discharge Prescription / Medications Yes ☐

Discharge in care of parents / guardian Yes ☐
Education / Fact Sheet Yes ☐

MEDICAL AUTHORISATION

Authorised as safe for discharge Yes ☐
NUM/ Senior ED Nurse Name:
NUM/Senior ED Nurse Sign:
Date: **Time:**

Authorised as safe for discharge Yes ☐
ED Medical Officer Name:
ED Medical Officer Sign:
Date: **Time:**

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART 1 - 4 YEARS

SMR110.003

SMR110003

NSW CRITICAL CARE TERTIARY REFERRAL NETWORKS & TRANSFER OF CARE (ADULTS) (PD2018_011)

PD2018_011 rescinds PD2010_021.

PURPOSE

This Policy Directive refers to critically ill or injured adult patients and those **at risk of critical deterioration** requiring referral and transfer of care to a higher level facility.

The policy defines the links between Local Health Districts (LHDs) and tertiary referral hospitals and takes into account established functional clinical referral relationships.

The policy outlines the roles of state clinical specialty referral networks that operate in conjunction with the NSW Critical Care Tertiary Referral Networks (Section 10). It describes the process for time urgent and non-time urgent patients, referral process for retrieval services, the default adult intensive care unit (ICU) bed policy and the requirement for LHD escalation processes.

MANDATORY REQUIREMENTS

- Access to emergency care and/or surgical intervention for time urgent critically ill or injured patients must not be delayed due to “no-available” ICU or specialty bed e.g. burns, cardiac or spinal. Should this situation arise Aeromedical Control Centre (ACC) is to be contacted immediately.
- Requirements for transfer of critically ill obese patients outlined in Section 6 must be applied.
- Each LHD must have documented and implemented escalation plans to ensure the appropriate accommodation of critically ill or injured patients. This should include procedures for clinicians to obtain timely clinical advice and/or support to expedite the review and referral of non-time urgent critical patients (Section 8). Escalation plans must also include procedures for clinicians to follow in instances where an appropriate bed is not available within the network or difficulties are experienced with patient acceptance and placement.
- Every hospital is linked to a designated tertiary referral hospital which is networked to a group of referring hospitals to provide critical care for their patients. In situations where no adult intensive care beds are available across NSW, the default adult ICU bed policy may be invoked (Section 12). When the default policy is invoked the designated tertiary hospital is responsible for providing critical care, irrespective of bed status, to a specified group of referral hospitals. This responsibility includes assisting with patient placement to an appropriate alternative location for treatment and care.
- In time urgent situations the ACC has the authority to transport the patient directly to the designated tertiary hospital regardless of available bed state. If there is a closer hospital that can provide the time urgent treatment required, ACC may elect to transport the patient there. This may include referral across LHD boundaries. In each case the ACC Consultant must notify the receivingclinician.

IMPLEMENTATION

Local Health District Chief Executives are responsible for:

- Ensuring implementation of the policy directive and the delegation of a single point of arbitration and decision making to ensure clinically appropriate transfers in appropriate timeframes.
- Meeting the critical care and intensive care needs of that LHD and linked rural LHD, where specified. This includes the provision of clinical advice and ensuring access to appropriate treatment.
- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe. 298(28/03/18)

- Ensuring that all options for placement of the critically ill patient within the originating LHD have been explored. This includes appropriate transfers from ICUs within the LHD to inpatient areas to create capacity.
- Ensuring the continued effective operation of the NSW Critical Care Tertiary Referral Network.
- Ensuring formalised intra and inter-LHD referral and/or cross jurisdictional arrangements exist for critically ill or injured patients needing a higher level of definitive care and include ongoing formal communication with review and feedback.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.
- Ensuring that compliance with this policy is audited and regularly monitored in collaboration with intra and inter-LHD stakeholders.

Intensive Care Units are responsible for:
- Ensuring the information in the Critical Care Resource management System (CCRS) or Patient Flow Portal (PFP) is current and correct at each shift handover.
- Bed finding for non-time urgent critically ill or injured patients

Patient Flow Units/Bed/ After Hours Managers are responsible for**:**
- Facilitating referrals for all non-time urgent critically ill patients.

The NSW Aeromedical Control Centre (ACC) (**1800 650 004)** is responsible for:
- Coordination of adult medical retrieval for time urgent critically ill patients in collaboration with the Regional Retrieval Services across NSW.

1 Background

1.1 About this document

This policy directive provides guidance on the appropriate process for referring and transferring critically ill or injured adult patients to a higher level facility for definitive care.

Patients who are critically ill, injured or at risk of critical deterioration need appropriate access to critical care resources. In order to achieve safe, timely and efficient transfer of these patients to a higher level facility a streamlined process must exist. This document aims to support a seamless and integrated network of critical care services to best meet the needs of patients.

State clinical specialty referral networks operate in conjunction with the critical care networks.

These networks assist in ensuring appropriate and timely patient referral and transfer. Once critical care resources are no longer required by the patient a similarly efficient return transfer to the originating hospital is essential.

The Critical Care Resource management System (CCRS) provides information about available adult critical care beds across NSW. CCRS should be used to inform coordination and placement of critically ill patients to the appropriate higher level facility.

The Aeromedical Control Centre (ACC) is responsible for the statewide coordination of adult medical retrieval services for time urgent critically ill or injured patients in collaboration with the Regional Retrieval Services. The ACC is the central point of contact for the medical retrieval of all time urgent critically ill or injured adult patients.

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Each Local Health District (LHD) is responsible for ensuring that escalation plans are in place to ensure clinicians can obtain timely clinical advice and/or support to expedite the review, referral and

appropriate placement of critically ill or injured patients. This must include procedures for clinicians to follow for referral of non-time urgent critically ill patients in situations where there are no appropriate beds and negotiation with the receiving hospital is required (Appendix 2).

Implementation of local models, such as the Greater Western Critical Care Advisory Service (CCAS), should be considered to provide critical care specialist advice and support when required.

This policy does not include referral of paediatric, neonatal, obstetric or patients requiring specialist care and does not override referral networks established within the following policy directives:

- Critical Care Tertiary Referral Networks (Paediatrics) PD 2010_030 1
- Critical Care Tertiary Referral Networks (Perinatal) PD 2010_069 2
- Inter-facility Transfer Process for Adults Requiring Specialist Care PD2011_0315

Table 1 provides a summary of the referral process, contact pathways and responsibilities for time urgent and non-time urgent critically ill patients.

Table 1: Referral Process Summary

Referral Process Summary					
Clinical Condition	**Urgency of Transfer**	**Contact**	**Bed finding responsibility**	**Initiating Transport**	**Transfer to**
Critically ill or injured	**Time urgent** Fastest response and or transport by appropriate team (often medical retrieval team)	ACC [1] Advice for stabilisation and transfer	ACC[1] Patient automatically transported to nearest hospital that can provide definitive care without delay Hospital acceptance or available bed is desirable but not mandatory NB: Communication **must** occur with the receiving hospital prior to transfer	ACC [1]	Linked Tertiary Hospital
	Non-time urgent Response and or transport by appropriate team within appropriate timeframe (often medical retrieval team)	Linked Tertiary Hospital for ICU advice	Linked Tertiary Hospital using CCRS[2]/PFP and PFU[3]/hospital bed manager	Referring clinician contact ACC[1]	Linked Tertiary Hospital
Require Specialist Care	Refer to Inter-facility Transfer Process for Adults Requiring Specialist Care PD2011_0315				

1 Aeromedical Control Centre (ACC) 1800 650 004
2 Critical Care Resource management System (CCRS) http://ccrs.health.nsw.gov.au
3 Patient Flow Unit (PFU) and Hospital Bed managers cannot refuse transfer of time urgent critically ill patients

Key definitions

Aeromedical Control Centre (ACC): A NSW Ambulance unit providing clinical support and advice, transport and escort services for critically ill or injured patients requiring medical retrieval.

Conference call: "One phone call" referral where possible to connect the referring clinician, medical retrieval consultant and receiving clinician.

Critical Care Resource management System (CCRS): provides information about available adult critical care beds across NSW to inform coordination and placement of critically ill patients to the appropriate level of definitive care.

Critically ill/injured: A patient whose illness, injuries or physiologic instability constitutes a significant and imminent threat to their life without appropriate resuscitation and support. Patients may be classified as:

- **Time urgent:** Requiring emergency care at the closest appropriate hospital in the shortest time possible to achieve early intervention and stabilisation.
- **Non-time urgent:** Stabilised requiring transfer for a higher level of definitive critical care or clinical specialty, but whose transfer is not time-urgent.

Patient at risk of critical deterioration: A patient who has suffered a significant injury or illness who may appear to be stable but whose condition may quickly deteriorate requiring constant monitoring and early transfer for definitive critical care.

Non-critical patient requiring specialist definitive care: A patient requiring referral and transfer for specialist care facilitated by the LHD Patient Flow Unit in consultation with the patient's clinical management team.

Escalation process: Defined procedure for escalation for decision making, when an issue regarding patient transfer arises which will impact on the patient accessing safe and timely care within the medically agreed timeframe.

Major Trauma Service (MTS): Can provide the full spectrum of care for major and moderately injured trauma patients.

Neonatal and paediatric Emergency Transport Service (NETS): A medical retrieval service for babies and children who require intensive care.

Patient Flow Portal (PFP): Electronic system which aims to improve patient flow within a ward, hospital or LHD.

Patient Flow Unit (PFU): Responsible for managing patient flow within a given facility or LHD. In rural areas this may be a bed or after hours manager.

Primary Retrieval: A patient transferred directly from the scene of an incident or medical emergency to hospital.

Regional Trauma Service (RTS): Can provide all aspects of care to patients with moderate to minor trauma, and definitive care to a limited number of major trauma patients in collaboration with the MTS

.**Secondary Retrieval:** A patient transferred between health facilities.

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2 NSW Critical Care Tertiary Referral Networks (Adults)

The NSW adult Critical Care Tertiary Referral Networks define the links between LHDs and tertiary referral hospitals. The networks take into account established clinical referral relationships which may include referral patterns across LHD boundaries and cross jurisdictional border arrangements. In

addition, some ICUs may have functional links with a higher level ICU in a networked approach to provide access to senior critical care advice under the Intensive Care Service Model.3

It is not the intention of this policy directive to specify each individual hospital's referral pathways. The referral pathways defined within this document are the established links and the **default** patterns to be used when the default adult ICU bed policy is invoked (Section 12).

Operating in conjunction with the critical care referral networks are state clinical specialty referral networks, which are also defined within this Policy Directive. These referral networks and processes are in place to assist clinicians and Patient Flow Units (PFU) to ensure appropriate and timely referrals. These include:

- NSW Burn Injury Service (Adult)
- NSW Acute Spinal Cord Injury Service (Adult)
- NSW Major Trauma Referrals (Adult)
- NSW Rural Cardiac Catheterisation Services (Adult)
- NSW Extra Corporeal Membrane Oxygenation (ECMO) MedicalRetrieval

Table 2 outlines the Critical Care Tertiary Referral Networks for critically ill adult patients requiring transfer to a tertiary facility. These are also the default network for private hospitals within LHDs. Due to proximity some LHDs may also have cross jurisdictional border networks with tertiary critical care services in other states and territories, as outlined below.

Table 2: NSW Adult Critical Care Tertiary Referral Network

Referring LHD	Receiving Tertiary Hospital
Central Coast	Royal North Shore
Far West	Royal Prince Alfred, South Australia (Adelaide)1
Hunter New England	John Hunter
Illawarra Shoalhaven	St George
Mid North Coast	John Hunter, Queensland3
Murrumbidgee	ACT2 (Canberra), Prince of Wales, St George, St Vincent's, Victoria (Mlb)4
Nepean Blue Mountains	Nepean
Northern NSW	John Hunter, Queensland3
Northern Sydney	Royal North Shore
South Eastern Sydney	Prince of Wales, St George
South Western Sydney	Liverpool
Southern NSW	ACT (Canberra)2, Prince of Wales, St George
Sydney	Royal Prince Alfred
Western NSW	Royal Prince Alfred
Western Sydney	Westmead
Due to proximity some LHDs and facilities also maintain clinical referral networks as follows: • Far West: South Australia1. • Murrumbidgee: ACT 2 (Batlow, Boorowa, Murrumbarrah-Harden, Tumut, Young), Victoria 4 (Albury) • Mid North Coast: Queensland 3. • Northern NSW: Queensland 3 (Tweed) • Southern NSW: ACT2 (Bateman's Bay, Bombala, Boorowa, Braidwood, Crookwell, Cooma, Delegate, Goulburn, Moruya, Pambula, Queanbeyan South East Regional (Bega) and Yass)	

3 **Which Adults May Need Medical Retrieval?**

Patients with actual *or* ***potential*** **significant illness or injuries who are at risk of critical deterioration** and **may** require retrieval in the event that the originating hospital is unable to safely continue care include:

Airway
- All intubated patients
- Patients potentially requiring airway intervention enroute (threatened airway obstruction, altered or decreasing LOC, head/neck trauma, head/neck / inhalation burns)

Breathing
- Significant respiratory distress or compromise after treatment
- RR < 8 or >30, SpO2 < 90% on 15L oxygen
- Pa02 <60 or PaC02 >60 or pH < 7.2 or BE <-5
- Respiratory dependency on NIV

Circulation
- Circulatory shock of any cause
- Heart rate < 40 or > 140 beats per minute with compromise
- SBP ≤ 90mmHg
- Complex or recurrent arrhythmias with compromise (e.g. recurrent VF, sustained VT, CHB)
- Ongoing significant bleeding

Disability
- Significant altered LOC - GCS ≤ 13
- Significant head injury
- Severe burns
- Acute spinal cord injuries
- Recurrent or prolonged seizures
- Intracerebral bleeding

Other
- Acute life-threatening electrolyte abnormality

Note: This list does not necessarily indicate time urgent, but is a list of patients who may need physician-escorted retrieval

4 NSW Aeromedical Control Centre (ACC)

The Aeromedical Control Centre (ACC) is a unit of NSW Ambulance which provides statewide 24-hour coordination and support:

- For **time urgent** critically ill or injured patients, the ACC will provide critical care clinical advice from a critical care consultant, location of and referral to an appropriate receiving hospital and mobilise a medical retrieval team (Section 7).
- For non-time urgent critically ill or injured patients, the ACC will organise and mobilise an appropriate clinical team (usually physician escort) (Section 8).
- The ACC will coordinate and mobilise an appropriate medical retrieval team for all medical retrievals (from both public and private facilities, to public facilities).
- Where possible; the ACC will coordinate a one phone call referral via conference call to connect the referring clinician, retrieval consultant and receiving clinician. The
- ACC and regional Ambulance Control Centres monitor all 000 calls for mechanisms and injuries suggestive of severe trauma, and dispatch appropriate retrieval teams (usually Doctor/paramedic) where indicated.
- The medical retrieval team can provide a variety of interventions including; advanced airway management, chest trauma management, advanced vascular access, transfusions, compression of bleeding sites and some time urgent surgical procedures where no viable alternative exists.

The ACC is **not** responsible for coordinating the transfer of non-critically ill patients. These patients must be managed by the LHD as per Section 9.

5. Key Elements of the Medical Retrieval System

- The ACC provides statewide coordination of adult medical retrieval services, in collaboration with the regional retrieval services.
- Retrievals may be undertaken by road, fixed wing aircraft or helicopter. Vehicle choice is based on the clinical urgency, transport requirements, optimum transport team, vehicle utilisation and available resources.
- All retrieval services can transport critically ill or injured patients by road ambulance using appropriate advanced medical equipment and clinical staff. An overview of adult retrieval services can be found at Table 3.
- Fixed wing aircraft and helicopters are not capable of safe flight in adverse weather conditions. The ACC uses a protocol to balance clinical priority and aviation risk. Factors such as fatigue, darkness and cold temperatures (fog, icing) increase aviation risk. Therefore, non-urgent transfers are not usually undertaken between midnight and 0700hrs.
- Aviation factors may influence the destination hospital and in some cases alternatives such as long road transfers, with or without an appropriate medical retrieval team, may be necessary.
- Critically ill or injured patients must be transferred to the nearest (in-time) designated appropriate facility (e.g. Major Trauma Service), irrespective of ICU bed status, so that emergency stabilisation and treatment can commence with minimal delay.
- In some cases, the referring clinician, retrieval consultant and receiving clinician may decide to refer a patient to a different hospital which is considered more clinically appropriate for that patient’s definitivecare.
- Ultimate responsibility for vehicle and team choice rests with the ACC retrieval consultant, with input from relevant stakeholders. Where there is a difference in clinical opinion regarding the appropriateness of the transfer, the final decision will be made by the ACC. This will follow a conference call between the referring clinician, retrieval consultant and receiving clinician, as per retrieval resources (Appendices 5-7).

Table 3: Overview of adult aeromedical retrieval services

Overview of adult medical retrieval services							
Aircraft	Location	Uses	Number of aircraft	Patient capacity	Bariatric capacity Max	IABP transfers	ECMO transfers
Fixed Wing	**Broken Hill** (Royal Flying Doctor Service)	Inter hospital transfer Primary mission Outreach clinic service	1	1 -2	230kg	Fixed wing and helicopters are capable of IABP and ECMO transfer Originate from Sydney and require specialist medical staff and equipment	
	Dubbo (Royal Flying Doctor Service)	Inter hospital transfer	1	1 -2			
	Sydney (Bankstown)	Inter hospital transfer	4	1 -2			
Helicopter	**Sydney** (Bankstown)	Primary mission	3	1 critically ill 2 in some cases	130kg* / 200kg		
	Lismore	Retrieval	1				
	Tamworth		1				
	Newcastle (JHH)	Search & rescue	1				
	Orange	Water Rescue	1				
	Wollongong		1				
	Canberra		1				

* Standard helicopter stretcher capacity is 130kg. Patients exceeding this need a 200kg stretcher and the ACC must be advised of this need in advance. Other requirements outlined in section 6 must also be met.

6. Obese Patients

The transfer of critically ill or injured obese patients can be clinically and logistically challenging. Different vehicles and stretchers are used to transport obese patients and limitations in weight capacity need to be considered including:

- The weight the stretcher, loading and securing mechanisms, and vehicle floor can support
- The stretcher width and whether the patient can physically fit and be restrained safely.

The transfer of obese patients by any vehicle is usually much slower than normal transfers. Occasionally the retrieval may occur in two separate stages; with rapid dispatch of clinical retrieval staff to aid in resuscitation the first step, followed by transport to definitive care.

Prior to commencing retrieval of any patient above 110kg, an **accurate** weight and maximum measured width must be determined, as per Bariatric Sizing Chart (Appendix 5). **Hospitals must ensure they can weigh patients**, as an estimate is unacceptable and may result in delays as alternative vehicles, stretchers and restraint systems are sourced.

In addition to the patient's weight and measurement, any logistical issues and resource requirements such as sufficient personnel, equipment and facilities to transport the patient to and into the vehicle must be considered, as per Table 4. Lack of resources may delay or negate the possibility of transfer or necessitate road transfer irrespective of distance.

At the time of retrieval request, the above information must be communicated to the ACC to help determine the most appropriate mode of transport.

The NSW Health Guideline GL2005_070 "*Occupational Health & Safety Issues Associated with Management of Bariatric (Severely Obese) Patients"* 4 should be referred to for the management of obese patients.

Table 4: Retrieval transport modes and resource considerations

Vehicle type	Road	Road Multi Purpose Vehicles (MPVs)	Fixed wing	Helicopter
Maximum weight	200kg	Any weight and size	230kg	130kg - normal stretcher 230kg - bariatric stretcher (must be added **before** leaving base)
Considerations	Patient width	Limited number of vehicles May not be available in suitable timeframe, depending on patient location	Can road legs to / from airports accommodate patient weight	Onsite concrete helipad Flat paved pathways into/out of hospital
Resources	Sufficient personnel Equipment and facilities to transport patient to and into vehicle: • Manual handling aides • Height adjustable trolley (as per below)			
Hospital trolley	Minimum safe working load	300kg		
	Height adjustable	660mm to 1020mm above ground level		
	Patient platform length	2 metres- with no raised edging at one end		
	Patient platform width	700mm		
	Patient platform surface	Smooth with raised edges on both sides and one end		
	Patient restraint system	Must have		
	Large wheels	Suitable for manoeuvring from hospital to helipad		
Bariatric chart	Complete and return to ACC as soon as possible			
Contact ACC	Provide weight, measurement and logistical considerations as soon as possible to inform transport mode			

[1] Standard helicopter stretcher capacity is 130kg. Patients exceeding this need a 200kg stretcher and the ACC must be advised of this in advance.

7. Time Urgent Patients Requiring Critical Care Referral

The ACC should be the first point of contact for all time-urgent critically ill or injured patient referrals, as per Appendix 1. PFUs should **not** be the first point of contact.

The ACC will provide critical care clinical advice, referral to the appropriate linked tertiary hospital consultant, bed finding and patient transfer for **time urgent** critically ill or injured patients from public and private facilities to public facilities.

Some examples of time-urgent patients include; traumatic head injury requiring urgent craniotomy, exsanguinating multi trauma patient, STEMI with cardiogenic shock, severe burns, acute spinal cord injury with motor sensory level and uncontrolled bleeding with ongoing shock after resuscitation from gastrointestinal or obstetric blood loss.

All time urgent transfers must be discussed with a retrieval consultant, even if the referring clinician believes a medical retrieval will not be the best option for the patient. There are added risks involved with transferring patients between hospitals without appropriately trained staff and properly secured medical equipment. If it is agreed that another option such as road ambulance transfer, with or without nurse or local doctor escort, is best, the retrieval consultant can organise an expedited ambulance response.

The referral process for **time urgent** critically ill or injured patients is:

- Referring clinician to contact ACC and, where possible, a conference call will be established; between the referring clinician, retrieval consultant and receiving clinician at the linked tertiary hospital.
- If a closer hospital can provide the time urgent treatment, the ACC may elect to transport the patient there. In each case the retrieval consultant will notify the receiving clinician.
- Clinical and logistical advice will be provided to the referring clinician to support the stabilisation and resuscitation of the patient.
- The timing of transfer will be triaged and coordinated by the ACC within the context of competing priorities.
- The ACC is responsible for providing timely updates to the referring clinician on dispatch and estimated time of arrival of the medical retrieval team.
- The referring clinician is responsible for ensuring:
  - Specific information regarding the patient's clinical status, management and any special considerations such as weight or logistical issues are provided to the ACC.
  - Timely updates of any significant changes in the patient's condition are provided to the ACC.

- The referring and receiving hospitals are responsible for notifying their PFU/hospital bed or after hour's managers of the impending transfer. However, PFU/ hospital bed or after hours managers **cannot** refuse transfer of time urgent critically ill or injured patients.

The ACC can be contacted on: 1800 650 004.
Retrieval resources including the bariatric sizing chart as per Appendices 5-8.

8 Non-Time Urgent Patients Requiring Critical Care Referral

The LHD is responsible for providing 24/7 mechanisms for critical care clinical advice, location of an appropriate receiving hospital and bed (which may be outside the LHD). Established LHD processes are usually via a critical care consultant attached to the linked tertiary hospital or PFU and the Critical Care Resource management System.

The ACC retrieval consultant is available to supplement clinical advice and task an appropriate clinical team to effect the transfer.

Some examples of non-time urgent patients include; ventilated and stable drug overdose, patients ventilated for respiratory failure who do not require an urgent life-saving procedure, stable ventilated multi trauma patients that have been appropriately imaged and do not require urgent surgery or intervention.

The ACC should be contacted as soon as possible and advised of the impending retrieval as outlined in Appendix 1. However, the role of ACC does **not** extend to locating beds or facilitating clinical referral for critically ill or injured patients who are **non-time urgent**. This remains the responsibility of the LHD, regardless of whether the linked tertiary hospital or LHD can provide an appropriate bed themselves.
Communication must occur with the receiving hospital prior to transfer. Once the patient has been accepted at the receiving hospital then ACC should be contacted to undertake the retrieval.

The referral process for **non-time urgent** critically ill or injured patients is:

- Referring clinician to contact their LHD's nominated central point for critical care advice such as the CCAS model with PFU attached medical officer, or linked tertiary referral hospital
- Clinical discussion to occur between referring clinician and LHD central point to determine clinical transfer priority, facilitate conference call with appropriate receiving consultant, facilitate transfer and assist with bed location as required
- Referring clinician/LHD central point to contact ACC to initiate transport and, where possible, a conference call will be established; between the referring clinician, retrieval consultant and receiving clinician
- The timing of transfer will be triaged and coordinated by the ACC and communicated within the context of competing priorities
- The referring clinician/LHD central point is responsible for ensuring communication of all relevant information to the ACC, as per Section 7
- The referring and receiving hospitals are responsible for notifying their PFU/hospital bed or after hour's managers of impending transfers.

9 Non-Critical Patients Requiring Referral for Specialist Care (Adults)

The role of ACC does **not** extend to locating beds or facilitating clinical referral for non-critical patients requiring specialist care.
Some examples of these patient types include; physiologically stable STEMI and conscious FAST-positive stroke patients requiring consideration of thrombolysis or neurointervention. All transfers must occur as per "Inter-facility Transfer Process for Adults Requiring Specialist Care" PD2011_031.

The volume of referrals and multitude of clinical referral networks for non-critical patients necessitates a decentralised model. However, it is recognised that in some cases, unless the referral and transfer is timely, the situation may become critical.

Each LHD has intra and inter LHD clinical networks for non-critical patients requiring referral for a higher level of specialist care. Formalisation of these networks and an "escalation of care" process

must be in place to ensure patients who require specialist referral are afforded timely access to definitive care.

PFUs/hospital bed or after hours managers support these established networks and facilitate non-critical referrals for patients requiring a higher and/or more specialised level of definitive care. All non-critically ill patients who require time urgent treatment and inter facility referral and transfer for specialist care should be facilitated through the LHD PFU/hospital bed or after hours manager, LHD transport services and if needed NSW Ambulance.

10 Critical Care Resource Management System(CCRS)

Currently the CCRS provides information about available adult critical care beds across NSW. There are plans to include this functionality into the PFP, however until this time CCRS should be used to inform coordination and placement of critically ill patients.

The web based CCRS receives automated data feeds from the Patient Flow Portal (PFP) every fifteen minutes via the LHD Patient Administration Systems (PAS) to inform ICU bed status. Manual updates are also required in real time to ensure that information is accurate and reflective of issues which can affect bed availability, such as staff availability. CCRS can be accessed via **http://ccrs.health.nsw.gov.au**.

The aim of CCRS is to improve access to adult intensive care beds for critically ill patients across NSW. Where appropriate, regional critical care services should be considered as potential sites to refer critically ill patients to improve overall access to intensive care beds. Statewide networking increases the number of patients able to be managed in regional centres and cared for closer to their home and family.

The linked tertiary hospital is responsible for bed finding using CCRS. If the patient has a time urgent critical condition needing transfer in the shortest time possible ACC should be contacted as per Section 7.

Each ICU is responsible for ensuring the information in CCRS is correct and current. Each ICU is required to check and verify the unit bed status at each nursing shift handover.

11 Statewide Clinical Specialty Referral Networks

Operating in conjunction with the adult critical care referral networks are the state adult clinical specialty networks. These networks are designed to achieve appropriate concentration of highly specialised services which can respond to the needs of NSW residents.

These specialty networks are outlined in Sections 11.1-11.6 and include:

- Burns
- Spinal
- Trauma
- Cardiac Catheterisation
- Extra Corporeal Membrane Oxygenation (ECMO)

Note should be taken of the most appropriate referral facility and the ability to take combined injuries such as burns, spinal and trauma if needed.

11.1 NSW Severe Burn Injury Service Referral Network (Adult)

The NSW Adult Statewide Severe Burn Injury Service is located at Concord Repatriation General Hospital and Royal North Shore Hospital. Patients may be retrieved to either one of these, except in the following circumstances where patients should be transported directly to Royal North Shore Hospital:

- Adult with burn injury and actual or suspected severe trauma
- Adult with burn injury and acute spinal cord injury
- Adult with burn injury during 2nd and 3rd trimester pregnancy.

Patients with severe burn injury should be referred according to the "NSW Burn Transfer Guidelines NSW Burn Injury Service"6, available at: https://www.aci.health.nsw.gov.au/resources/burn-injury.

The Severe Burn Injury Service Referral Network defines specialist burn injury services for severe burns and networked LHDs.

Table 5: NSW State Burn Injury Service Referral Network (Adult)

NSW Severe Burn Injury Service Referral Network (Adult)	
Referring Local Health District	Receiving Severe Burn Hospital
Australian Capital Territory (ACT) Far West NSW LHD Illawarra Shoalhaven LHD Murrumbidgee LHD Nepean Blue Mountains LHD South Eastern Sydney LHD South Western Sydney LHD Southern NSW LHD Sydney LHD Western NSW LHD Western Sydney LHD	**Concord Repatriation General Hospital** • Burns Registrar/Consultant on-call Ph: (02) 9767 5000 then page • Intensive Care Unit Ph: (02) 9767 6404 • Burn Unit/Ambulatory Care Ph: (02) 9767 7775 (b/h) Ph: (02) 9767 7776 (a/h) Fax (02) 9767 5835 • Burns CNC Ph: (02) 9767 5000 then page Office (02) 9767 7798
Central Coast LHD Hunter New England LHD Mid North Coast LHD Northern NSW LHD Northern Sydney LHD	**Royal North Shore Hospital** • Burns Registrar/Consultant on-call Ph: (02) 9926 7111 then page Registrar on call. • Intensive Care Unit Ph: (02) 9463 2600 • Burns Unit/Ambulatory Care Ph: (02) 9463 2108 (b/h) Ph: (02) 9463 2111 Fax: 9463 2006 • Burns/Plastics CNC Ph: 9926 7111 then page 41731 Office (02) 9463 2102

Due to proximity some LHD and hospitals may maintain specialty referral networks interstate; **Adult Retrievals: Contact ACC 1800 650 004**

11.2 NSW State Spinal Cord Injury Referral Network (Adult)

The NSW Adult State Spinal Cord Injury Service (SSCIS) is located at Prince of Wales Hospital and Royal North Shore Hospital. Patients may be retrieved to either one of these, except patients who have combined severe trauma and acute spinal injury should be transported directly to Royal North Shore Hospital, if clinically appropriate

The SSCIS is responsible for the management of patients who have sustained an acute spinal cord injury where there is persistent neurological deficit arising from damage to neural tissue as a result of trauma, or a non-progressive disease process (e.g. transverse myelitis, vascular occlusion, compression by infective process or haemorrhage).

Trauma patients who have sustained a spinal injury with neurological deficit must be transferred to a SSCIS as soon as medically stable. The relevant SSCIS should be notified immediately in all cases where a spinal cord injury has been sustained to facilitate referral and transfer as soon as possible, and to obtain clinical management advice.

This referral process only relates to acute spinal cord injuries with neural loss and those spinal cord injuries as defined by the SSCIS. Patients with vertebral fractures only, are to be referred to a Spinal/Orthopaedic or Neurosurgeon via the existing specialist trauma referral process for each LHD.

The State Spinal Cord Injury Referral Network defines specialist spinal services for acute spinal cord injuries and networked LHDs.

Table 6: NSW State Spinal Cord Injury Service (SSCIS) Referral Network (Adults)

NSW State Spinal Cord Injury Service (SSCIS) Referral Network (Adults)	
Referring Local Health District	Receiving Spinal Cord Injury Service
Australian Capital Territory (ACT) Illawarra Shoalhaven Murrumbidgee South Eastern Sydney Southern NSW South Western Sydney Sydney St Vincent's Health Network	**Isolated Spinal Cord Injury:** **Prince of Wales Hospital PH: (02) 9382 2222** **ASK for** - On-Call Spinal Surgical Consultant **NB:** For referrals with an acute SCI, transfer arrangements within 24 hrs. of injury will be expedited through the POWH policy of non-refusal
Central Coast Far West Hunter New England Mid North Coast Nepean Blue Mountains Northern NSW Northern Sydney Western NSW Western Sydney	**Isolated or combined severe trauma and Spinal Cord Injury:** **Royal North Shore Hospital PH: (02) 9926 7111** (For **acute** traumatic and non-traumatic SCI) **ASK for:** On-Call Spinal Surgical Consultant **Royal Rehab PH: (02) 9807 1144** (For SCI Rehabilitation)

Due to proximity some LHD/ hospitals may maintain specialty referral networks interstate.; **Adult Retrievals: Contact ACC 1800 650 004**

11.3 NSW Major Trauma Referral Networks (Adult)

The NSW adult trauma services provide expert multidisciplinary care for injured patients. The referral network for NSW trauma patients includes Regional Trauma Services (RTS) and Major Trauma Services (MTS). For patients with time urgent critical injuries, the first call should be to the ACC.

The trauma response begins with early identification of actual or potential severely injured patients by paramedics on scene or by hospital clinical staff. Transfer notification for major trauma patients should occur concurrently with treatment and imaging, and should not be delayed for want of a definitive diagnosis.

When an injured patient is initially managed at a local hospital, the hospital should expedite consultation and transfer to the networked RTS or MTS, as per trauma guidelines7.

RTS can provide all aspects of care to moderate - minor trauma patients and definitive care to a limited number of major trauma patients, in consultation with the networked MTS. This may include transfer to a MTS for services not available at the RTS.

The MTS can provide the full spectrum of care to major - moderately injured patients.

Patients with major trauma injury should be referred according to the “NSW Major Trauma Retrieval & Transfers Consensus Guidelines - NSW Institute of Trauma and Injury Management (ITIM)”, available at: **https://www.aci.health.nsw.gov.au/get-involved/institute-of-trauma-and-injury-management/clinical/trauma-guidelines/Guidelines**

All time urgent critically injured trauma patients must be transferred directly to the networked designated trauma service that can provide the required time urgent treatment (usually damage control surgery) prior to subsequent transfer. The ACC or regional retrieval consultant will make this decision in consultation with the referring hospital, retrieval team and receiving hospital.

If clinically appropriate, the following groups of trauma patients should be transferred directly as follows:

- **Isolated injury - acute spinal cord injury or burn injury** - to relevant service (see 11.1-11.2)
- **Combined injury** - acute spinal cord injury or burn injury and severe trauma - to Royal North Shore Hospital

All non-time urgent major trauma patients should be transferred to the nearest appropriate trauma service which may be either an RTS or MTS.

The NSW Trauma Services Referral Network defines specialist trauma services for trauma injuries and networked LHD’s.

Table 7: NSW Trauma Services Referral Networks (Adult)

NSW Trauma Services Referral Networks (Adult)		
Referring Local Health District	Regional Trauma Service	Major Trauma Service
Central Coast Northern Sydney	Gosford	Royal North Shore
Far west[4] Nepean Western NSW Western Sydney	Nepean Orange	Westmead
Hunter New England Mid North Coast Northern NSW[1]	Coffs Harbour Lismore[1] Port Macquarie Tamworth Tweed[1]	John Hunter
Illawarra Shoalhaven Murrumbidgee[2&3] South Eastern Southern NSW[3]	Wollongong Wagga	St George Australian Capital Territory
South Western Sydney	NA	Liverpool
Sydney	NA	Royal Prince Alfred
NA	NA	St Vincent's

Due to proximity the following LHD/ hospitals maintain referral networks as follows:
1. Northern NSW - Queensland. 2. Victoria.
3. The ACT (Canberra) - Batemans Bay, Batlow, Bombala, Boorowa, Braidwood, Cooma, Crookwell, Delegate, Goulburn, Moruya, Pambula, Queanbeyan, South East Regional (Bega), Tumut, Yass and Young.
4. Broken Hill - South Australia.

Adult Retrievals: Contact ACC 1800 650 004

11.4 NSW Rural Cardiac Catheterisation Laboratory Referrals (Adults)

Rural adult cardiac catheterisation services are located at Tamworth, Orange, Wagga Wagga, Port Macquarie, Coffs Harbour and Lismore.

Critically ill patients requiring time urgent inter-hospital transfer from a rural cardiac catheter service to a tertiary hospital for an urgent procedure (usually interventional cardiology or surgery) should be immediately transferred, regardless of bed availability as per Section 7.

The ACC should be contacted to facilitate the transfer. Where an Intra-Aortic Balloon Pump (IABP) device is required for an aeromedical transfer the ACC, must provide their own IABP device (authorized for aeromedical transport) and team (both located in Sydney).

If an IABP is not absolutely required to manage an unstable patient, referring cardiologists should consider whether the presence of the IABP is more important than the necessary delay in transfer time it will incur. The ACC consultant can advise in individual cases what the time differential is likely to be.

The Cardiac Catheterisation Laboratory Referrals (Adults) defines services and networked LHDs.

Table 8: NSW Cardiac Catheterisation Laboratory Referral Networks

NSW Cardiac Catheterisation Laboratory Referral Networks	
Referring Local Health District	Receiving Cardiac Catheterisation Service
Far West	South Australia
Hunter New England	John Hunter
Murrumbidgee	St Vincent's
Mid North Coast	Prince of Wales
Northern NSW	Lismore, Queensland
Southern NSW	Australian Capital Territory (ACT)
Western NSW	Royal Prince Alfred

Due to proximity some LHD and hospitals may maintain specialty referral networks interstate.
Some sites listed may not be operational 24/7. Sites should periodically update local information to include availability
Retrievals- Adults: Contact ACC 1800 650 004

11.5 NSW Extra Corporeal Membrane Oxygenation (ECMO) Medical Retrieval Service

ECMO therapy is used in many tertiary hospital ICUs to temporarily support patients with cardiac and/or respiratory failure. Most commonly this is post cardiothoracic surgery or patients with refractory respiratory failure unresponsive to advanced mechanical ventilation techniques.

Patients who are in smaller hospitals with severe cardiac and/or respiratory failure may also be approaching or beyond the limits of conventional organ support (mechanical ventilation, inotropes etc.). Some of these patients are not safely transportable even by medical retrieval teams.

The NSW ECMO retrieval service enables patients in non-tertiary hospitals to receive this therapy if appropriate and be transported to a tertiary hospital for ongoing care.

ECMO is provided by either Royal Prince Alfred (RPAH) or St Vincent's Hospitals (SVH) via a roster system. The service involves collaboration between the active ECMO/ICU clinicians, medical retrieval services and NSW Ambulance. A combined ECMO and retrieval team is transported to the referring hospital with appropriate equipment to establish the patient on ECMO and transport the patient back to RPAH or SVH by helicopter, fixed wing or road vehicle.

To organise the referral and transfer of a patient requiring rescue ECMO the following steps must occur:

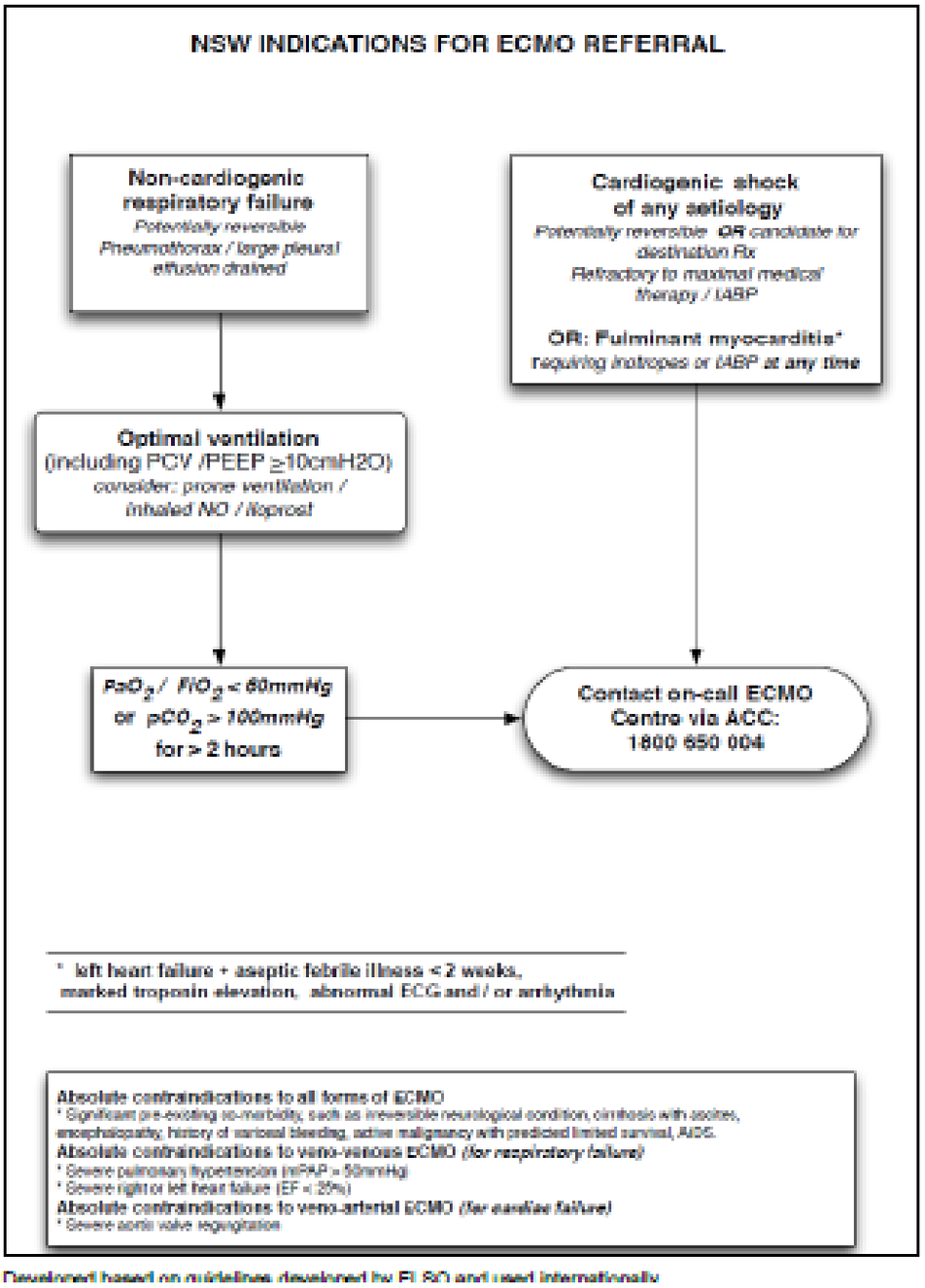
- Early notification of a patient potentially requiring referral for ECMO (Diagram 1)
- Initial contact to be made with ACC who will contact the active ECMO service
- A one phone call referral via conference call is used to connect the referring clinician, medical retrieval consultant and receiving ICU consultant
- The destination hospital will be determined according to the patients underlying condition, required clinical/surgical intervention and access to an available ICU bed.

ECMO Services	
Royal Prince Alfred Hospital	**St Vincent's Hospital**
PH: (02) 95156111 **Ask for**: ECMO intensivist on call	**PH:** (02) 83821111 **Ask for:** ICU North consultant on duty
The RPA and SVH ECMO roster is available at https://www.google.com/calendar/embed?src=7p3e1u53fvo59tkmfiok2qad6k%40group.calendar.google.com&ctz=Australia/Sydney (requires Chrome, not reliable with internet explorer)	

Retrievals- Adults: Contact ACC 1800 650 004

Case selection and treatment protocols used during ECMO are defined by the international Extracorporeal Life Support Organisation (ELSO). Diagram 1 outlines the indications for ECMO therapy and referral based on guidelines developed by ELSO and used internationally.

Diagram 1: NSW Indications for ECMO Referral



Developed based on guidelines developed by ELSO and used internationally

11.6 NSW Paediatric, High Risk Obstetric and Perinatal Referrals

All paediatric referrals and transfers must be arranged according to the Critical Care Tertiary Referral Networks (Paediatrics) PD 2010_030 1 and coordinated via NETS.

All high risk obstetric and perinatal transfers must be arranged according to the Critical Care Tertiary Referral Networks (Perinatal) PD 2010_0692 and coordinated via the Pregnancy Advice Line (PAL) and NETS on 1300 36 2500.

12 NSW Default Adult ICU Bed Policy

Access to emergency care and/or urgent surgical intervention for time urgent critically ill or injured patients must not be delayed due to no-available ICU bed. The ACC should be contacted immediately for such patients.

In time urgent situations, the ACC has the authority to transport the patient directly to the linked tertiary hospital designated by the NSW Adult Critical Care Referral Network regardless of bed state. If there is a closer facility that can provide the time urgent treatment, ACC may elect to transport the patient there.

Each LHD is ultimately responsible for meeting the critical care and intensive care needs (except for super-specialty services) of that LHD and linked rural LHD, where specified. This includes the provision of clinical advice and access to appropriate treatment. In addition, each LHD has a responsibility to ensure that all options for placement of the patient within the LHD have been explored and that all appropriate transfers from ICU to inpatient wards have been made to create capacity.

The LHD Chief Executive (CE) is responsible for; ensuring formalised intra and inter LHD and/or cross jurisdictional referral arrangements exist for critically ill or injured patients needing a higher level of definitive care and for non-critically ill or injured patients requiring referral for specialist care and; that clinical referral and support processes are transparent and effectively communicated to all staff to ensure patients can access definitive care in an appropriate timeframe. The ACC may contact the CE where necessary to resolve inter-LHD and non-urgent transfers.

The NSW default adult ICU bed policy may be invoked, when there are no adult intensive care beds available across NSW for a non-urgent critical patient. This must only occur after thorough assessment of ICU capacity and intra/inter-LHD critical care referral networks to ensure all potential referral options have been exhausted.

If the NSW Default Adult ICU Bed Policy is activated, the tertiary referral hospital designated by the NSW Adult Critical Care Referral Network (will be responsible for providing critical care, irrespective of bed status, to a specified group of referral hospitals. (Table 2 and Appendix 3). This responsibility includes assisting with patient placement to an appropriate alternative location for treatment and care.

The NSW Default Adult ICU Bed Policy is based on a hospital-to-hospital network and does not necessarily follow the normal LHD Critical Care Referral Networks.

In specific cases the referring clinician, retrieval consultant and the receiving clinician may decide to refer a patient to a different hospital which is considered more clinically appropriate for the patient’s definitive care.

If the default adult ICU bed policy is invoked, a phone referral via conference call, outlined in Section 4, must still occur and the receiving clinician **must** be notified as soon as possible and prior to patient arrival.

12.1 Invoking the Default Adult ICU Bed Policy:

- For time urgent patients, the ACC will contact the linked tertiary hospital, or if appropriate a closer facility, and transport the patient there, regardless of bed state.

- In all other cases, the referring hospital should contact their linked tertiary ICU. If the linked ICU does not have an available bed they are responsible for finding an alternative bed which may be within or outside of the LHD.

- All units to use their escalation policy to review exit blocked beds, liaise with the hospital executive to have them cleared and update CCRS.

- The LHD's tertiary ICU verifies that there are no appropriate available ICU beds either within or outside the LHD, with the assistance of CCRS.

- Where no appropriate available ICU bed can be identified across the system the **designated tertiary ICU** will accept the patient, irrespective of bed status.

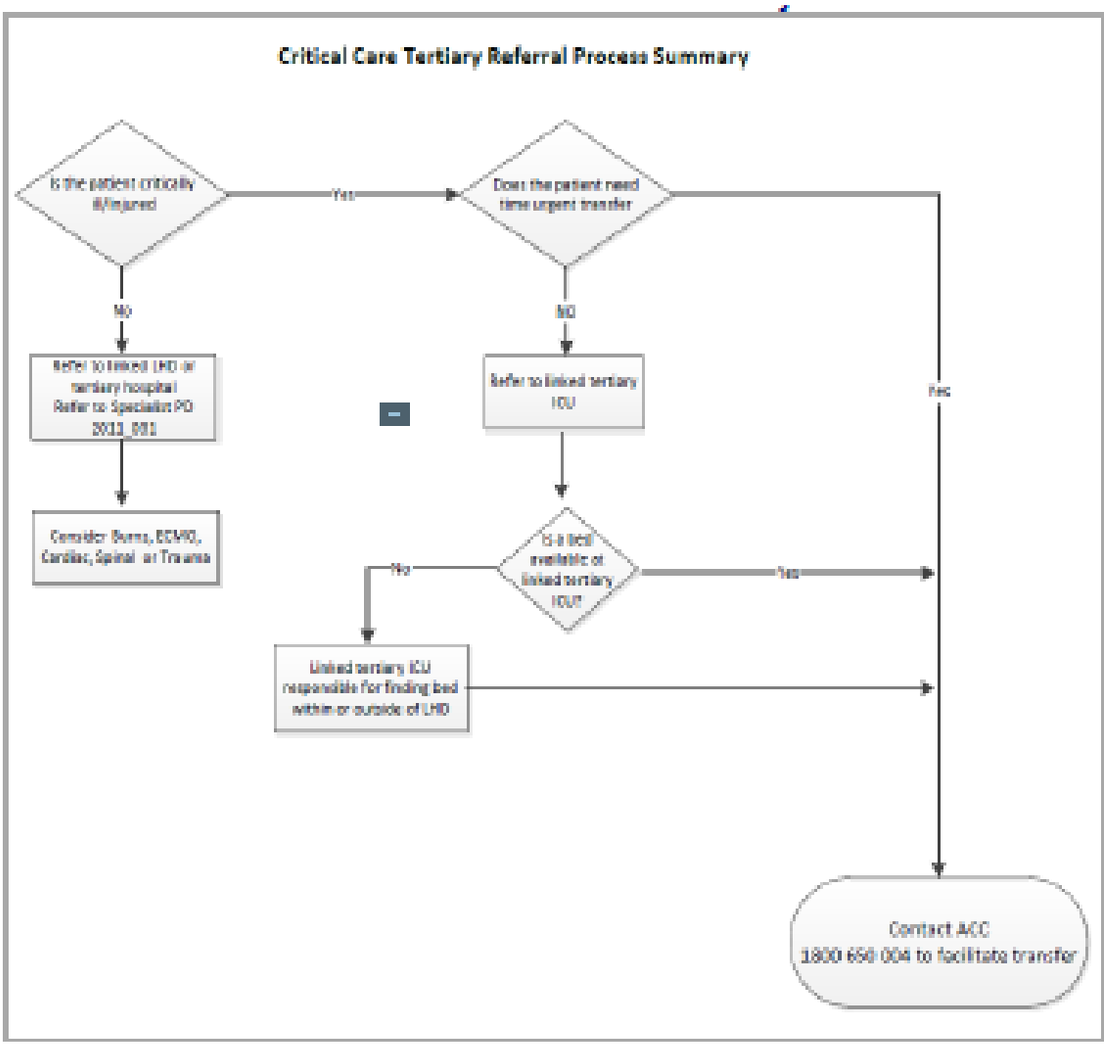
Prior to patient transfer a phone referral via conference call, outlined in Section 4, must occur and the receiving clinician must be notified as soon as possible and prior to patient arrival.

Fundamental to this procedure being activated is the principle that:

Where a patient requires time urgent critical care, not available at the referring hospital, then the patient must be transferred immediately to the facility designated by the NSW Adult Critical Care Tertiary Referral Network that is able to provide appropriate emergency treatment irrespective of bed status.

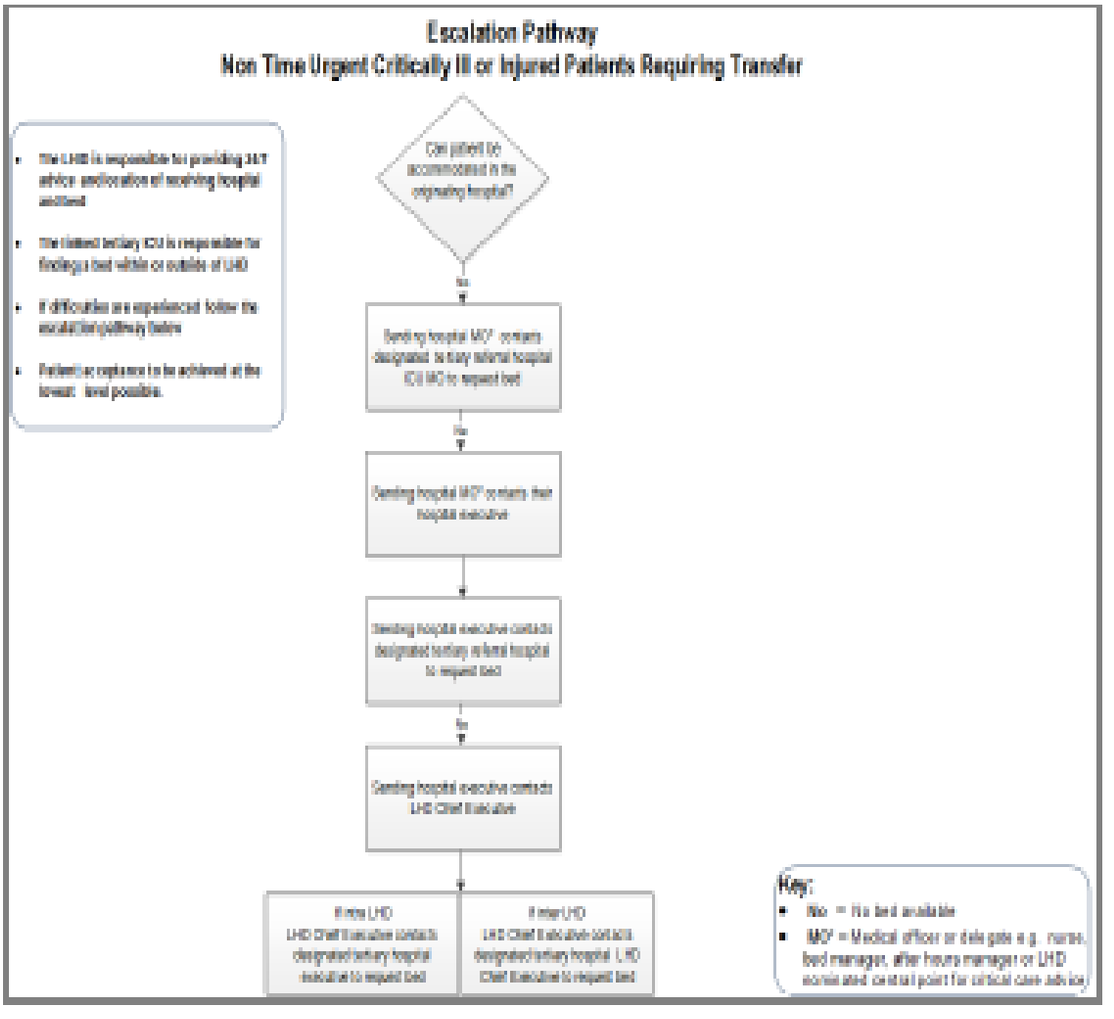
Aeromedical Control Centre (ACC) 1800 650 004.

APPENDIX 1: Critical Care Referral Process- Summary



- Time urgent referral - ACC 1800 650 004.(In emergencies notification can occur prior to full patient assessment and investigation)
- Non-time urgent referral - facilitated via CCRS via http://ccrs.health.nsw.gov.au
- Clinical specialty networks:
  - Burns - section 11.1:
    - Concord Hospital (02) 9767 5000
    - Royal North Shore Hospital (02) 9926 7111
  - Spinal - section 11.2
    - Prince of Wales Hospital (02) 9382 2222
    - Royal North Shore Hospital (02) 9926 7111
  - Trauma - section 11.3
  - Cardiac Catheterisation - section 11.4
  - Extra Corporeal Membrane Oxygenation (ECMO) - section 11.5
- Patients above 110kg must have bariatric sizing chart completed and sent to ACC.

APPENDIX 2: Escalation Pathway - Example



APPENDIX 3: Critical Care Referral Networks

LHD	Facilities	Tertiary Hospital
Central Coast	Gosford, Long Jetty, Woy Woy, Wyong	Royal North Shore
Far West [1]	Balranald, Broken Hill, Ivanhoe, Menindee, Tibooburra, Wentworth, White Cliffs, Wilcannia	Royal Prince Alfred, South Australia
Hunter New England	Armidale, Barraba, Belmont, Bingara, Boggabri, Bulahdelah, Cessnock, Denman, Dungog, Emmaville/Vegetable Creek, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, John Hunter, Kurri Kurri, Maitland, Manilla, Merriwa, Moree, Murrurundi/Wilson, Muswellbrook, Narrabri, Nelson Bay, Newcastle, Newcastle Mater, Quirindi, Scone, Singleton, Tamworth, Taree/Manning, Tenterfield/Prince Albert, Tingha, Walcha, Warialda, Wee Waa, Werris Creek, Wingham	John Hunter
Illawarra Shoalhaven	Bulli, Coledale, David Berry, Kiama, Milton Ulladulla, Port Kembla, Shellharbour, Shoalhaven, Wollongong	St George
Mid North Coast [3]	Bellingen, Coffs Harbour, Dorrigo, Kempsey, Mackaville, Port Macquarie, Wauchope	John Hunter
Murrumbidgee [2] and [4]	Batlow, Tumut	Australian Capital Territory
	Boorowa, Murrumburrah-Harden, Young	Prince of Wales
	Lake Cargelligo	Royal Prince Alfred
	Barham Koondrook, Berrigan, Corowa, Culcalm, Deniliquin, Finley, Henty, Holbrook, Jerilderie, Tocumwal, Urana	St George
	Coolamon, Cootamundra, Griffith, Gundagai, Hay, Hillston, Junee, Leeton, Lockhart, Narrandera, Temora, Tumbarumba, Wagga Wagga, West Wyalong	St Vincent's
	Albury	Victoria
Nepean Blue Mountains	Blue Mountains, Hawkesbury, Lithgow, Nepean, Portland, Springwood	Nepean
Northern NSW	Ballina, Bonalbo, Byron, Casino, Coraki, Grafton, Kyogle, Lismore, Maclean, Murwillumbah, Nimbin, Tweed, Urbenville	John Hunter, Queensland
Northern Sydney	Castlecrag (Private), Dalcross (Private), Greenwich, Hornsby, Macquarie, Manly, Mater Misecordiae (Private), Mona Vale, Neringah, North Shore (Private) Royal North Shore, Royal Rehabilitation, Ryde, Sydney Adventist (Private)	Royal North Shore
South Eastern Sydney	Calvary Healthcare, Gower Wilson (Lord Howe Island), Prince of Wales, Prince of Wales Private, Royal Hospital for Women, St George, Sutherland, St Vincent's, St Vincent's Private, Sydney & Eye Hospital, War Memorial	Prince of Wales, St George
South Western Sydney	Bankstown, Braeside, Bowral, Camden, Campbelltown, Fairfield, Liverpool	Liverpool
Southern NSW [4]	Batemans Bay, Bega (South East Regional) Bombala, Braidwood, Cooma, Delegate, Moruya, Pambula, Queanbeyan, Yass	Australian Capital Territory
	Crookwell, Goulburn	Prince of Wales
Sydney	Balmain, Canterbury, Concord, Royal Prince Alfred	Royal Prince Alfred
Western NSW	Baradine, Bathurst, Blayney, Bourke, Brewarrina, Canowindra, Cobar, Collarenebri, Condobolin, Coolah, Coonabarabran, Coonamble, Cowra, Cudal, Dubbo, Dunedoo, Eugowra, Forbes, Gilgandra, Goodooga, Grenfell, Gulargambone, Gulgong Lightning Ridge, Molong, Mudgee, Narromine, Nyngan, Oberon, Orange/Bloomfield, Parkes, Peak Hill, Rylstone, Tottenham, Trangie, Trundle, Tullamore, Walgett, Warren, Wellington	Royal Prince Alfred
Western Sydney	Auburn , Blacktown, Baulkham Hills (Private),Cumberland, Mount Druitt, Westmead, St Josepha, Westmead Private	Westmead
St Vincent's	St Josepha	St Vincent's

Due to proximity some patients may be referred to: South Australia*, Queensland *, Victoria * and Australian Capital Territory *
Retrievals- Adults: Contact ACC 1800 650 004

APPENDIX 4: Clinical Referral Networks and Specialty Referral Networks

LHD	Facilities	Receiving Tertiary Hospital				
		Critical Care	Burns	Spinal	Trauma	
					Regional	Major
ACT		NA	CRGH	POW	NA	NA
Central Coast	Gosford, Long Jetty, Woy Woy, Wyong	RNS	RNS	RNS	Gosford	RNS
Far West[1]	Balranald, Broken Hill, Ivanhoe, Menindee, Tibooburra, Wentworth, White Cliffs, Wilcannia	RPA SA- Adelaide	CRGH	RNS	Orange	Westmead, SA- Adelaide
Hunter New England	Armidale, Barraba, Belmont, Bingara, Boggabri, Bulahdelah, Cessnock, Denman, Dungog, Emmaville/Vegetable Creek, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, John Hunter, Kurri Kurri, Maitland, Manilla, Merriwa, Moree, Murrurundi/Wilson, Muswellbrook, Narrabri, Nelson Bay, Newcastle Newcastle Mater, Quirindi, Scone, Singleton, Tamworth, Taree/Manning, Tenterfield/Prince Albert, Tingha, Walcha, Warialda, Wee Waa, Werris Creek, Wingham	JHH	RNS	RNS	Tamworth	JHH
Illawarra Shoalhaven	Bulli, Coledale, David Berry, Kiama, Milton Ulladulla, Port Kembla, Shellharbour, Shoalhaven, Wollongong	STG	CRGH	POW	Wollongong	STG
Mid North Coast[2]	Bellingen, Coffs Harbour, Dorrigo, Kempsey, Macksville, Port Macquarie, Wauchope	JHH	RNS	RNS	Coffs Harbour, Port Macquarie	JHH
Murrumbidgee [1and4]	Batlow, Tumut	ACT	CRGH	POW	Wagga	ACT
	Boorowa, Murrumburrah-Harden, Young	POW				
	Lake Cargelligo	RPA				STG
	Barham Koondrook[3], Berrigan[3], Corowa[3], Culcairn[3], Deniliquin[3], Finley[3], Henty[3], Holbrook[3], Jerilderie[3], Mercy Health Service, Tocumwal, Urana	STG			Wagga, Vic[3]	STG, Vic[3]
	Coolamon, Cootamundra, Griffith, Gundagai, Hay, Hillston, Junee, Leeton, Lockhart, Narrandera, Temora, Tocumwal[3], Tumbarumba[3], Wagga Wagga, West Wyalong	SVH				
	Albury[1]	Vic[3]			Vic[3]	Vic[3]
Nepean Blue Mountains	Blue Mountains, Hawkesbury, Lithgow, Nepean, Portland, Springwood	Nepean	CRGH	RNS	Nepean	Westmead
Northern NSW[3]	Ballina, Bonalbo, Byron, Casino, Corindi, Grafton, Kyogle, Lismore, Maclean, Murwillumbah, Nimbin, Urbenville	JHH, QLD[3]	RNS	RNS	Lismore,	QLD
	Tweed[3]	JHH, QLD[3]			Tweed[3]	
Northern Sydney	Castlecrag (Private),Dalcross (Private), Frenches Forrest, Greenwich, Hornsby, Macquarie, Manly, Mater Misericordiae (Private), Mona Vale, Northgosh, North Shore (Private) Royal North Shore, Royal Rehabilitation, Ryde, Sydney Adventist (Private)	RNS	RNS	RNS	NA	RNS
South Eastern Sydney	Calvary Healthcare, Gower Wilson (Lord Howe Island), Prince of Wales, Prince of Wales Private, Royal Hospital for Women, St, George, Sutherland, St Vincents, St Vincents Private, Sydney & Eye Hospital, War Memorial	POW, STG	CRGH	POW	NA	STG
South Western Sydney	Bankstown, Braeside, Bowral, Camden, Campbelltown, Fairfield, Liverpool	Liverpool	CRGH	POW	NA	Liverpool
Southern NSW[4]	Batemans Bay, Bega (South East Regional), Bombala, Braidwood, Cooma, Delegate, Moruya, Pambula, Queanbeyan, Yass	POW, ACT[4]	CRGH	POW	NA	ACT[4]
	Crookwell, Goulburn	POW, STG				
Sydney	Balmain, Canterbury, Concord, Royal Prince Alfred	RPA	CRGH	POW	NA	RPA
Western NSW	Bandine, Bathurst, Blayney, Bourke, Brewarrina, Canowindra, Cobar, Collarenebri, Condobolin, Coolah, Coonabarabran, Coonamble, Cowra, Cudal, Dubbo, Dunedoo, Eugowra, Forbes, Gilgandra, Goodooga, Grenfell, Gulargambone, Gulgong Lightning Ridge, Molong, Mudgee, Narromine, Nyngan, Oberon, Orange/Bloomfield, Parkes, Peak Hill, Rylstone, Tottenham, Trangie, Trundle, Tullamore, Walgett, Warren, Wellington	RPA	CRGH	RNS	Orange	Westmead
Western Sydney	Auburn , Bladtown, Baulkham Hills (Private),Cumberland, Mount Druitt, Westmead, St Josephs, Westmead Private	Westmead	CRGH	RNS	NA	Westmead
St Vincents	St Josephs	SVH	CRGH	POW	NA	NA

KEY

Due to proximity some patients may be referred to:
1. SA
2. QLD
3. VIC
4. ACT

ACT- Australian Capital Territory
CRGH- Concord
JHH- John Hunter
POW- Prince of Wales
RPA- Royal Prince Alfred
RNS- Royal North Shore
SA- South Australia
STG- St George
SVH- St Vincents
QLD- Queensland

Due to proximity some patients may be referred to: South Australia [1], Queensland [2], Victoria [3], Australian Capital Territory [4]

Retrievals- Adults: Contact ACC 1800 650 004

APPENDIX 5: Bariatric Sizing Chart for Aeromedical Transport

NSW Ambulance

NSW Ambulance

Aeromedical Control Centre

Bariatric Sizing Chart

For all patients above 110kg

Patient Name..... Booking Reference No.....

Requesting Hospital..... Hospital Fax No.....

INSTRUCTIONS FOR MEASURING PATIENT

- Take measurements with patient lying on the mattress.
- Measure width of mattress (see diagram)
- Measure from side of patient to edge of mattress at A and B (refer to diagram below).
- Do these measurements at the patient's widest part. (This may be at the shoulders, abdomen or hips)
- Write results in boxes below. We will calculate the patient's width from the measurements you send us.

Width of Mattress	cm
Measurement A	cm
Measurement B	cm
Accurate Patient's Weight	kg
Patient's Height	cm

Widest Part (tick ✓ where measurements were taken at) Shoulders ☐ Abdomen ☐ Hips ☐

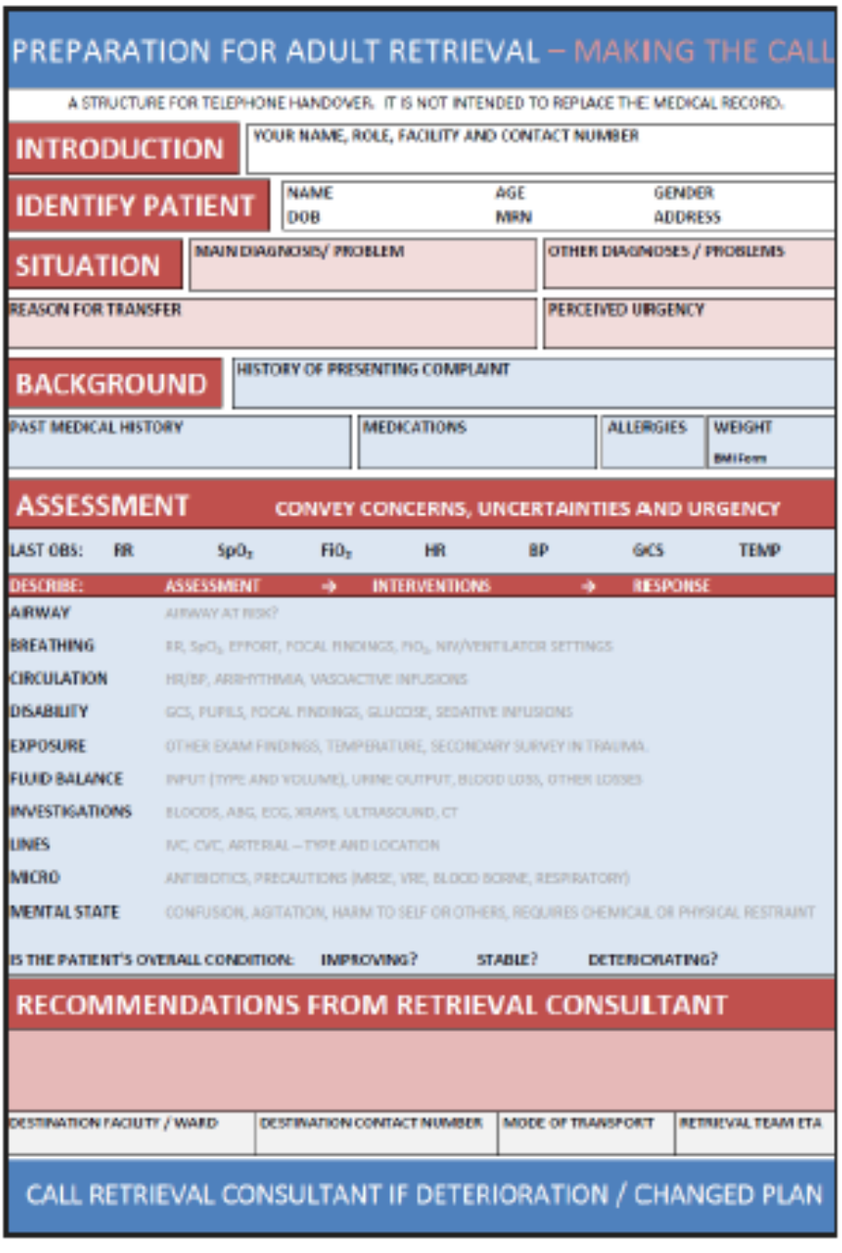
Inaccurate measurements may result in significant delay of transport of your patient.

When complete please fax to: 02 9553 2270

Thank you

Version 1 10/09/2014

APPENDIX 6: Preparation for Retrieval - Making the Call



PREPARATION FOR ADULT RETRIEVAL – MAKING THE CALL

A STRUCTURE FOR TELEPHONE HANDOVER. IT IS NOT INTENDED TO REPLACE THE MEDICAL RECORD.

INTRODUCTION YOUR NAME, ROLE, FACILITY AND CONTACT NUMBER

IDENTIFY PATIENT NAME AGE GENDER DOB MRN ADDRESS

SITUATION MAIN DIAGNOSIS/ PROBLEM | OTHER DIAGNOSES / PROBLEMS

REASON FOR TRANSFER | PERCEIVED URGENCY

BACKGROUND HISTORY OF PRESENTING COMPLAINT

PAST MEDICAL HISTORY | MEDICATIONS | ALLERGIES | WEIGHT BMI Form

ASSESSMENT CONVEY CONCERNS, UNCERTAINTIES AND URGENCY

LAST OBS: RR SpO_2 FiO_2 HR BP GCS TEMP

DESCRIBE:	ASSESSMENT →	INTERVENTIONS →	RESPONSE
AIRWAY	AIRWAY AT RISK?		
BREATHING	RR, SpO_2, EFFORT, FOCAL FINDINGS, FiO_2, NIV/VENTILATOR SETTINGS		
CIRCULATION	HR/BP, ARRHYTHMIA, VASOACTIVE INFUSIONS		
DISABILITY	GCS, PUPILS, FOCAL FINDINGS, GLUCOSE, SEDATIVE INFUSIONS		
EXPOSURE	OTHER EXAM FINDINGS, TEMPERATURE, SECONDARY SURVEY IN TRAUMA		
FLUID BALANCE	INPUT (TYPE AND VOLUME), URINE OUTPUT, BLOOD LOSS, OTHER LOSSES		
INVESTIGATIONS	BLOODS, ABG, ECG, XRAYS, ULTRASOUND, CT		
LINES	IVC, CVC, ARTERIAL – TYPE AND LOCATION		
MICRO	ANTIBIOTICS, PRECAUTIONS (MRSE, VRE, BLOOD BORNE, RESPIRATORY)		
MENTAL STATE	CONFUSION, AGITATION, HARM TO SELF OR OTHERS, REQUIRES CHEMICAL OR PHYSICAL RESTRAINT		

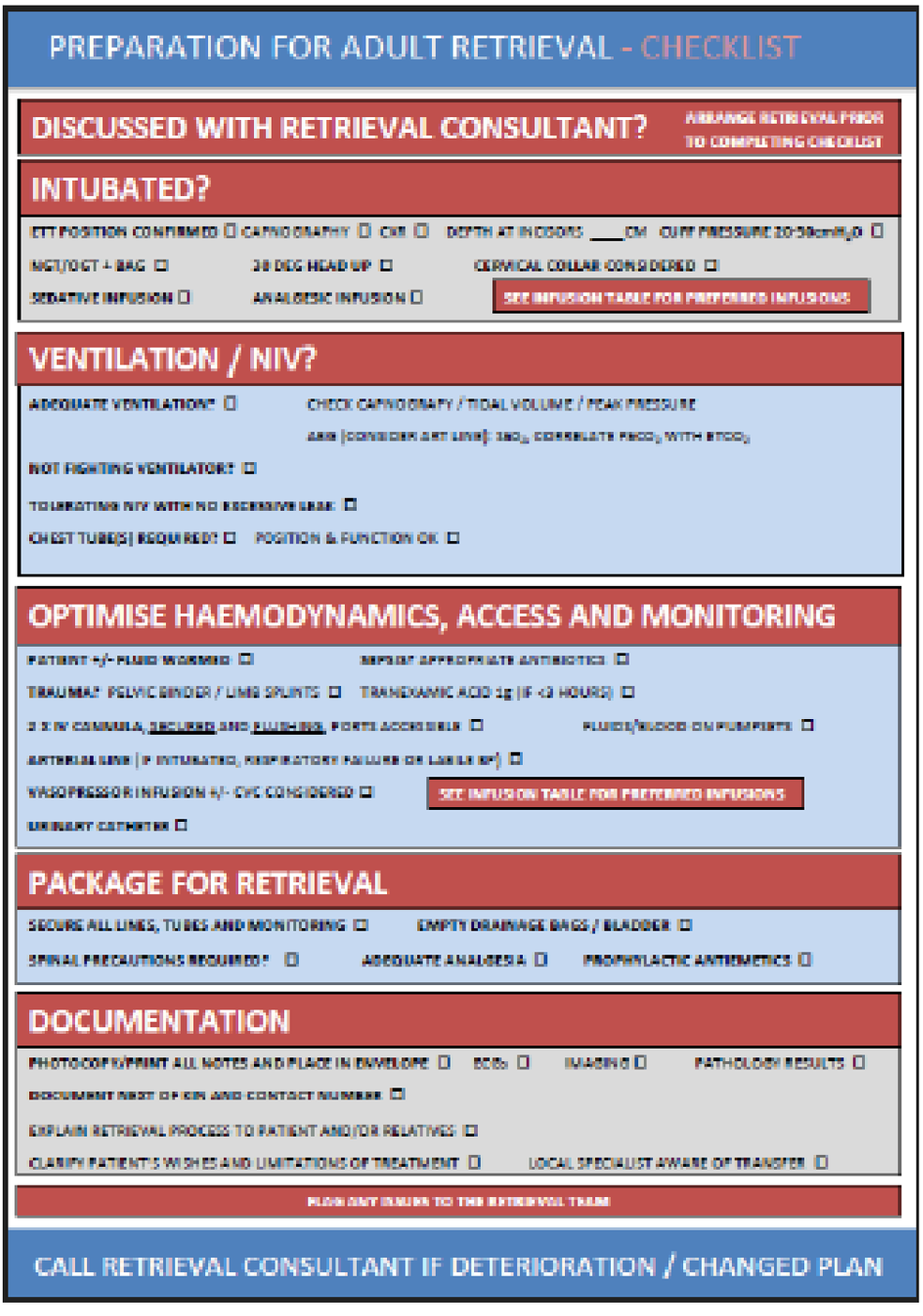
IS THE PATIENT'S OVERALL CONDITION: IMPROVING? STABLE? DETERIORATING?

RECOMMENDATIONS FROM RETRIEVAL CONSULTANT

DESTINATION FACILITY / WARD	DESTINATION CONTACT NUMBER	MODE OF TRANSPORT	RETRIEVAL TEAM ETA

CALL RETRIEVAL CONSULTANT IF DETERIORATION / CHANGED PLAN

APPENDIX 7: Preparation for Retrieval – Checklist



PREPARATION FOR ADULT RETRIEVAL - CHECKLIST

DISCUSSED WITH RETRIEVAL CONSULTANT? ARRANGE RETRIEVAL PRIOR TO COMPLETING CHECKLIST

INTUBATED?

ETT POSITION CONFIRMED ☐ CAPNOGRAPHY ☐ CXR ☐ DEPTH AT INCISORS ___CM CUFF PRESSURE 20-30cmH$_2$O ☐

NGT/OGT + BAG ☐ 30 DEG HEAD UP ☐ CERVICAL COLLAR CONSIDERED ☐

SEDATIVE INFUSION ☐ ANALGESIC INFUSION ☐ SEE INFUSION TABLE FOR PREFERRED INFUSIONS

VENTILATION / NIV?

ADEQUATE VENTILATION? ☐ CHECK CAPNOGRAPHY / TIDAL VOLUME / PEAK PRESSURE

ABG (CONSIDER ART LINE): SaO_2, CORRELATE $PaCO_2$ WITH $ETCO_2$

NOT FIGHTING VENTILATOR? ☐

TOLERATING NIV WITH NO EXCESSIVE LEAK ☐

CHEST TUBE(S) REQUIRED? ☐ POSITION & FUNCTION OK ☐

OPTIMISE HAEMODYNAMICS, ACCESS AND MONITORING

PATIENT +/- FLUID WORKING ☐ REPEAT APPROPRIATE ANTIBIOTICS ☐

TRAUMA? PELVIC BINDER / LIMB SPLINTS ☐ TRANEXAMIC ACID 1g (IF <3 HOURS) ☐

2 X IV CANNULA, SECURED AND FLUSHING, PORTS ACCESSIBLE ☐ FLUIDS/BLOOD ON PUMPS/BTS ☐

ARTERIAL LINE (IF INTUBATED, RESPIRATORY FAILURE OR LABILE BP) ☐

VASOPRESSOR INFUSION +/- CVC CONSIDERED ☐ SEE INFUSION TABLE FOR PREFERRED INFUSIONS

URINARY CATHETER ☐

PACKAGE FOR RETRIEVAL

SECURE ALL LINES, TUBES AND MONITORING ☐ EMPTY DRAINAGE BAGS / BLADDER ☐

SPINAL PRECAUTIONS REQUIRED? ☐ ADEQUATE ANALGESIA ☐ PROPHYLACTIC ANTIEMETICS ☐

DOCUMENTATION

PHOTOCOPY/PRINT ALL NOTES AND PLACE IN ENVELOPE ☐ ECGs ☐ IMAGING ☐ PATHOLOGY RESULTS ☐

DOCUMENT NEXT OF KIN AND CONTACT NUMBER ☐

EXPLAIN RETRIEVAL PROCESS TO PATIENT AND/OR RELATIVES ☐

CLARIFY PATIENT'S WISHES AND LIMITATIONS OF TREATMENT ☐ LOCAL SPECIALIST AWARE OF TRANSFER ☐

PLAN ANY ISSUES TO THE RETRIEVAL TEAM

CALL RETRIEVAL CONSULTANT IF DETERIORATION / CHANGED PLAN

APPENDIX 8: Preparation for Retrieval - Common Infusion Table

PREPARATION FOR RETRIEVAL – COMMON INFUSION TABLE

USE 50ml LUER LOCK SYRINGES WITH MINIMUM VOLUME TUBING

ADRENALINE 1mg Dilute to 50ml with 5% dextrose (100microg/ml) Commence at 1ml/hr, usual rate 1-20ml/hr

DRAW UP INFUSION DRUG

DRUG	DOSE	DILUTION	CONCENTRATION	TYPICAL RATE
PROPOFOL	500mg	Drawn up **undiluted** in 50ml	10mg/ml	1-20ml/hr
FENTANYL	500micrograms	Dilute to 50ml with 0.9% NaCl	10microg/ml	1-20ml/hr
MIDAZOLAM	50mg	Dilute to 50ml with 0.9% NaCl	1mg/ml	
KETAMINE	400mg	Dilute to 40ml with 0.9% NaCl	10mg/ml	Loading dose 2-5ml, usual rate 1-20ml/hr
MORPHINE	50mg	Dilute to 50ml with 0.9% NaCl	1mg/ml	
MORPHINE 50mg + MIDAZOLAM 50mg		Dilute to 50ml with 0.9% NaCl	1mg+1mg/ml	Loading dose 2-5ml, usual rate 1-5ml/hr
ADRENALINE	1mg	Dilute to 50ml with 0.9% NaCl	80microg/ml	Commence at 1ml/hr, usual rate 1-20ml/hr
NORADRENALINE	4mg	Dilute to 50ml with 0.9% NaCl	80microg/ml	Commence at 1ml/hr, usual rate 1-20ml/hr

PRIME LINES AFTER MIXING

IF >15mls/hr REQUIRED, DOUBLE INFUSION CONCENTRATION

DRUG	DOSE	DILUTION	CONCENTRATION	RATE
ADRENALINE	8mg	Dilute to 50ml with 0.9% NaCl	320microg/ml	
NORADRENALINE	4mg	Dilute to 50ml with 0.9% NaCl	320microg/ml	

CALL RETRIEVAL CONSULTANT IF DETERIORATION / CHANGED PLAN

APPENDIX 9: References

1. NSW Health Policy Directive, Critical Care Tertiary Referral Networks (Paediatrics) (PD 2010_030), 2010
2. NSW Health Policy Directive, Critical Care Tertiary Referral Networks (Perinatal) (PD 2010_069), 2010
3. The Agency for Clinical Innovation (ACI), Intensive Care Network, Intensive Care Service Model: NSW Level 4 Adult Intensive Care Units, ACI, 2015
4. NSW Health Guideline, Occupational Health & Safety Issues Associated with the Management of Bariatric Patients (GL2005_070), 2005 **http://www.health.nsw.gov.au/policies/gl/2005/GL2005_070.html**
5. NSW Health Policy Directive, *Inter- facility Transfer Process for Adults Requiring Specialist Care, (PD2011_031), 2011*
6. The Agency for Clinical Innovation (ACI), Statewide Burn Injury Service, NSW Burn Transfer Guidelines **https://www.aci.health.nsw.gov.au/resources/burn-injury**
7. The Agency for Clinical Innovation (ACI), NSW Institute of Trauma and Injury Management (ITIM), Trauma Guidelines **https://www.aci.health.nsw.gov.au/get-involved/institute-of-trauma-and-injury-management/clinical/trauma-guidelines/Guidelines**
8. Australian and New Zealand College of Anesthetists (ANZCA) Guidelines for Transport of Critically ill patients PS52 (2015)
9. NSW Health (2008) *Between the Flags Project- The Way Forward (Keeping Patients Safe),* Clinical Excellence Commission, Sydney, Australia.http://www.cec.health.nsw.gov.au/files/between-the-flags/publications/the-way-forward.pdf
10. The Agency for Clinical Innovation (ACI), Emergency Care Institute (ECI) preparation for adult retrieval resources **https://www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/retrieval**

AUTONOMIC DYSREFLEXIA (REVISED) – SAFETY NOTICE 014/10

Safety Notice 014/10 replaces IB2001/1.

Background

Autonomic dysreflexia is a medical emergency that can occur in people with spinal cord injury at or above the sixth thoracic (T6) level. It is a sudden and severe rise in blood pressure resulting from overactivity of an isolated sympathetic nervous system below the lesion, triggered by a nociceptive stimulus that can result in intracranial haemorrhage, fits, arrhythmias, hypertensive encephalopathy and even death. This potentially life-threatening condition requires immediate and decisive action.

Spinal units are very familiar with the diagnosis and treatment of autonomic dysreflexia. However, people with spinal cord injury most often present or are taken by an ambulance to their local healthcare facility. As spinal cord injury is not a common condition local healthcare professionals may have little or no experience in recognising or managing autonomic dysreflexia. This has resulted in preventable adverse outcomes with a minimum of 3-4 critical incidents reported each year in NSW.

Symptoms and Signs

The person may present with all or some of the following:

- Pounding headache, which gets worse as the blood pressure rises.
- Flushing or blotching of the skin and/or profuse sweating above Spinal Cord Injury (SCI) lesion level.
- Skin pallor and goose pumps below the SCI lesion level.
- Blurred vision, nasal congestion (stuffiness).
- Chills without fever.
- Shortness of breath, sense of apprehension or anxiety.
- Hypertension - blood pressure is significantly elevated (at least 20-40 mmHg above normal resting systolic level).

Note: It is important to remember that blood pressure for individuals with high paraplegia or tetraplegia may usually be low, around 90-100/60 mmHg lying down and possibly lower whilst sitting. Therefore, patients with spinal cord injury may become symptomatic with blood pressure in the normal range for the general population.

- Bradycardia (as secondary compensatory response to raised blood pressure).

Common Causes of Autonomic Dysreflexia

Any irritating stimulus below the level of the spinal cord injury lesion may precipitate autonomic dysreflexia. Causes of irritation include the following:

- Bladder-related: bladder distension, urine infection, calculus, epididymo-orchitis.
- Bowel-related: bowel distension from constipation, inflamed haemorrhoids, chemical irritation from suppositories.
- Skin-related: pressure sore, burn, ingrowing toenail.
- Other: fractured bones, contracting uterus, acute abdominal condition.

Treatment

Refer below for the Autonomic Dysreflexia Treatment Algorithm.

Treatment Alert

DO NOT use glyceryl trinitrate if sildenafil (Viagra) or vardenafil (Levitra) has been taken in the previous 24 hours or tadalafil (Cialis) in the previous 4 days. In situations where glyceryl trinitrate is contraindicated, an alternative (short-acting) anti-hypertensive agent, such as captopril should be used. Captopril, administered sublingually[1] as a 25mg tablet, has been shown to effectively lower blood pressure within 15 minutes. Advantages of sublingual administration are that the drug enters the general circulation directly, with therapeutic concentrations and onset of action achieved more rapidly than with oral administration. In addition, the partially dissolved tablet may be spat out if there is a very rapid reduction in blood pressure. A rectal examination or insertion of an indwelling catheter may exacerbate autonomic dysreflexia.

Suggested Actions

Emergency Departments and the Ambulance Service are often the first point of contact for the person with autonomic dysreflexia. To prevent delayed or missed diagnosis of autonomic dysreflexia, it is recommended that the following steps be followed.

Ambulance Officers and Services

- Ambulance triage officers should be familiar with the symptoms and signs of autonomic dysreflexia and be able to alert and dispatch Paramedics to respond quickly to this situation.
- When assessing a person with spinal cord injury at/above the T6 level, a high index of suspicion for autonomic dysreflexia is required. The person should be asked if they have had autonomic dysreflexia before and simple measures to reduce blood pressure should be taken.
- Ring ahead to alert the Emergency Department that a person with suspected autonomic dysreflexia is arriving.
- Ensure the autonomic dysreflexia management algorithm is readily available in ambulances.
- Provide education on autonomic dysreflexia management on a regular basis.
- Have glyceryl trinitrate sublingual (eg: Anginine tablets, Nitrolingual Pumpspray) or transdermal patches available.

Emergency Departments

- On arrival at the Emergency Department, the patient should be seen immediately by the triage nurse. Suspected autonomic dysreflexia should be assigned a Category 2.
- Care should be directed by the most senior doctor present in the Emergency Department (ED) with appropriate specialist consultation.
- The cause of autonomic dysreflexia needs to be identified and treated for resolution. If no cause is found and/or autonomic dysreflexia persists, blood pressure must be adequately controlled. Management of hypertensive crisis with intravenous medication may be required to control blood pressure, while contact is being made with a spinal specialist about further management (see below).
- After resolution of an autonomic dysreflexia episode, blood pressure should be monitored for 4 hours. In some severe cases of autonomic dysreflexia, the person should be admitted for observation.
- Ensure the autonomic dysreflexia management algorithm (see below) is easily available in the ED and education on autonomic dysreflexia management is provided.
- For facilities using the EDIS/FirstNet, a clinical alert should be entered onto the system noting that **"the patient is at risk of autonomic dysreflexia please refer to Safety Notice 014/10 - Autonomic Dysreflexia for guidance in the management of this condition".**

Staff in general hospitals and wards

- Any person with spinal cord injury at/above the T6 level should have a "when necessary" order for sublingual glyceryl trinitrate (eg Nitrolingual Pumpspray or Anginine tablet/s) recorded on the drug chart on admission.
- Development of symptoms and signs of autonomic dysreflexia requires immediate attention to assess blood pressure and look for reversible causes. If a reversible cause is not rapidly found, prompt medical review is necessary to further assess possible causes and initiate appropriate treatment.
- The autonomic dysreflexia management algorithm (see below) should be easily accessible.
- For facilities using the electronic medical record a clinical alert should be entered onto the system noting that "the **patient is at risk of autonomic dysreflexia please refer to Safety Notice 014/10 - Autonomic Dysreflexia for guidance in the management of this condition".**

Further Advice about Patient Management

If glyceryl trinitrate or captopril do not lower the blood pressure sufficiently and/or the cause of the autonomic dysreflexia has not been identified, please contact, via the hospital switch board, the on-call Spinal Cord Injury Physician at either Royal North Shore Hospital (02) 9926 7111 or the Prince of Wales Hospital (02) 9382 2222.

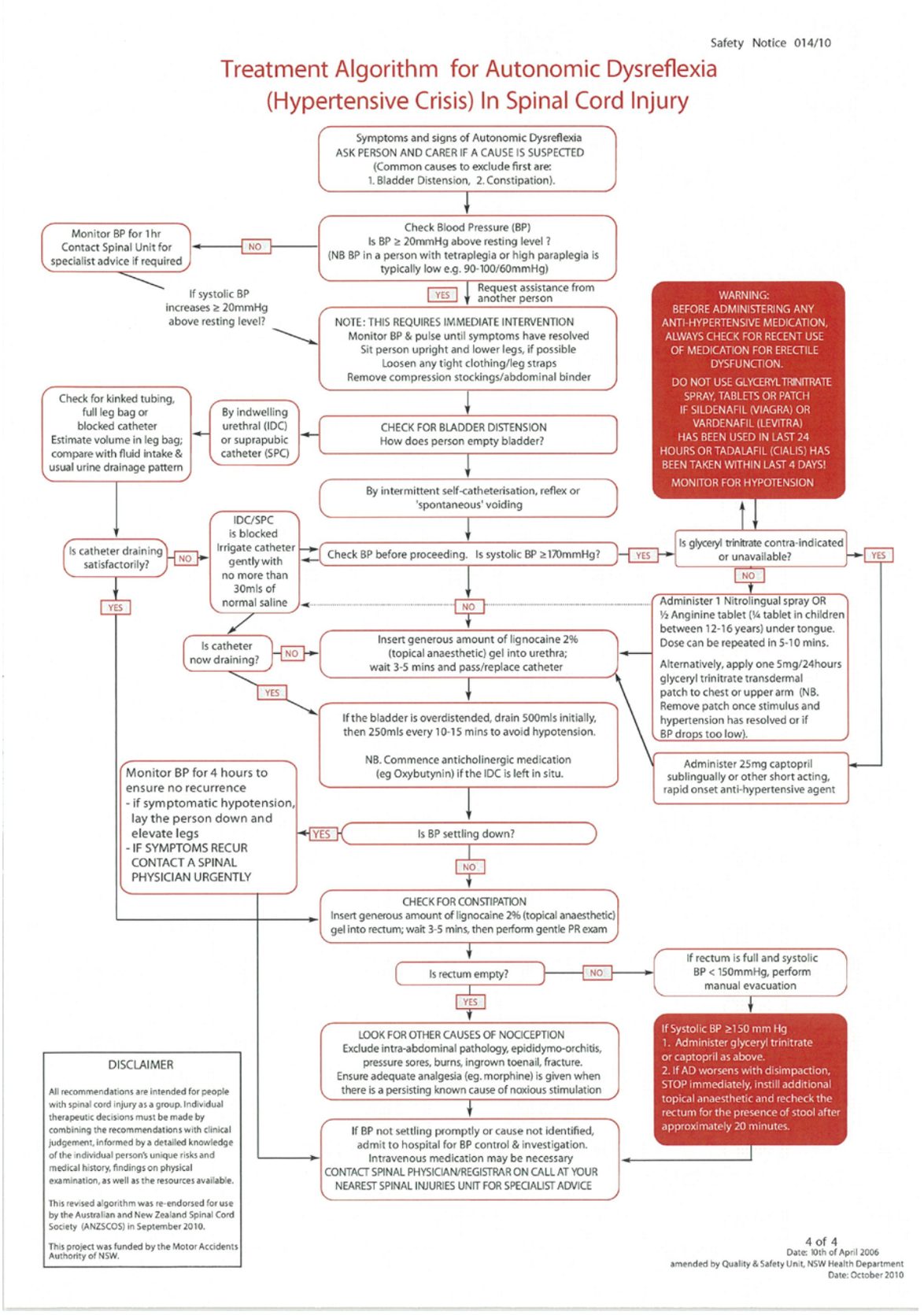
Other Suggested Actions

- Consult the patients and carers, determine if they know about this condition as they can often suggest a cause of the symptoms and management strategies.
- Check if patients are carrying an Autonomic Dysreflexia Management Card that can assist to identify the cause of symptoms and provide treatment strategies.
- It is suggested that Autonomic Dysreflexia is noted in the EDIS, NSW Health medical record or Electronic Medical Record Alert and NSW Ambulance Service Alert (Protocol 71 or electronic Mobile Data Terminal) systems.

Further Information about Autonomic Dysreflexia

The **NSW State Spinal Cord Injury Service** website includes clinical information sheets and practice guides about:

- Treatment of Autonomic Dysreflexia for Adults and Adolescents with spinal cord injury
- An Overview of Skin and Pressure Ulcer Management
- Management of the Neurogenic Bladder in spinal cord injury
- Management of the Neurogenic Bowel in spinal cord injury


Safety Notice 014/10
Treatment Algorithm for Autonomic Dysreflexia
(Hypertensive Crisis) In Spinal Cord Injury
Symptoms and signs of Autonomic Dysreflexia
ASK PERSON AND CARER IF A CAUSE IS SUSPECTED
(Common causes to exclude first are:
1. Bladder Distension, 2. Constipation).
Check Blood Pressure (BP)
Is BP ≥ 20mmHg above resting level ?
(NB BP in a person with tetraplegia or high paraplegia is typically low e.g. 90-100/60mmHg)
NO
Monitor BP for 1hr
Contact Spinal Unit for specialist advice if required
If systolic BP increases ≥ 20mmHg above resting level?
YES
Request assistance from another person
NOTE: THIS REQUIRES IMMEDIATE INTERVENTION
Monitor BP & pulse until symptoms have resolved
Sit person upright and lower legs, if possible
Loosen any tight clothing/leg straps
Remove compression stockings/abdominal binder
WARNING:
BEFORE ADMINISTERING ANY ANTI-HYPERTENSIVE MEDICATION, ALWAYS CHECK FOR RECENT USE OF MEDICATION FOR ERECTILE DYSFUNCTION.
DO NOT USE GLYCERYL TRINITRATE SPRAY, TABLETS OR PATCH IF SILDENAFIL (VIAGRA) OR VARDENAFIL (LEVITRA) HAS BEEN USED IN LAST 24 HOURS OR TADALAFIL (CIALIS) HAS BEEN TAKEN WITHIN LAST 4 DAYS!
MONITOR FOR HYPOTENSION
CHECK FOR BLADDER DISTENSION
How does person empty bladder?
By indwelling urethral (IDC) or suprapubic catheter (SPC)
Check for kinked tubing, full leg bag or blocked catheter
Estimate volume in leg bag; compare with fluid intake & usual urine drainage pattern
By intermittent self-catheterisation, reflex or 'spontaneous' voiding
Check BP before proceeding. Is systolic BP ≥170mmHg?
YES
Is glyceryl trinitrate contra-indicated or unavailable?
YES
NO
Administer 1 Nitrolingual spray OR ½ Anginine tablet (¼ tablet in children between 12-16 years) under tongue. Dose can be repeated in 5-10 mins.
Alternatively, apply one 5mg/24hours glyceryl trinitrate transdermal patch to chest or upper arm (NB. Remove patch once stimulus and hypertension has resolved or if BP drops too low).
Administer 25mg captopril sublingually or other short acting, rapid onset anti-hypertensive agent
NO
IDC/SPC is blocked Irrigate catheter gently with no more than 30mls of normal saline
Is catheter draining satisfactorily?
NO
YES
Is catheter now draining?
NO
YES
Insert generous amount of lignocaine 2% (topical anaesthetic) gel into urethra; wait 3-5 mins and pass/replace catheter
If the bladder is overdistended, drain 500mls initially, then 250mls every 10-15 mins to avoid hypotension.
NB. Commence anticholinergic medication (eg Oxybutynin) if the IDC is left in situ.
Monitor BP for 4 hours to ensure no recurrence
- if symptomatic hypotension, lay the person down and elevate legs
- IF SYMPTOMS RECUR CONTACT A SPINAL PHYSICIAN URGENTLY
YES
Is BP settling down?
NO
CHECK FOR CONSTIPATION
Insert generous amount of lignocaine 2% (topical anaesthetic) gel into rectum; wait 3-5 mins, then perform gentle PR exam
Is rectum empty?
NO
YES
If rectum is full and systolic BP < 150mmHg, perform manual evacuation
If Systolic BP ≥150 mm Hg
1. Administer glyceryl trinitrate or captopril as above.
2. If AD worsens with disimpaction, STOP immediately, instill additional topical anaesthetic and recheck the rectum for the presence of stool after approximately 20 minutes.
LOOK FOR OTHER CAUSES OF NOCICEPTION
Exclude intra-abdominal pathology, epididymo-orchitis, pressure sores, burns, ingrown toenail, fracture.
Ensure adequate analgesia (eg. morphine) is given when there is a persisting known cause of noxious stimulation
If BP not settling promptly or cause not identified, admit to hospital for BP control & investigation.
Intravenous medication may be necessary
CONTACT SPINAL PHYSICIAN/REGISTRAR ON CALL AT YOUR NEAREST SPINAL INJURIES UNIT FOR SPECIALIST ADVICE
DISCLAIMER
All recommendations are intended for people with spinal cord injury as a group. Individual therapeutic decisions must be made by combining the recommendations with clinical judgement, informed by a detailed knowledge of the individual person's unique risks and medical history, findings on physical examination, as well as the resources available.
This revised algorithm was re-endorsed for use by the Australian and New Zealand Spinal Cord Society (ANZSCOS) in September 2010.
This project was funded by the Motor Accidents Authority of NSW.
4 of 4
Date: 10th of April 2006
amended by Quality & Safety Unit, NSW Health Department
Date: October 2010

MATERNITY – RESUSCITATION OF THE NEWBORN INFANT (GL2018_016)

GL2018_016 rescinds PD2008_027

PURPOSE

This Guideline aims to optimise, facilitate and standardise newborn resuscitation by endorsing the Australian and New Zealand Committee on Resuscitation (ANZCOR) Guidelines - Section 13: Neonatal Guidelines (2016- 17)1 for use by NSW Health.

KEY PRINCIPLES

This Guideline applies to all clinicians who care for newborn infants in maternity and related environments and to the resuscitation of the newborn immediately following birth and during the birth admission.

USE OF THE GUIDELINE

This Guideline:

- replaces the Policy Directive PD2008_027 Maternity - Clinical Care and Resuscitation of the Newborn Infant
- endorses ANZCOR Guidelines (2016-2017) Section 13 - Neonatal guidelines 13.1-13.10 and the Newborn Life Support algorithm (Attachment 1)
- outlines local health district responsibilities to develop systems to ensure:
  - clinicians are appropriately targeted to complete mandatory and recommended newborn basic life support education, training and proficiency requirements
  - locally determined clinicians complete newborn advanced life support education, training and proficiency requirements, and are in attendance at the birth of newborn infants who are at higher risk of requiring resuscitation at birth
  - standardised newborn resuscitation equipment is available and operational and clinicians are familiar with the equipment
  - local procedures are in place to review resuscitation interventions and outcomes to monitor patient safety and quality of care and improve training and performance.

To download the complete Maternity – Resuscitation of the Newborn Infant Guideline please go to: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_016

HOSPITAL RESPONSE TO PANDEMIC INFLUENZA PART 1: EMERGENCY DEPARTMENT RESPONSE (PD2007_048)

Section 1: Overview

Introduction

This document describes the response of emergency departments (EDs) and multi purpose services to an influenza pandemic. For simplicity, when the term 'emergency department' is used in this document, it refers to all facilities in NSW with an emergency department, and all multi purpose services.

Due to the wide variability of health care facilities in New South Wales (NSW), a document such as this cannot be entirely prescriptive. Rather, it should be seen as a guide for developing and implementing a local response to pandemic influenza. Strategies will need to be implemented at each facility to ensure they meet the objectives described in this document.

The two main stages of the pandemic response are the containment stage and the 'maintenance of social function' stage.

In the containment stage, the emphasis is on slowing the spread of a pandemic to reduce the burden on the health system and to buy time for the development of a pandemic influenza vaccine. The main strategies in this stage are to:

- prevent people with pandemic influenza entering Australia
- find people with pandemic influenza, isolate them, and treat them with antiviral medication
- trace the contacts of these people, provide them with antiviral prophylaxis, and quarantine them.

A close liaison between clinicians and public health unit (PHU) personnel is vital for containment to be successful.

The 'maintenance of social function' stage will occur when the resources required for containment are exceeded. In this stage, the key role of EDs will be to manage the potentially large number of patients with pandemic influenza who require high level medical care.

A response to an influenza pandemic will require the mobilisation of resources from across the area health services (AHSs), particularly during the later stages. Each AHS will be required to develop plans to operationalise the ED response to an influenza pandemic at all facilities with an ED.

The *Hospital Response to Pandemic Influenza. Part 1: Emergency Department Response* document should be read in conjunction with the *Interim National Pandemic Influenza Clinical Guidelines* and *Interim Infection Control Guidelines for Pandemic Influenza in Healthcare and Community Settings*, which are appendices to the *Australian Health Management Plan for Pandemic Influenza* (AHMPPI) (June 2006).

Overview of emergency department response to an influenza pandemic

EDs have a key part to play in the response to an influenza pandemic in NSW, particularly in their role in activating enhanced ED triage and influenza screening stations.

6. EMERGENCY CARE 6.94

To respond to the changing nature of an influenza pandemic, a graded response to the threat will be required. This response will range from the establishment of enhanced ED triage (when a new influenza strain is reported to be causing clusters of human disease with human-to-human transmission overseas) to the establishment of ED screening stations (when there is a high likelihood that a patient meeting the case definition will present to an ED). Once there are clusters of cases in Australia that exceed (or are expected to exceed) the capacity of EDs such that a broader AHS response is required, stand-alone influenza clinics will be established. The role of stand-alone influenza clinics will be to see suspected pandemic influenza patients who are not in need of high-level ED care. Stand-alone influenza clinics will not provide high-level emergency care; this role will be maintained by the EDs.

The NSW Department of Health (NSW DoH) will request initiation and escalation of response through the AHS chief executives. The NSW DoH will define the level of the operational response required, which will depend upon the epidemiological characteristics of the disease, including the extent of pandemic influenza overseas, transmissibility of the pandemic influenza virus, and the level of morbidity and mortality resulting from the new influenza strain.

Table 1 summarises the levels of response required and the drivers that will determine the need for an increase in the level of response. All NSW public and private hospitals with EDs will be required to initiate the response described in this table. Each facility will need to consider their own circumstances and devise strategies to ensure they meet the response objectives.

Table 1. Description, drivers for activation, and purpose of emergency department (ED) response to an influenza pandemic

Response	Description	Drivers for activation	Purpose
Enhanced emergency department (ED) triage initiated	Additional screening conducted at the usual ED triage point, based on an up-to-date case definition.	Declaration of overseas pandemic alert phase 4[1] (OS phase 4) - clusters with human-to-human transmission overseas - where the clusters are occurring in a relatively isolated region. (If first clusters are in a major centre overseas, a move directly to pandemic influenza screening stations may be required.)	**Containment stage** To decrease the rate of transmission of pandemic influenza in the community, general practice surgeries, hospitals and other health care facilities by: ensuring rapid identification and isolation of suspected cases allowing diagnosis and treatment of cases with antiviral agents, if indicated providing a linkage with the public health response of contact tracing and provision of anti viral prophylaxis allowing collection of epidemiological and clinical data to inform clinical management and public health decisions.
ED pandemic influenza screening station established	Pandemic influenza screening station established at the entrance to ED to identify patients who meet the pandemic influenza case definition before they enter the waiting room.	No cases in Australia (Australian pandemic alert phase 0-3) but outbreaks occurring in areas overseas from which it is significantly likely that people will be travelling to Australia. Widespread outbreaks overseas. Significant morbidity and mortality from pandemic influenza overseas. Declaration of Australian pandemic alert phase 4 (i.e., clusters with human-to-human transmission in Australia).	**Containment stage** As for enhanced ED triage, and to allow a higher level of vigilance than provided by enhanced ED triage in light of an increased likelihood of pandemic influenza cases being encountered.
Stand-alone influenza clinic37 established. **ED pandemic influenza screening station established/maintained.**	A separate influenza clinic facility established to identify and treat those who meet the case definition for pandemic influenza. Note: an influenza screening station at the entrance to ED will still need to be maintained.	**At containment stage** ED capacity to isolate and manage suspected cases is exceeded. **At 'maintenance of social function' stage** Inability to contain pandemic influenza outbreaks (resulting in declaration of 'maintenance of social function' stage). Declaration of influenza pandemic (Australian phase 6b).	**Containment stage** As for enhanced ED triage, and to allow effective management of an increased number of pandemic influenza patients. **'Maintenance of social function' stage** To provide standardised assessment, triage, and management of patients with suspected pandemic influenza. To reduce patient presentations to EDs and general practices, thereby allowing those facilities to continue their core business and reduce the risk of transmission within those settings. To collect epidemiological data to monitor progress of the pandemic and inform optimal resource allocation.

[1]This assumes that a pandemic starts overseas. If a pandemic starts in Australia, an elevated level of response will be immediately required.
[2] The governance structure of the stand-alone influenza clinic will need to be determined by the area health service (AHS) and identified in AHS and facility plans.

Activation of enhanced triage, influenza screening stations and influenza clinics

The NSW Chief Health Officer (CHO) will notify the AHS chief executives of the change in the pandemic alert level and instruct AHSs to activate one of the ED response strategies listed below. The response will depend on the phase of the pandemic alert, the number and location of people with pandemic influenza, and the epidemiology of the new influenza virus. The three levels of response are:

- enhanced triage within EDs
- separate pandemic influenza screening stations
- stand-alone influenza clinics (note: if a stand-alone influenza clinic is required, screening stations will still need to operate at the entrance to the ED).

Activation of enhanced triage within EDs will be required within 8 hours of notification; activation of ED screening stations will be required within 12 hours, and activation of stand-alone influenza clinics within 48 hours. The NSW DoH will require confirmation by AHS chief executives that activation has occurred.

A pandemic influenza case definition to be used for screening purposes will be provided to all AHSs at, or shortly after, the formal request to activate an ED response. The new case definition, and subsequent case definitions, will be available on the **NSW Health intranet and internet websites**, and will be found immediately after the Netepi login page. Netepi is a web-based public health data collection and management system.

A detailed breakdown of the ED pandemic influenza response, according to the containment and 'maintenance of social function' stages, is provided in Section 2 of this document.

Governance structure

The governance structure for the various response levels will need to be determined by individual AHSs and outlined in the AHS plan.

Patient disposition

Following assessment of patients' clinical condition, likelihood of complying with home isolation, and ability to care for themselves, patients will be either admitted to hospital and isolated or discharged for self-care in home isolation. The decision to discharge a potentially infectious patient must be made in consultation with the PHU and relevant specialists. Patients must remain in isolation (in hospital or at home) until an alternative diagnosis is made or the infectious period is over.

If admitted to hospital, the patient may be admitted to either the hospital to which the patient has presented or to another hospital in accordance with AHS plans for suspected and confirmed cases of pandemic influenza. If admitted to hospital, the patient should be cared for in a single room. Patients with confirmed pandemic influenza should also be cared for in a single room; however, if insufficient single rooms are available, patients with confirmed pandemic influenza can be cohorted and isolated in a separate ward or wing of the hospital. The number of staff who come into contact with the patient should be minimised.

The collection of clinical and demographic information required to facilitate contact tracing by the PHU will be an important activity in the ED response. The investigation does not have to be carried out in the ED, but it is important that the patient is kept in isolation at the facility while this investigation is being carried out.

Accompanying persons

It is likely that patients who are suspected of being infected with pandemic influenza will present with accompanying persons. In all but exceptional circumstances (e.g., where the suspected case is a child) accompanying persons who do not meet the case definition should be provided with information about pandemic influenza, have their contact details collected and provided to the PHU, and (upon advice of the PHU) be sent to home quarantine. The PHU will provide advice about the management of accompanying persons.

If the ED clinician decides that it is necessary for an accompanying person to remain with the patient, advice must be sort from the PHU before the accompanying person is allowed into the isolation room with the suspected case.

Management procedures for persons accompanying children presenting to a children's hospitals have not yet been finalised. This document will be updated when these procedures are available.

Section 2: Response levels

Enhanced emergency department triage

During the containment stage - when small clusters of human-to-human transmission of the new influenza virus have been reported overseas (WHO Overseas phase 4, Australian phase 0-3) - all facilities with emergency departments (EDs), and multipurpose services, will be required to commence enhanced ED triage with screening for pandemic influenza. Screening is to be performed at the beginning of the ED triage process, and provision must be made for the isolation and management of suspected pandemic influenza patients in single rooms. To ensure the safety of health care workers, screening should be conducted from behind a physical barrier such as a glass screen or by keeping more than a metre away from the patient. If this is not possible, full personal protective equipment (PPE) should be worn.

Operating requirements

Once advised to activate enhanced ED triage screening, a senior medical or nursing staff member, as designated in the AHS pandemic influenza plan, will be required to ensure:

- correct signage is displayed
- an up-to-date version of the case definition is available
- all presentations to ED are screened for pandemic influenza during the triage process
- there is a one-way flow of suspected pandemic influenza patients through the ED
- the availability of at least one single room to be used for isolating a suspected case of pandemic influenza (this room should be selected beforehand and identified in the AHS pandemic influenza plan)
- there is an adequate stock (20-100, depending on the facility size) of P2 masks and other PPE for use by the doctor/nurse(s) assessing and managing the suspected case(s), and that these staff use the PPE appropriately
- PPE stock is replenished as required

- a medical officer (or experienced nurse where no medical officer is normally available) is nominated to assess person(s) meeting the case definition. The staff member should be familiar with the case definition and with protocols for diagnosis, clinical management and infection control
- the PHU is contacted immediately upon identification of a suspected case
- viral swabs (as per testing algorithm) are readily accessible (the designated person should, ideally, be experienced in taking nose and throat swabs for viral testing, given the importance of obtaining a quality specimen for an urgent influenza test)
- surgical masks and hand washing facilities (or alcohol-based gel) are available for use by the suspected pandemic influenza case(s)
- screening staff have access to hand washing facilities and/or alcohol-based gel and wash their hands frequently
- availability of anti-influenza medication for treatment of pandemic influenza patients (this should be detailed in the AHS pandemic influenza plan)
- an appropriate cleaning regime in accordance with infection control guidelines is in place to disinfect areas potentially infected.

Operating procedure

The procedure for enhanced ED triage is described below. A flow diagram summarising the process is shown in Figure 1.

Step 1: Screen

- At first contact, all patients are to be asked the up-to-date pandemic influenza screening questions.
- If a patient meets the case definition, proceed to Step 2. If a patient does not meet the case definition, the triage process continues as normal.
- Refer to Figure 2 for a more detailed description of the screening process.

Note 1: In facilities where the implementation of enhanced ED triage is not possible (e.g., in facilities that do not have a permanently staffed ED), different strategies will need to be implemented to keep pandemic influenza out of the facility. Strategies may include an early move to setting up a screening station at the entrance to a facility.

Note 2: Once enhanced ED triage is implemented, ambulance officers will screen all patients upon pickup and report identified suspected pandemic influenza cases to facilities prior to arrival. Section 3 of this document provides more information on the role of ambulance officers in response to pandemic influenza.

Note 3: When there is an outbreak or outbreaks of pandemic influenza overseas but not in Australia (WHO Overseas phase 4 or above, Australia phase 0-3) the epidemiological screening questions (on travel history) are to be asked before the clinical questions because they are the more specific discriminators and because they can be asked while keeping a safe distance. Once cases are identified widely in Australia (implying that overseas travel/contact with someone who has travelled overseas to the affected areas ceases to be the discriminating factor) travel history will be removed from the case definition and clinical features will prevail.

Step 2: Isolate

- If a patient meets the case definition, treat them as a suspected case of pandemic influenza: provide them with a surgical mask, instruct them to wash their hands, and isolate them immediately in a single room. If a single room is not available, cohort pandemic influenza patients in such a way that risk of transmission is minimised.

Note: If a patient with suspected pandemic influenza has not been triaged immediately on arrival at the ED, the contact details of all the people within the ED waiting room (including other patients and staff) who have been in contact with the suspected case must be recorded in case pandemic influenza is later confirmed and contact tracing is required.

- Clean the triage area as per infection control guidelines.

Step 3: Assess/manage

- Continue subsequent assessment and management of the patient with suspected pandemic influenza in a single room. If the patient requires immediate medical intervention, this should be performed in the single room wherever possible.
- Obtain demographic information for the patient.
- Perform a clinical assessment.
- Obtain appropriate specimens for laboratory testing. Details relating to the collection of microbiological specimens can be found in *Pandemic Influenza - Interim Response Protocol for NSW Public Health Units.* For viral specimen collection, one viral swab (not a bacterial swab) from the right nostril, one viral swab from the left nostril and one viral swab from the throat (i.e., three swabs in total) are required.

Step 4: Notify/consult

- If the suspected case still fits the case definition, notify the PHU of the suspected case by telephone and provide details of information collected to date. PHU staff are available 24 hours a day in all areas of NSW; contact details are available in the AHS pandemic influenza plan or via the AHS switchboard or the NSW Health intranet contact directory.
- Consult with PHU staff and infectious disease and/or other relevant physicians regarding diagnosis and continued management of the suspected case.
- Obtain advice from the PHU about where specimens should be sent.

Step 5: Send specimens

- Following consultation with the public health unit and infectious disease physician, and confirmation that the patient meets the case definition for pandemic influenza, send specimens.
- Specimens are to be labelled ‘suspect case of pandemic influenza’.
- The hospital laboratory is responsible for notifying the reference laboratory and ensuring the urgent transport of the specimens to the reference laboratory for specific detection of the pandemic influenza strain. The two reference laboratories in NSW are the Institute for Clinical Pathology and Medical Research (ICPMR) at Westmead, and the South East Illawarra Area Laboratory Service (SEALS) at Prince of Wales Hospital, Randwick.

- Other specimens (including microbiological specimens) should be processed following usual procedures.
- Specimens are to be packaged and transported in accordance with the National Pathology Accreditation Advisory Council's *Requirements for the packaging and transport of pathology specimens and associated materials.* (The National Pathology Accreditation Advisory Council guidelines can be found at) **http://www.health.gov.au/internet/publications/publishing.nsf/Content/npaac-pub-transp-path-spec-drft**

Step 6: Treat

- If there is a high index of clinical suspicion for pandemic influenza, assess the patient for contraindication to anti-influenza medication and consider administering the first dose of treatment while awaiting the pathology result (given the importance of administering anti-influenza medication as early as possible after symptom onset), and certainly within 48 hours.
- If reference laboratory confirmation of the diagnosis is likely to take longer than 8 hours, it is recommended that the first dose of anti-influenza medication be administered as soon as possible.

Step 7: Admit/discharge

- If the pandemic influenza test is positive or a diagnosis of pandemic influenza cannot be excluded, admit the patient to hospital or, following assessment of the patient's clinical condition and ability to comply, discharge them to home isolation. Discharge of potentially infectious patients *must* be made in consultation with the PHU and relevant specialists.
- If a decision has been made to admit the patient and they do not require further care in the ED, they can be transferred out of the ED and into a single room elsewhere in the facility. Further clinical and public health follow up can occur in that single room.

Figure 1. Flow diagram for the screening, assessment and management of a suspected pandemic influenza case in the emergency department

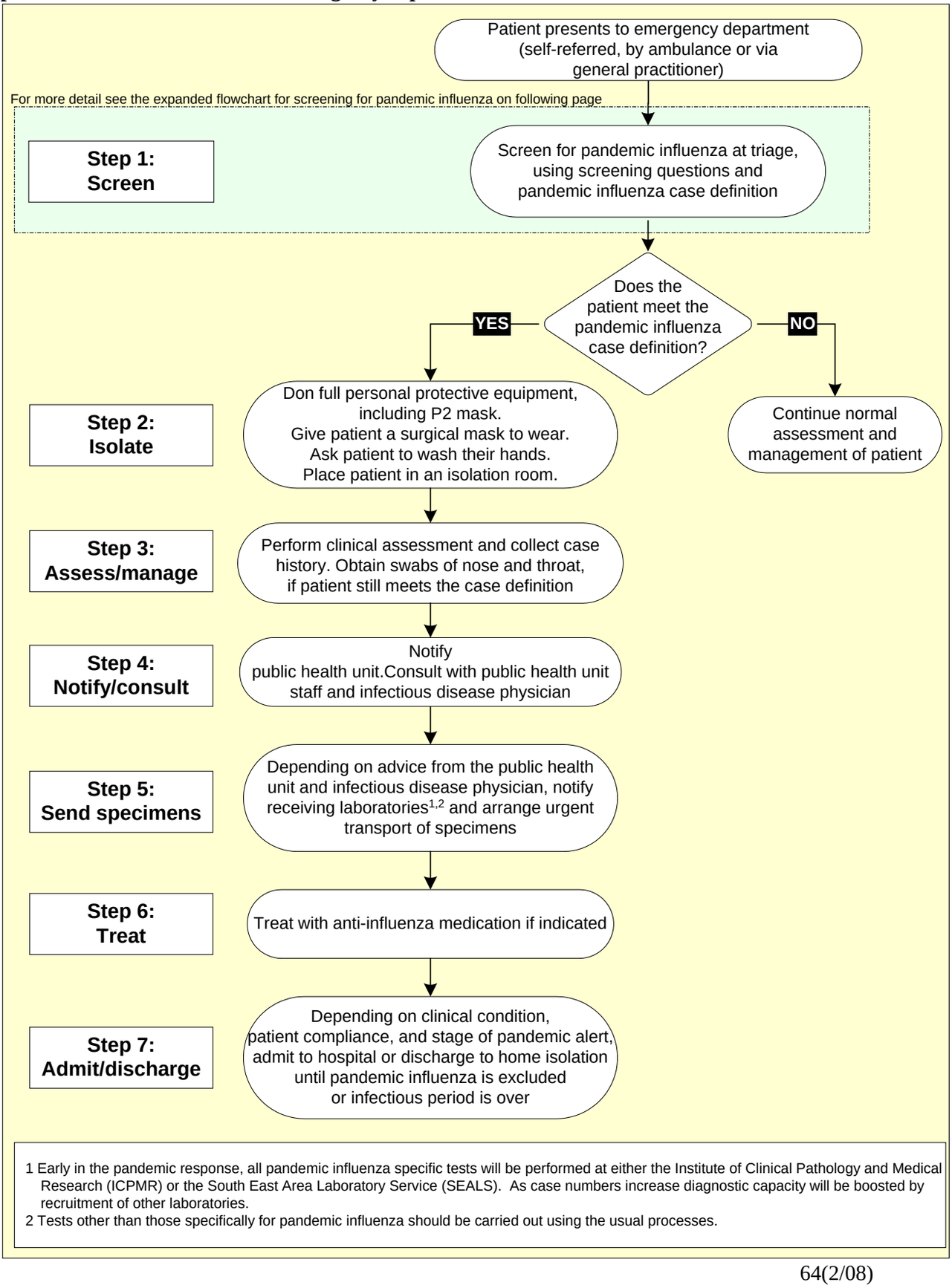
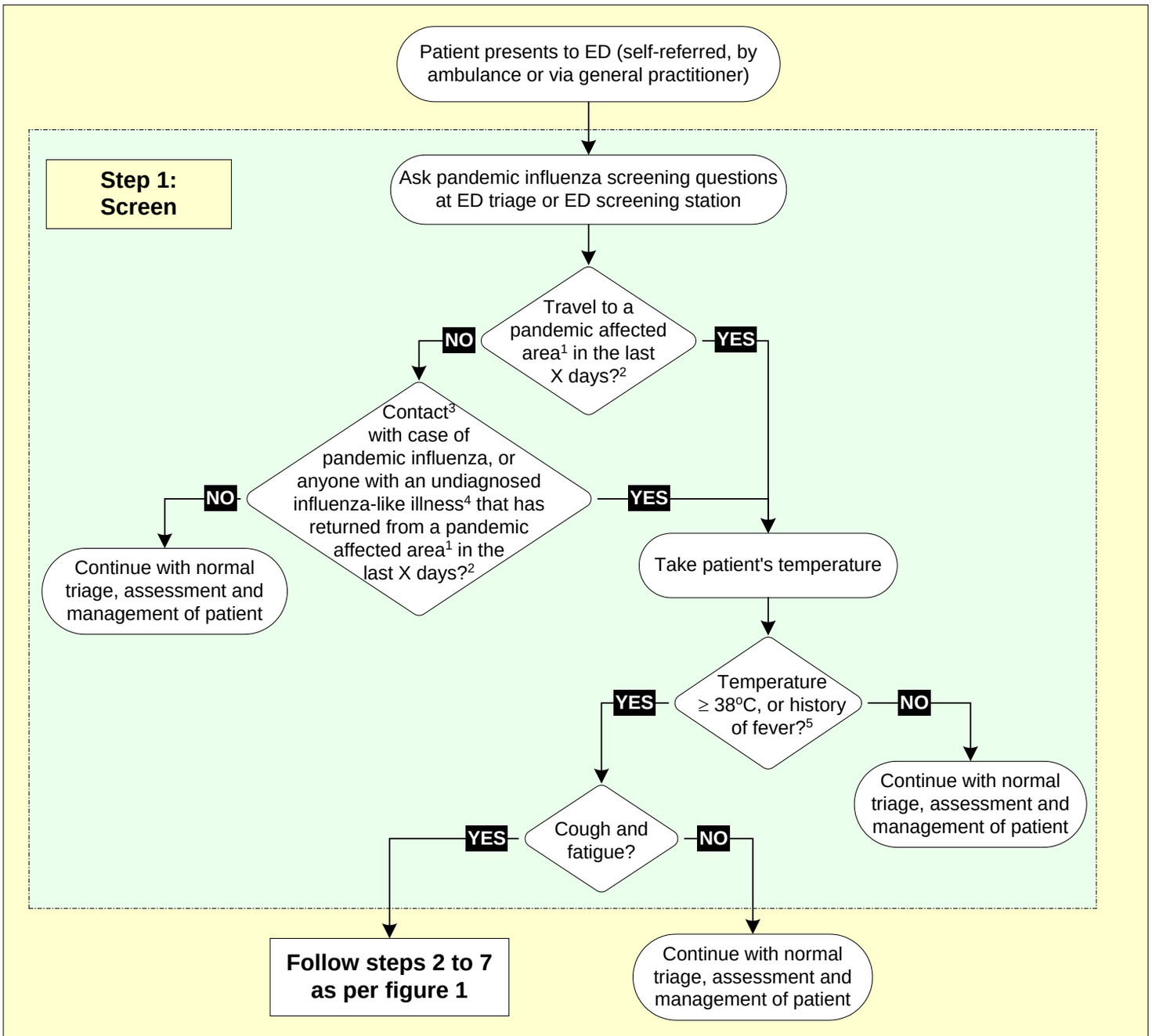


Figure 2. Flow diagram of the screening process for pandemic influenza



1 Pandemic affected areas may change rapidly. The most up-to-date listing of pandemic affected areas will be found in the case definition provided to hospitals and public health units, or at http://www.who.int/en/.

2 Number of days will depend on the epidemiological characteristics of the virus, including the incubation period and infectious period. This information will be included in case definitions provided to hospitals and public health units. If these values are not known, the default number is 7 days.

3 Contact is defined as having been within one metre of an infectious case, or in physical contact with a case or their respiratory droplets or secretions (see AHMPPI 2006 Annex: *Interim National Pandemic Influenza Clinical Guidelines,* pg 32 for more detail on definition of a contact).

4 An influenza-like illness is characterised by an abrupt onset of symptoms that includes fever and cough, and one or more of: headache, fatigue, sore throat, mylagia (muscle pain), chills and shortness of breath.

5 A history of fever includes either i) a recent temperature of≥ 38ºC (within the last 24 hours) as measured and reported by the patient, or ii) a description of chills and sweats, or a feeling of being hot, or hot and cold.

Emergency department screening stations

Screening for influenza using screening stations at the entrance to EDs (or in smaller facilities without permanent EDs, at the entrance to the facility) will commence when the likelihood of patients with pandemic influenza being encountered has increased to a stage that warrants screening of *all* people presenting to an ED *before* they enter the ED waiting room, and *before* they are triaged. This is expected to occur when Australia pandemic alert phase 4 is declared (clusters of cases with the new influenza strain with human-to-human transmission are reported in Australia) or when cases have not yet been reported in Australia but are occurring in major regional transport hubs. Activation of screening stations will be required within 8 hours in metropolitan and base hospitals and within 12 hours in rural hospitals. It is expected that close monitoring of epidemiological data will provide advanced warning that an elevation of response will be required.

It is possible that some parts of the state will establish ED screening stations, while others that are less likely to see patients with suspected pandemic influenza because of their distance from the reported cases of influenza, will continue with an enhanced ED triage response.

The driver for the activation of ED screening stations is principally an assessment that the new influenza virus poses an increased and imminent risk to NSW health facilities. This risk will be assessed based on the epidemiological characteristics of patients identified with the new influenza virus, the number and location of people with confirmed pandemic influenza , and the threat to the local area.

It is acknowledged that a number of very small facilities will not be able to implement screening stations. These facilities will need to be identified in AHS plans and will need to develop strategies locally to meet the objective of keeping pandemic influenza out of their facilities. Strategies may include screening through intercom, facility lock down, or advance screening by telephone.

A cascaded approach to ‘ramping up’ a broader whole-of-facility response to keeping pandemic influenza out of facilities will be implemented according to the level of threat. This will include limiting entry and exit points to facilities; limiting visitor number and times that visitors can enter facilities; postponing elective and non-urgent treatment for persons returning from pandemic influenza-affected areas; and screening staff. A policy designed to keep hospitals safe from the threat of pandemic influenza is being developed.

Operating requirements

In essence, an ED screening station is similar to the enhanced ED triage response, and the operating requirements are also similar. The significant difference is that with a screening station the screening for pandemic influenza will occur at the entrance to the ED and not at the normal ED triage point. Screening stations will need to operate 24 hours and screen all patients and accompanying persons who present to the ED. The location and management of this screening station will be described in the AHS pandemic influenza plan.

Operating requirements and procedure

The operating requirements for ED screening stations are similar to those for enhanced triage, described in Section 2.1, except that a screening table, chairs and, if appropriate, shelter will be required.

The operating procedure is also similar, apart from the changes and additions listed below.

Step 1: Screen

- All patients and accompanying persons attending the ED must be screened at the influenza screening station located at the entrance to the ED.
- All patients presenting are to be asked screening questions based on an up-to-date pandemic influenza case definition.
- If the patient does not meet the case definition, the patient proceeds to triage as normal.

Note: All staff at pandemic influenza screening stations must wear full PPE while screening and the screening station must be disinfected in accordance with infection control guidelines each time a suspect case is identified.

Steps 2 to 7

If the patient meets the case definition, follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure described in Section 2.1.

Refer to Figure 2, above, for a summary of the process of screening for pandemic influenza.

Stand-alone influenza clinic (during containment stage)

Stand-alone influenza clinics will commence operation in a location separate from the ED when the number of people with suspected pandemic influenza exceeds the capacity of the ED to isolate and manage them appropriately.

Stand-alone influenza clinics will require activation within 24 hours of notification in metropolitan and base hospitals and within 48 hours in rural and remote hospitals. It is expected that close monitoring of epidemiological data will provide advanced warning of the need to activate stand-alone influenza clinics.

During the containment stage, the key roles of a stand-alone influenza clinic will be to continue the process of containing the spread of pandemic influenza by enabling the rapid identification, isolation, and management of patients with suspected pandemic influenza, and to expedite follow up of their contacts by the PHU. Stand-alone influenza clinics will relieve the patient load on EDs by assessing and managing patients who do not require high-level care in an ED, thus allowing EDs to continue their core role of treating critically ill patients.

Stand-alone influenza clinics will not have the capacity to provide high-level emergency care; EDs will maintain this role. If a patient with suspected pandemic influenza is sick enough to require high-level emergency care, they will need to be transferred to the ED.

Stand-alone influenza clinics will need to be prepared to operate 24 hours per day and have their own dedicated workforce.

Stand-alone influenza clinics will initially be established on hospital campuses. As the number of people affected by pandemic influenza increases, stand-alone influenza clinics may need to be established at other sites.

Operating requirements

A stand-alone influenza clinic during the containment stage will perform the same function as the enhanced ED triage and screening station, but operate on a larger scale. The driver for establishing a separate influenza clinic is an increase (or anticipated increase) in the numbers of patients that meet the pandemic influenza case definition, or an increase in the numbers of patients presenting at EDs in order to be screened for pandemic influenza.

Note that a screening station will still be required at the entrance to the ED when a stand-alone influenza clinic is in operation. Refer to Figure 3, following, for a summary of screening procedures for pandemic influenza at EDs when stand-alone influenza clinics have been activated. The procedures are described in more detail in the next section.

Operating procedure

Patients are likely to present at the stand-alone influenza clinic via two mechanisms:
- after being screened and triaged at an ED, or
- having come directly to the influenza clinic (see Figure 3).

The text below describes operating procedures for both the ED pandemic screening station and the stand-alone influenza clinic.

(i) Patients presenting to the ED pandemic influenza screening station

Step 1: Screen
- All patients and accompanying persons attending the ED must be screened at an influenza screening station located at the entrance to ED.
- All patients and accompanying persons presenting need to be asked screening questions based on an up-to-date case definition for pandemic influenza.
- If the patient does not meet the case definition they should be instructed to proceed through the hospital system as normal.
- Patients that meet the pandemic influenza case definition and are *not* in need of emergency treatment should be provided with a surgical mask and asked to wear it, be asked to wash their hands and then sent to the separate stand-alone influenza clinic for treatment.
- Patients that meet the pandemic influenza case definition and that *are* in need of emergency treatment should be triaged and treated in a single room in the ED.

Steps 2 to 7

Follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure above.

Refer to Figure 2, above, for a description of the process of screening for pandemic influenza.

(ii) Patients presenting to the stand-alone influenza clinic after being screened and triaged at an ED

Step 1: Identify screened patients

All patients and accompanying persons presenting to the stand-alone clinic after being screened and triaged at an ED need to be identified and placed in a separate queue.

Steps 2 to 7

Follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/ discharge) as outlined in the enhanced ED triage operating procedure above.

(iii) Patients presenting directly to the stand-alone influenza clinic

Step 1: Screen

- Patients and accompanying persons presenting directly to the stand-alone influenza clinic need to be screened to ensure that they meet the case definition:
  - If the patient meets the pandemic influenza case definition, they should be triaged and, if *not in need* of high-level emergency treatment, should be assessed and managed in the stand-alone influenza clinic
  - If the patient meets the pandemic influenza case definition, they should be triaged and, if *in need* of high-level emergency treatment, directed to the ED.
- Patients that do not meet the pandemic influenza case definition should be re-directed to the ED, other health care providers (a GP for example) or sent home. Patients that do not meet the influenza case definition should not be treated in an influenza clinic.

Steps 2 to 7

Follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure above.

Stand-alone influenza clinic (during 'maintenance of social function' stage)

The 'maintenance of social function' stage of an influenza pandemic will be declared when it is no longer possible to contain the spread of the new influenza virus in the community. Once the 'maintenance of social function' stage of the pandemic is declared, the purpose of stand-alone influenza clinics will change significantly, moving from a focus on containment (identification and isolation of patients, and quarantining of contacts) to a focus on maintaining essential health service delivery.

During this stage, stand-alone influenza clinics will operate as influenza triage, assessment, and management facilities for potentially large numbers of sick people. The stand-alone influenza clinic staff will determine whether the patient requires admission to a hospital or staging facility, or whether they can be discharged home with community follow-up as required. Laboratory testing for pandemic influenza will not routinely occur during this stage (unless the patient is hospitalised). Contact tracing will no longer be carried out. Current national policy is that stockpiled anti-influenza medications will be available for pre and post exposure prophylaxis and not for treatment of patients. However, this may change as the size of the stockpile is increased.

Operating requirements

The scope and capacity of the 'maintenance of social function' stage stand-alone influenza clinics will be determined by a number of factors including the epidemiological characteristics of the virus, the availability of anti-influenza medication for the treatment of cases and the availability of an effective vaccine.

Operating procedure

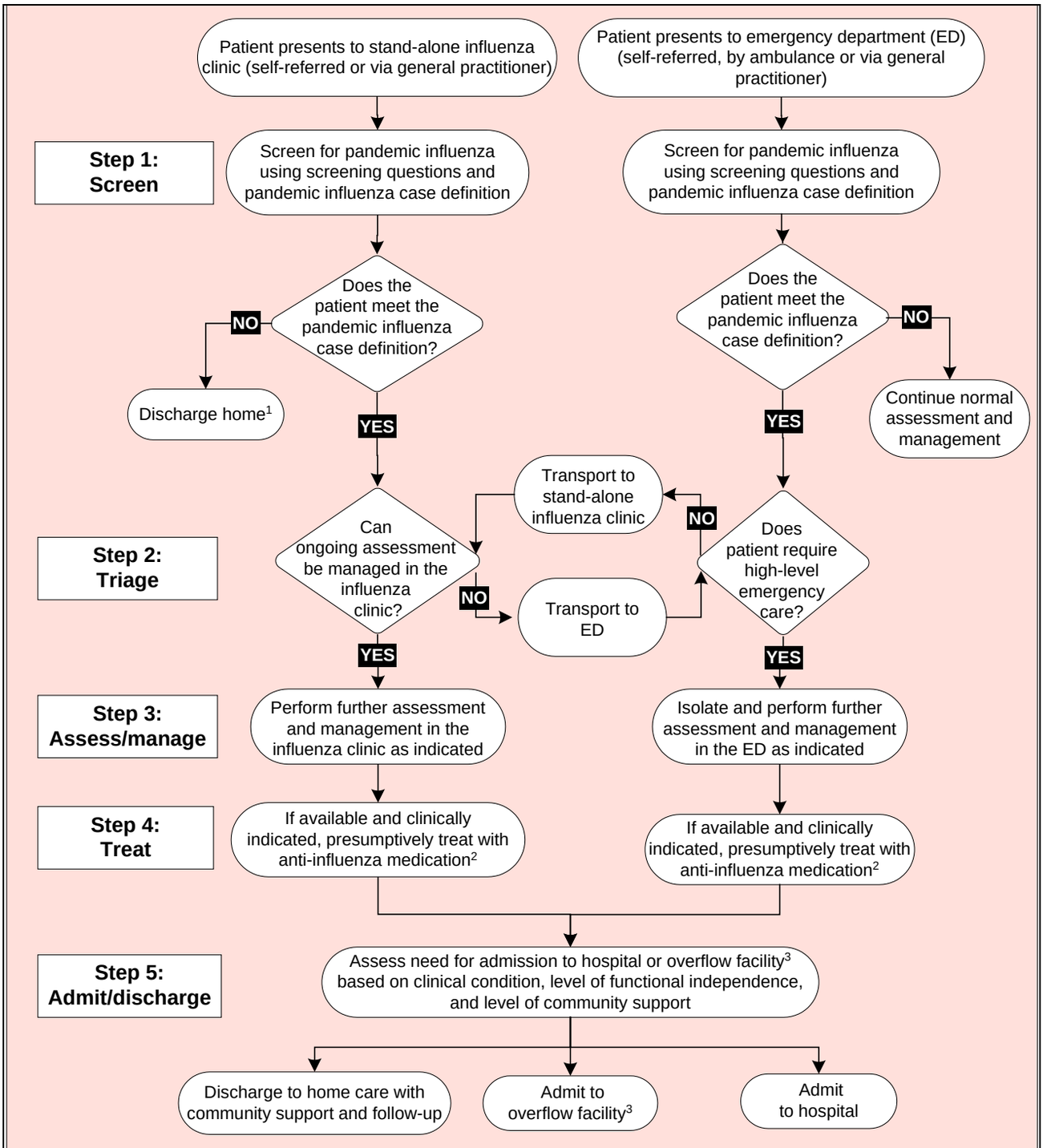
The procedure for operating a stand-alone influenza clinic during the maintenance of social function phase will be significantly different to those for previous response levels.

Staff in a stand-alone influenza clinic will:

- refer patients in need of high-level emergency care to an ED
- manage patients based on a clinical, rather than laboratory, diagnosis of pandemic influenza
- administer anti-influenza medication within 48 hours of symptom onset if medication is still available for treatment of patients, treatment is clinically indicated and there are no contraindications for treatment
- determine whether admission to a hospital, a staging facility, or discharge into home isolation with community follow-up, is required
- if discharging a patient to home care, provide appropriate advice to patient and carer(s) and refer for community follow-up.

A flow diagram summarising case management during the maintenance of social function stage is shown in Figure 3, below.

Figure 3. Flow diagram for the screening, assessment and management of patients with suspected pandemic influenza during the 'maintenance of social function' stage.



1 If the patient appears unwell or requires/requests further assessment, refer to a general practitioner or the nearest emergency department.
2 The current Australian policy for anti-influenza medication use during the maintenance of social function stage, is that if available, these medications will be used for pre- and post-exposure prophylaxis of workers considered to be at high risk through direct contact with influenza cases (see *Australian Health Management Plan for Pandemic Influenza*, June 2006, page 51).
3 Overflow facilities are temporary facilities for the accommodation and care of patients, when it is impractical to manage them at home or in a hospital. The role of these facilities will vary according to the severity of the pandemic but would, in general, be the provision of supportive care rather than the provision of high-level interventions.

Role of other health service providers

Role of general practitioners

The key role of general practitioners (GPs) during an influenza pandemic is to ensure that their usual primary health care services are maintained. If pandemic influenza is suspected in a patient, GPs are encouraged to provide the patient with a surgical mask, refer the patient to an emergency department (ED) or influenza clinic immediately, and notify the ED or influenza clinic that a suspect case has been referred. All suspected pandemic influenza patients should be referred to an ED or influenza clinic as these facilities have the capacity to appropriately assess and manage pandemic patients, access rapid diagnostic tests and anti-influenza medication, and contain further spread of infection.

An exception to this rule will occur in rural and remote areas where GPs may be the only health service provider, or be involved in providing ED response at a local facility. AHSs should plan with GPs as to what the GPs' role will be, and how the GPs' usual primary care role is to be maintained, particularly during the 'maintenance of social function' stage of an influenza pandemic.

The NSW DoH will provide information to all GPs when a change in pandemic alert phase occurs. This information will include advice to refer suspected pandemic influenza patients to EDs and will direct GPs to refer to the NSW DoH website to ensure they are up to date with current case definitions and protocols (e.g., infection control). GPs will also be asked to immediately notify their PHU and ED of any patients with suspected pandemic influenza that they identify and refer.

Role of Aboriginal Medical Services

In metropolitan areas, Aboriginal Medical Services (AMSs) will be encouraged to refer patients that meet the pandemic influenza case definition to EDs. In rural areas, a case-by-case assessment to define the role of AMSs will need to be undertaken, taking into account access to ED facilities, the capacity for isolation and management of patients, and the normal role of the AMS.

AHSs will be required to advise AMSs within their boundaries of any change in the pandemic alert phase or pandemic influenza case definition.

Role of private hospitals that provide emergency department services

The Hills Private Hospital, Kareena Private Hospital and Sydney Adventist Hospital are the only private hospitals in NSW that have EDs. These hospitals will be required to activate enhanced ED triage and ED screening stations at the same time as public hospitals. AHSs are responsible for notifying private hospitals within their boundaries whenever a change in pandemic alert phase and case definition occurs. The mechanism for notifying private hospitals and the role of private hospital EDs during an influenza pandemic, are to be described in the individual AHS influenza pandemic plans.

Role of the NSW Ambulance Service

Once enhanced ED triage is activated, NSW ambulance officers will screen all patients (that are able to be screened) for pandemic influenza on pick-up and, if a case is identified, will (if appropriate) provide the patient with a surgical mask and notify the ED of the suspect case in advance. When ED screening stations are activated, patients that cannot be screened will be presumed to be a suspect case of pandemic influenza, and treated accordingly until proven otherwise. The Ambulance Service of NSW is developing a protocol to guide this process.

The Ambulance Service of NSW is also in the process of developing a protocol defining when ambulances transporting patients who have been identified as suspected pandemic cases should by-pass smaller facilities.

The Ambulance Service of NSW will be involved in the transport of suspected and confirmed pandemic influenza patients between facilities. Protocols to cover this are being developed.

Role of pharmacies

The primary role of pharmacies during all stages of an influenza pandemic is to continue to provide their normal pharmaceutical services. Pharmacies in rural and remote areas in particular should plan for the need to continue to provide essential medicines during an influenza pandemic.

The NSW DoH will notify NSW pharmacies of a change in pandemic alert phase and the pandemic influenza case definition via the Pharmacy Guild. Pharmacies will be encouraged to refer patients that meet the case definition to the nearest public hospital ED.

PUBLIC HEALTH REAL-TIME EMERGENCY DEPARTMENT SURVEILLANCE SYSTEM (PHREDSS) – PUBLIC HEALTH UNIT RESPONSE GUIDELINES (GL2010_009)

PURPOSE

These guidelines describe the purpose and activities of the ED Surveillance Team in monitoring PHREDSS and reporting to Public Health Units (PHUs). It also describes the reasons that a PHREDSS Situation Report will be sent to a PHU and provides guidance for PHUs in considering activity in response to a PHREDSS Situation Report.

KEY PRINCIPLES

PHREDSS provides daily monitoring of ED visits presenting with various health problems grouped into syndromes. Each PHREDSS signal is assessed by the ED Surveillance Team before further reporting. The ED Surveillance Team issue a Situation Report via electronic mail to relevant Departmental and Area Health Service public health authorities for consideration if one or more of the following criteria are met:

- A higher than expected or sustained increase in ED visits (an unseasonal increase) for a syndrome;
- A significant change in the epidemiology of a syndrome (such as the age or sex distribution);
- An increase in the severity or urgency of the ED visits for a syndrome (based on admission status or triage category);
- An increase in an inherently severe syndrome such as meningitis/encephalitis, critical care admissions or deaths in ED; or
- An increase in a syndrome of particular interest to a stakeholder or stakeholder group (eg. influenza-like-illness, gastrointestinal illness, annual childhood asthma epidemics, drug or alcohol misuse).

USE OF THE GUIDELINE

The level of response from a PHU to a PHREDSS Situation Report should be graded according to:

- the apparent size of the increase in the syndrome reported;
- the severity of the illness being caused;
- the opportunity for intervention by the PHU; and
- any existing local knowledge.

NSW Department of Health may direct or provide guidance for a coordinated response.

PHREDSS provides daily monitoring of ED visits presenting with various health problems. Using the information transferred to the Department's PHREDSS database, computer programs automatically prepare statistical reports that highlight unusual trends in a range of acute health problems. Situation reports arising from the system are sent by PHREDSS personnel using electronic mail to relevant Departmental and Area Health Service public health authorities for consideration.

Surveillance Objectives

- To provide early warning of increases in disease activity in the population that may not be evident through other routine surveillance.
- To provide situational awareness and supplement other information on trends in acute disease and injury in the NSW population.
- To monitor syndrome epidemiology to assist the development and monitoring of prevention strategies for the causes of these syndromes.

Response options for the PHU receiving the situation report:

The level of response should be graded according to the apparent size of the increase, severity of illness being caused, opportunity for intervention and local knowledge. The NSW Department of Health may direct or provide guidance for a coordinated response.

Assessment should:

- Consider other available information such as notifiable disease reports, the presence of demographic changes through mass gatherings or similar events.
- Include case characteristics, such as: number of people affected, seasonality, age, sex, place of residence and severity of illness (as measured by increases in triage urgency or the proportion of patients being admitted for further treatment or being admitted to a critical care illness). Further information relating to a situation report can be obtained from the PHREDSS team or directly from the PHREDSS reports or other PHREDSS query tools (see next page).

Responses may include:

- For sharp increases in the number of ED visits apparently caused by infections or toxins, contacting the relevant ED director, (and other relevant personnel who managed the cases) to determine the likely cause of the increase and unless there is a good alternative explanation, encourage testing for likely causal agents on patients presenting over the next few days with similar syndromes.
- consultation with the relevant policy branch of NSW Health for advice.
- for diseases, including seasonal disease, where alerts to other clinicians or the public are considered likely to assist in prevention of further cases, the issuing of alerts through fax streams or the media.

Heightened surveillance

Options are available for heightened surveillance for planned events, such as mass gatherings, or emergencies. For planned events, several weeks notice is required. Options include: increased frequency of data updates; regular line listings of available data; reduced level at which increased activity is signalled, or creation of additional syndromes. For regular events, comparison with equivalent event days rather than the same weekday may be possible.

PHREDSS uses statistical methods to signal unusual occurrences in daily or weekly counts of ED visits categorised into a range of related diagnosis groupings. Each signal is assessed by the PHREDSS team before further reporting. Data available at 12 midnight on the previous day are included in the analysis. Total counts of ambulance arrivals, critical care ward admissions and ED deaths are monitored as well as diagnoses to identify large increases in severe illness. Reports are checked in the morning and afternoon on weekdays and mornings only on weekends and public holidays.

PHREDSS personnel evaluate each signal before issuing a "situation report", as follows:

- Has there been a recent increase in ED visits?
- Is the increase expected at this time of year (a seasonal increase)?
- How big is the increase compared with both recent and seasonal activity?
- Has the epidemiology of the syndrome changed (such as the age or sex distribution)?
- Has the severity or urgency of the visits increased (based on admission status or triage category)?
- How long has the increase been sustained?
- Is the diagnosis grouping inherently severe, such as meningitis/encephalitis, critical care admissions and ED deaths?
- Is the phenomenon of known interest to our stakeholders? E.g.: influenza-like-illness; gastrointestinal illness; annual childhood asthma epidemics; and drug or alcohol misuse.

The PHREDSS team issues a situation report if the answers to these questions justify informing relevant health stakeholders. The reports generally provide an overview summary along with a description of how the recent epidemiology compares with usual epidemiology. The epidemiological factors include age, sex, mode of arrival at ED, triage urgency, departure status from ED, locality of patient residence.

PHUs can view the PHREDSS reports directly. Various tools to assist with line listing review and statistical analysis (NetEpi Analysis) and 'keyword searches' to identify patient visits meeting certain presentation criteria are available from the home page of the PHREDSS reports. Available fields for each ED visit include: medical record number (for some hospitals); date and time of arrival; mode of arrival; presenting problem and triage nurse assessment; triage urgency category; mode of separation; and ED diagnosis. Patient names, addresses and dates of birth are not recorded.

The PHREDSS reports home page is available from the **Biosurveillance** link at:

hoist.health.nsw.gov.au (**NB**: this is on the intranet, not the internet).

A username and password are required, which can be obtained by completing the one-page form available at:

hoist.health.nsw.gov.au/Acumen_biosurveillance_confidentiality_agreement.pdf

and returning by facsimile to HOIST Support on: (02) 9391 9232.

For further information about PHREDSS please send an email to: **phredss@doh.health.nsw.gov.au**

RETRIEVAL HANDOVER (ADULTS) (PD2012_019)

PURPOSE

The purpose of this Policy is to confirm the process to ensure a coordinated handover and transfer of care between hospital clinicians and medical retrieval teams. Compliance with this Policy will minimise the chances of adverse events during handover of adult retrieval patients between hospital and retrieval teams.

A medical retrieval is defined as the interhospital transfer of an acutely or critically ill patient by a team that includes a medical (physician) escort. The majority of medical retrievals are done by teams with specific training, equipment and experience in out-of-hospital care for critically ill patients. These teams belong to medical retrieval services that are recognised and authorised by NSW Health.

This policy is intended for use by senior clinical medical and nursing staff in critical care areas of hospitals, particularly the Emergency Department and Intensive Care Units. The procedures for retrieval handover are regarded as a safe and appropriate approach for the efficient handover of clinical care of adult patients between the retrieval team and the senior clinician at the hospital.

Timely and efficient handover of clinical care of patients between the retrieval team and the senior clinician at the hospital should occur before the transfer of management begins (unless urgent resuscitation is required) to ensure a systematic transfer of patient care. The full transfer of care is completed once all monitoring and therapies are safely established and this is verbally confirmed by the team who are taking over the care of the patient.

This Policy is complements **Clinical Handover – Standard Key Principles (PD2009_060)** which mandates the implementation of standard principles for all types of clinical handover.

MANDATORY REQUIREMENTS

This policy requires all health services to have local guidelines/protocols for retrieval handover in place for all hospitals and facilities involved in the transfer of care of adult patients between hospital and retrieval teams.

IMPLEMENTATION

Chief Executives must ensure that health facilities implement a process for retrieval handover to ensure the safe transfer of patient care between retrieval teams and hospitals.

Attachment 1: Retrieval Handover (Adults)

RETRIEVAL HANDOVER PROCEDURE

The retrieval team is responsible for directing the coordinated handover and transfer of care.

This is a **vulnerable** time for the patient.

HANDOVER

- The handover should be between the most senior Hospital clinician caring for the patient and the Retrieval clinician.
- The handover should take place at a predictable time – an estimated time of arrival for the Retrieval team should be provided, with the expectation that the relevant team is **assembled at the agreed time**.
- The handover should occur **before the transfer of management** begins (unless urgent resuscitation is required). This ensures all staff listen to the handover and then focus on the systematic transfer of patient care.

HANDOVER PROCESS

1. **At handover the following information is exchanged:**
   - Presenting problem and relevant past history
   - Initial and current management (including monitoring, infusions, ventilation)
   - Response to management and current condition (including current vital signs)
   - Significant results - verbally, plus paper/electronic copy
   - A list of issues that need addressing within the next 60 minutes.
2. **Transfer to stretcher/bed**

   The hospital is responsible for ensuring that sufficient staff and equipment are available. The retrieval team is responsible for coordinating the move, as they are familiar with the retrieval equipment.
3. **Transfer Monitors**

   Monitoring should be transferred between the hospital monitors and retrieval bridge monitors one at a time. There should be no disruption to the continuity of monitoring.
4. **Transfer Therapies**

   Therapies should be transferred one at a time, at the direction of the Retrieval team.

   Ventilation:
   - Hospital bed to retrieval stretcher = transfer ventilation last
   - Retrieval stretcher to hospital bed = transfer ventilation first; note when transferring from retrieval to hospital equipment, the retrieval team will prescribe initial ventilation parameters.

   Drug infusions:
   - One drug at a time, like-to-like, ensure no dead space
   - Retrieval team will determine initial concentration and rate

   Specific therapies: i.e. intercostal drainage systems, EVDs, Sengstaken Blakemore tubes, IV fluids.

   Routine therapies: i.e. nasogastric tubes, urinary catheters etc.

Full transfer of care is not complete until all monitoring and therapies are safely established and this is verbally confirmed by the team who are taking over the patient.

EMERGENCY DEPARTMENT SHORT STAY UNITS (PD2014_040)

PURPOSE

This policy outlines the mandatory requirements for the use of Emergency Department Short Stay Units (EDSSUs) in NSW Hospitals. EDSSUs are Inpatient Units, managed by Emergency Department (ED) staff, designated and designed for the short term (generally up to 24 hours) treatment, observation, assessment and reassessment of patients initially triaged and assessed in the Emergency Department.

The National Partnership Agreement on Improving Public Hospital Services clearly states the requirements for EDSSUs in Australia. However further detail is required for NSW Hospitals to ensure correct implementation of these requirements.

MANDATORY REQUIREMENTS

Emergency Department Short Stay Units in NSW must adhere to the following principles:

- EDSSUs are Inpatient Units attached to emergency departments, managed under the clinical governance of the ED senior clinical management team located at the hospital.
- EDSSUs are designated and designed for the short term treatment, observation, assessment and reassessment of patients with selected conditions, initially triaged and assessed in the ED.
- The aim of EDSSU is to improve care of ED patients, improve the flow of patients through the ED, thereby improving ED bed access and reducing inpatient ward length of stay for EDSSU appropriate patients.
- EDSSUs must have specific admission and discharge criteria and policies. General principles for admission to EDSSU should focus on patients that are:
  - Clinically stable AND
  - Anticipated to require a period of observation or treatment less than 24 hours.

  In some facilities, it may be appropriate for clinically stable ED patients being transferred to another facility, after confirmation of timely availability of a bed at the accepting facility has occurred, to be admitted to EDSSU pending transport to the accepting facility.
- The design of the EDSSU should be a purpose built facility which allows it to be physically separated but in close proximity to the ED, have a static number of beds with oxygen suction and include its own patient bathroom and shower facilities.
- EDSSUs are not a temporary ED overflow area nor used to keep admitted patients who are solely awaiting an inpatient bed nor awaiting treatment in the ED prior to medical assessment.
- EDSSUs are staffed by dedicated Medical, Nursing and Allied Health staff with appropriate skills and knowledge to manage EDSSU patients. Patients are admitted under the care of the designated Specialist Emergency Physician rostered for EDSSU. In facilities with no Specialist Emergency Physician, other Specialist Medical Officers credentialed to admit patients to the hospital as a treating Specialist may be designated as responsible for EDSSU admissions.
- Patients admitted to EDSSU whose condition changes and therefore require a bed on an appropriate inpatient ward should have timely allocation of the bed through hospital patient flow processes. This is to ensure timely access to appropriate care and flow of ED patients into EDSSU is not impeded.

- Regular monitoring of EDSSUs is important to ensure efficient and appropriate use of EDSSU beds. An admission rate (from EDSSU into the hospital) of 10%-15% is considered acceptable.
- Regular review of incidents should be undertaken as per the EDs procedure for compliance with **PD2014_004 Incident Management Policy** and be included in ED Morbidity and Mortality meetings.
- Two specific measures for patients admitted to EDSSU (Bed Type 59) which are monitored on a statewide level are:

  1. Length of Stay in the EDSSU, reported as:
     - Percentage of all patients admitted to EDSSU with a LOS (in the EDSSU) less than or equal to 24 hours (calculated in minutes), and
     - Percentage of all patients admitted to the EDSSU with a length of stay less than 4 hours (calculated in minutes).
  2. Destination on departure from the EDSSU
     - Percentage of all patients admitted to EDSSU who were either:
       - Discharged home
       - Transferred to another admitted patient setting in the same service
       - Discharged to another health service.

  Local teams should review adherence to these monitoring measures.

IMPLEMENTATION

Local Health District Chief Executives are responsible for:

i. Assigning responsibility, personnel and resources to implement this policy.
ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for admission of patients to EDSSU. This should include nomination of an executive sponsor.
iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance unit, ED senior management, and clinical staff.

1. BACKGROUND

1.1 About this document

This Procedure document supports and further explains the mandatory requirements of the Emergency Department Short Stay Unit (EDSSU) Policy through the following components:

- Background and use of EDSSU in NSW
- Clinical governance of EDSSU
- EDSSU admission and discharge criteria
- EDSSU design considerations
- Admitted patients in EDSSU
- Paediatric patients in adult EDSSU
- EDSSU staffing
- EDSSU monitoring measures.

1.2 Key definitions

- EDSSU – (also previously known as 'Emergency Medical Units' 'EMU' and 'ESSU') are Inpatient Units, managed by Emergency Department (ED) staff, designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the Emergency Department.
- Bed type 59 - is a bed, staffed 24 hours a day that is designated for the accommodation of patients requiring emergency medical care who would otherwise have remained in the general Emergency Department. Beds in this category may be used for a mix of both day stay and overnight patients, but must be staffed for overnight patient care.

2. PROCEDURE FOR USE OF EDSSU

2.1 Background

Short stay medicine in Emergency Departments (EDs) offers intensive short-term assessment, observation or therapy, in a 'ward-like' environment, to optimise the early treatment and discharge of selected ED patients. The model is an alternative to extended stays in hospital EDs and/or the use of multi-day inpatient beds for short-term care.

The aim of the EDSSU is to improve care of patients requiring short term inpatient clinical management. EDSSUs have been shown to reduce inpatient ward length of stay for appropriately selected patients who would otherwise have been admitted to a ward bed, and improve care of those who may have stayed within the ED for prolonged periods. EDSSUs improve the flow of patients through the ED, thereby improving access to care for new emergency patients.

EDSSUs are designated for patients who are to be discharged within 24 hours. This includes stable patients who require observation and/or further investigation to ascertain the seriousness of their condition (e.g. minor head injury, chest pain, infections) or a short course of treatment for conditions that may be rapidly resolved (e.g. asthma, allergic reactions, snake bite and renal colic). Patients are admitted and managed under the care of local Specialist Emergency Physicians (EPs).

EDSSUs also provide a location for ED patients who may require allied health and social support intervention, such as physiotherapy, occupational therapy or social welfare services prior to discharge.

2.2 Clinical governance of EDSSU

Governance of the clinical and operational management of the EDSSU is the responsibility of the ED Director and Nurse Manager/Nursing Unit Manager.

Patients accepted for admission to EDSSU must be authorised by the duty Specialist Emergency Physician or delegate (e.g. emergency registrar overnight) following direct consultation.
Clinical governance includes:

- Review of the EDSSU admission policy and procedures for common Diagnostic Related Group admission categories.
- Medical governance to ensure that all practices in patient care delivery are consistent with high quality evidence based practice, and local LHD, state or national guidelines.
- Governance of patient care, safety and quality, incident reporting and management within an ED quality framework.
- Ensuring that peer review of clinicians involved in the care of patients in the EDSSU occurs and that supervision practices are adequate.

2.3 EDSSU admission and discharge criteria

EDs should devise local guidelines regarding the inclusion or exclusion of patients into EDSSU based on local availability of resources and practices which may/may not preclude the management within 24 hours. Some principles which may be used for development of local inclusion and exclusion criteria are as follows.

2.3.1 Patient Inclusion Criteria

Anticipated LOS < 24 hours

- EDSSU should target patients with a range of low to moderate risk symptom complexes who, with optimal diagnostic support and clinical management, can be discharged within a 4-24 hour period.
- There should be a focused goal for the period of observation.
- Patients should be clinically stable.

2.3.2 Patient Exclusion Criteria

Anticipated LOS >24 hours

The criteria for patient exclusion from an EDSSU will vary between institutions but should be consistent with the following principles:

- It is anticipated that the duration of treatment will be more than 24 hours.
- The patient is admitted under the care of an inpatient team. (local procedures for Hospital in the Home patients returning to hospital for review should be established.)
- The patient has been transferred to the hospital for admission under care of an inpatient team.

Clinical exclusion criteria

- The EDSSU cannot provide a suitable level of care or the patient has complex care needs which are unable to be met in the EDSSU.
- Psychotic/violent/disruptive patients/patients at risk of absconding, including patients detained under the **Mental Health Act 2007** may often be unsuitable to be cared for in EDSSU unless appropriate resources are available to manage them in the EDSSU environment. Forward planning of resource requirements for this group of patients must be undertaken and not addressed on an ad-hoc basis.
- The patient is clinically unstable. No patients with 'red zone' vital signs according to the **Standard Observation Charts** and Between the Flags process should be admitted to EDSSU unless there are documented alterations to the calling criteria.
- The patient has no clear diagnosis or provisional diagnosis.

2.3.3 Admission and Discharge procedures

Procedure for admitting a patient to EDSSU

- Discuss with the Specialist Emergency Physician or their delegate on duty for EDSSU.
- Complete an EDSSU admission which must include the applicable medical history, examination findings, provisional and differential diagnoses, a management plan and any outstanding results to be followed up.
- Complete a diagnosis in eMR.
- Complete a clinical hand over of the patient to EDSSU staff including outstanding results or reviews required, and subsequent management plan.

While in EDSSU

- Any patient in EDSSU must be included in clinical handover rounds.
- Minimum 4th hourly observations should be performed or as determined by Specialist Emergency Physician.
- The Specialist Emergency Physician must be informed about any deterioration in an EDSSU patient and normal escalation processes utilised across the ED/EDSSU should be followed.

On discharge from EDSSU

- Discharge of patients from the ED SSU will be to home or usual residence, inpatient unit (including Hospital in the Home) or another hospital.
- Discharge process should adhere to **PD2014_025 Departure of ED Patients** and follow the four principles of departure outlined in the policy.
- A discharge summary must be completed for all patients leaving EDSSU.

2.4 EDSSU design considerations

EDSSUs must be designed in a way that allows the unit to be physically separate but in close proximity to the ED. EDSSUs are designated inpatient care areas and as such, the physical design should reflect this. Design should be in line with the **Australasian Health Facility Guidelines – Emergency Unit**.

The Australasian College for Emergency Medicine **Emergency Department Design Guidelines** recommend *a minimum of 8 beds with the capability to monitor each bed to the same level as an acute cubicle*. Beds are to be static in number and are separate to the ED bed base. Decisions regarding final numbers of EDSSU beds/clinical spaces will be determined locally.

It is recognised that some EDSSUs may utilise a process where one clinical bed space may accommodate several recliner chairs for patients staying short periods in the EDSSU. This process should not be used for overnight patients and must ensure appropriate staffing and other resources are maintained.

A dedicated nursing station and adequate desk space for both medical and nursing staff is required. The EDSSU is to have its own patient toilet and shower facilities.

Additionally, the following criteria should be considered in EDSSU design:

- Should have a single room(s) with en suite for the management of short term infectious patients (e.g. gastroenteritis).
- Designs may allow for infection control cohort of patients (or as part of a disaster management response).
- 'Lounge area' where patients can be treated that do not require a bed.
- Beverage Bay facilities.
- Storage facilities as well as clean and dirty utility located in the unit (or in close proximity) to maximise productivity and efficiency.

2.5 Admitted patients in EDSSU

An admission rate (from EDSSU into the hospital) of 10%-15% is considered acceptable. as it provides a balance of appropriate patient selection, cost effective resource utilisation, and optimisation of quality of patient care.[38] Admission may be required due to a change in the patient's clinical condition or the subsequent requirement for specialised care and investigations outside of the remit of EDSSU. 229(20/11/14)

38 Chan, T., Arendts, G. and Stevens, M. (2008), Variables that predict admission to hospital from an emergency department observation unit. Emergency Medicine Australasia, 20: 216–220. doi: 10.1111/j.1742-6723.2007.01043.x

Patients must be referred, accepted and transferred from the EDSSU to another appropriate inpatient ward within the 24 hours of arrival to the EDSSU. Direct consultation between the Specialist Emergency Physician and the in-patient consultant (or their delegates) should facilitate clinical handover of the patient as well as the use of NSW Health Policy **PD2009_055 "Emergency Department- Direct Admission to Inpatient Wards"**

Movement of patients out of EDSSU to a hospital inpatient bed should be a priority to ensure continued flow of appropriate ED patients into EDSSU. Effective communication with the Hospital Bed Manager and After Hours Nursing Manager is essential.

Once transfer of care has taken place, all aspects of clinical care for those patients who are admitted under inpatient teams; but are still in the physical bed space of the EDSSU are the responsibility of the admitting team's Medical Officers. This includes liaising with family members and carers, reviewing medications, clinical reviews and appropriate discharge planning. Deterioration of these patients whilst they remain in the EDSSU should follow usual local escalation process with the patient being managed jointly by the inpatient team and EDSSU staff.

The EDSSU should not be used to board those patients who are known or expected to be admitted to an in-patient ward from the ED whilst waiting for that bed to become available. Patients who are admitted to inpatient wards via EDSSU are known to have longer total lengths of stay in hospital and utilise more resources than patients admitted directly to the hospital inpatient wards from the ED[39]

2.6 Paediatric patients in adult EDSSU

Children requiring short stay admission should be accommodated in paediatric specific units. NSW Health Policy states that "*children admitted to NSW Health acute facilities are not to be accommodated with adult patients"* **PD2010_033 Children and Adolescents - Safety and Security in NSW Acute Health Facilities**.

If no other option exists, any admission of paediatric patients to adult EDSSU is under the strict guidance of PD2010_033 to ensure they are accommodated in *designated paediatric safe beds.* These admissions should occur in consultation with the on call Paediatrician or delegate, or according to local procedures and care must be provided in accordance with the requirements of **PD2010_034 Children and Adolescents - Guidelines for Care in Acute Care Settings**.

The definition of a child in this document is any person under the age of 16 years, neonates excluded. It is acknowledged that adolescents are defined as those of an age 12-18 years.

Documented local processes may vary between units and are dependent on appropriate resources being provided, however the following principles should provide guidance.

No paediatric patient will be admitted to an EDSSU where the child is:

- Clinically unstable
- Has no definitive diagnosis
- Has no clear signs of clinical improvement following initial treatment
- Is subject to any suspicion of child protection issues
- Has any significant co-morbidity
- Has known acute mental health issues.

[39] Arendts, G. Mackenzie, J. & Lee, J.. Discharge planning and patient satisfaction in an emergency short-stay unit. Emerg. Med. Aust. 2006; 18: 7-14.

2.7 EDSSU staffing

Staffing must be commensurate with achieving the EDSSU key functions of: close observation, specialist assessment and diagnosis, short-term high-level care and management of patient conditions[40].

2.7.1 Medical Staffing

- A Specialist Emergency Physician will be designated and identified on the senior staff roster as EDSSU admitting officer at all times.
- Medical staffing of the EDSSU must ensure senior medical input is available and occurs for every patient.
- Medical staffing must be sufficient to meet the objectives of the EDSSU in providing quality timely care.
- Where junior medical staff are rostered to the EDSSU, the roster profile will be structured to allow direct supervision, on a case by case basis, for every patient by a more senior medical officer (at least registrar level).
- Medical staff in a supervisory role in the EDSSU must be specifically trained and credentialed in emergency medicine.

2.7.2 Nursing Staffing

- Staffing must meet the needs of the patient groups streamed to the EDSSU, and ensure reasonable nurse workloads are maintained.[41]
- A senior nurse in the EDSSU will be allocated per shift that will have first-line management responsibility for the running of the unit, and, working closely with the EDSSU Specialist Emergency Physician/or their delegate, to proactively 'pull' appropriate patients from ED into EDSSU.[3]
- At least 1 nurse per shift should be allocated to the EDSSU that has skills in Emergency nursing[42] [43] to ensure a range of patient conditions can be managed in the EDSSU.

2.7.3 Allied Health in EDSSU

The EDSSU should have dedicated allied health professionals with appropriate skills and knowledge to provide early intervention, discharge planning and prevent non-medical admission of patients.

Allied health services should be delivered as part of a multidisciplinary team, with staffing levels and skill mix varying in response to the clinical needs of the facility. For an EDSSU, it may be necessary for allied health professionals to work extended hours, on weekends or on-call.

2.8 EDSSU monitoring measures

The ongoing performance of the EDSSUs should be evaluated against the principles and intent of this policy. Data and other monitoring information should be used to drive improvements in service delivery, safety and quality in the EDSSU.

Services should establish mechanisms to ensure that their performance against relevant monitoring measures is regularly reviewed and where issues are identified that there are processes in place to facilitate appropriate action. Monitoring and review should address both the specifically identified state level indicators as well as other locally meaningful measures. 229(20/11/14)

[40] 2012 NSW Health. Emergency department models of care: Emergency Care Institute (**available:**)
[41] 2011 NSW Health. 2011. Public health system nurses' and midwives' (state) award.(**available**)
[42] 2013 College of Emergency Nursing Australasia, Standards for the Emergency Nursing Specialist (**available**)
[43] 2011 NSW Health Transition to Specialty Practice Emergency Nursing Program (**available**)

Core monitoring measures of for EDSSUs (Bed Type 59) at a state level will include:

- Length of Stay in the EDSSU, reported as:
  - Percentage of all patients admitted to EDSSU with a LOS (in the EDSSU) less than or equal to 24 hours (calculated in minutes) and
  - Percentage of all patients admitted to the EDSSU with a length of stay less than 4 hours (calculated in minutes).

- Destination on departure from the EDSSU
  - Percentage of all patients admitted to EDSSU who were either:
    - Discharged home
    - Transferred to another admitted patient setting in the same service
    - Discharged to another health Service

These measures will be calculated by the MoH using existing admitted patient data routinely submitted to the State centralised data warehouse. EDSSU patients should be included in local hospital Morbidity and Mortality meetings.

As well as the core state level indicators, services may wish to investigate the use of other locally meaningful measures, for example:

- Volume of patients admitted and discharged in ED – before and after establishment of the short stay unit.
- Volume of patients admitted from ED to other inpatient locations with LOS less than 24hrs.
- Unplanned representations to ED within 48 hours for patients discharged from an EDSSU.
- NSW Patient Survey Program information.

EMERGENCY DEPARTMENT, NURSE DELEGATED EMERGENCY CARE, MEDICATION STANDING ORDERS (PD2015_024)

PURPOSE

The Nurse Delegated Emergency Care (NDEC) patient care model has been developed to support rural and remote facilities provide care for patients presenting to Emergency Departments with low-risk, low-acuity conditions. Under NDEC the care of these patients is managed entirely by an appropriately trained and credentialed Registered Nurse (RN), under the explicit delegation of the site Medical Officer/s.

The statewide Standing Order authorises an appropriately trained and credentialed Registered Nurse to administer and/ or supply specified medications for the purpose of treatment of defined low-risk conditions specified under the NDEC patient care model. The Standing Orders describe procedures for ordering, storing, administering, and supplying (for take-home use) the specified medication. Any medication Standing Order must be used in conjunction with the applicable NDEC Nursing Management Guideline.

The statewide Standing Order for Nurse Delegated Emergency Care applies where the provision of medication is required to treat patients in the Emergency Department with certain less-urgent, low-risk conditions.

MANDATORYREQUIREMENTS

This policy is for the management of patients presenting to Emergency Departments with certain less-urgent, low-risk conditions by appropriately trained and credentialed registered nurses practicing under the NDEC model.

When the implementation requirements outlined in this policy are met, the statewide Standing Order provides the basis for Institutional/Local Health District (LHD) Drug and Therapeutics Committees (DTC) to adopt the NDEC patient care model. DTCs must review and endorse Standing Orders locally.

IMPLEMENTATION

In order to fulfil the standing order, supply of medications will need to be arranged with a public hospital pharmacy department, on behalf of the public health organisation, and at the request of the Public Health Officer (if a medical officer) or a medical officer designated by the District's Public Health Unit Director/Public Health Officer.

The standing order authorises a registered nurse to administer and supply medications to patients with defined conditions for the purpose of treatment of defined low-risk conditions. Administration or supply may only be carried out in Emergency Departments by registered nurses trained and credentialed to operate the Nurse Delegated Emergency Care patient care model.

LEGAL INSTRUMENT

POISONS AND THERAPEUTIC GOODS ACT 1966

Authorisation to Supply Poisons and Restricted Substances

PUSUANT to clauses 170 and 171 of the Poisons and Therapeutic Goods Regulation 2008, I, Dr Kerry Chant, Chief Health Officer, a duly appointed delegate of the Secretary of the Ministry of Health, do hereby grant AUTHORITY to registered nurses hereby specified as a class of persons, to supply those poisons and restricted substances listed in the Schedule hereunder either singly or in combination, pursuant to clauses 17 and 53 of that Regulation and subject to the following conditions:

(1) The registered nurse is employed in a public health organisation within the meaning of the Health Services Act 1997.
(2) The supply of the poisons or restricted substances is in accordance with the NSW Health Policy Directive PD2015_024, Standing Orders for the Supply or Administration of Medication under the NDEC Model.

SCHEDULE

cephalexin
chloramphenicol
ibuprofen
paracetamol

Dated: Sydney, 20 July 2015

Dr KERRY CHANT
Chief Health Officer
Ministry of Health, New South Wales

1 BACKGROUND

1.1 About this document

The Standing Order authorises an appropriately trained and credentialed Registered Nurse to administer and/or supply specified medications for the purpose of treatment of defined low-risk conditions specified under the Nurse Delegated Emergency Care (NDEC) patient care model. The Standing Orders describe procedures for ordering, storing, administering, and supplying (for take-home use) the specified medication. Any medication Standing Order must be used in conjunction with the applicable NDEC Nursing Management Guideline. The NDEC state-wide Guidelines and Standing Orders are for the management of patients presenting to Emergency Departments (EDs) with the following conditions:

- Minor burns
- Earache
- Eye problems
- Foreign body - minor
- Mild/minor head injury
- Insect bites and stings
- Soft tissue limb injuries
- Stings from marine creatures
- Pain
- Rash
- Respiratory type illness
- Tick bite
- Urinary symptoms
- Vomiting and Diarrhoea.

The state-wide medication Standing Orders form part of a comprehensive suite of patient care resources and, together with the Education and Accreditation Framework and implementation support materials and structures, comprise the Nurse Delegated Emergency Care model.

The NDEC patient care resources include a set of procedures known as Nursing Management Guidelines (NMGs) which can be found online: http://www.ecinsw.com.au/node/282. The NMGs direct all clinical care provided through the NDEC patient care model and these Standing Orders are only applicable in accordance with the appropriate NDEC NMG.

The Medication Standing Orders in this document include links to the relevant NMG, describing the types of clinical conditions for which they may be used.

1.2 Key definitions

Treatment	An intervention (including medication) to treat an individual case of disease or medical condition.
Supply/ Administration	To provide to or for a specific patient and is consistent with the definition of supply in section 4 of *the Poisons and Therapeutic Goods Act 1966*. This includes medication selection, recording, labelling, handover to patient/carer, verbal counselling and provision of information sheets and/or Consumer Medicines Information. In this document: a) To 'administer' means the supervised administration of a medication in a health facility. b) To 'supply' means the provision of a medication for take-home use.
Registered Nurse	A nurse or midwife who (i) is on the register of the Nursing and Midwifery Board of Australia, (ii) has completed a 3-year nursing degree from a higher education institution or equivalent from a recognised hospital-based program, and (iii) fulfils all of the ongoing requirements of the Nursing and Midwifery Board of Australia's registration standards.
General Practitioner (GP)	Refers in this document to a GP who has a Visiting Medical Officer (VMO) appointment at a health facility, usually in a rural or remote area, and is a Medical Officer for that site.
Local Facilitator	A key role within the local NDEC governance framework which is usually a senior nurse at a site or LHD level. The role is responsible for ensuring that implementation sites meet the requirements of the NDEC Education and Accreditation Framework.

1.3 Legal and legislative framework

Clauses 170 and 171 of the Poisons and Therapeutic Goods Regulation 2008 allow the Secretary of Health to authorise (for the purposes of the Act) a particular person (by means of an instrument in writing given to the person) or a specified class of persons (by means of an instrument published in a manner approved by the Secretary) to supply Schedule 4 medications (restricted substances) under clause 53 of the Regulation and Schedule 2 and Schedule 3 medications under clause 17 of the Regulation. The authorisation applies only to the listed medications for the Standing Orders included in this policy.

1.4 Nurse Delegated Emergency Care

The Nurse Delegated Emergency Care (NDEC) patient care model has been developed to support rural and remote facilities provide care for patients presenting to Emergency Departments with low-risk, low-acuity conditions. Under NDEC the care of these patients is managed entirely by an appropriately trained and credentialed Registered Nurse (RN), under the explicit delegation of the site Medical Officer/s. To be credentialed to practice NDEC, RNs must fulfil the requirements of the NDEC Education and Accreditation Framework, including satisfactory completion of the education modules, and competency assessment.

Rationale for development of the NDEC Model

NDEC has been developed to improve the care of patients presenting to Emergency Departments with minor illnesses/injuries, and to support the rural clinical workforce in small Emergency Departments. The Model defines the components of safe and quality care for selected low-acuity conditions, and outlines education, credentialing and quality assurance processes so that an episode of care may be delivered entirely by an NDEC credentialed nurse. A robust clinical framework supports care provision when the patient presents, even when no medical officer is available at the site, under a delegated care model.

Key features of NDEC include:

- Assessment of the patient against strict inclusion and exclusion criteria.
- If inclusion criteria are not met, a medical review/phone consult must be sought.

- If the patient is suitable for management under the NDEC model, the RN manages the episode of care using specified:
  - Nurse Management Guidelines
  - Medication Standing Orders
  - Patient Factsheets.
- Nurses may provide interventions to manage symptom relief. The patient will then be discharged with specific follow up instructions in accordance with **PD2014_025** Departure of Emergency Department Patients.
- The patient is asked to attend follow up with the local GP at their rooms or the ED. The patient will receive a follow up phone call from an NDEC RN within 24 hours of Emergency Department visit to check that symptoms have improved.
- The NDEC model may operate in a facility 24/7, or as an after-hours model, or when no GP is available.
- If at any stage the patient's condition deteriorates and they are deemed no longer suitable for NDEC, the RN is required to revert to "usual care" and contact a the medical officer for further review.
- RNs can opt out of the model if they are concerned about a patient's condition.

1.5 Implementation Requirements

Key prerequisites for the implementation of the NDEC include:

- Express support of care delegation and co-operation in implementing the model from the site General Practitioner(s), Health Service Manager/Nurse Unit Manager and Local Health District Executive is required.
- Submission of NDEC Site Nomination Form to the Agency for Clinical Innovation Emergency Care Institute NSW (ECI). Endorsement by the NDEC Steering Committee is required for sites to work with the ECI to support implementation.
- Pre-implementation education needs assessment.
- Pre-implementation "Snapshot" audit of Emergency Department (ED) presentations pertinent to NDEC.
- Pre-implementation staff survey.
- Pre-implementation patient survey.
- Pre-implementation audit covering existing clinical practice standards related to:
  - Patient assessment
  - Patient symptom management
  - Disposition practices
  - Documentation; and
  - Nursing staff competency and confidence with core nursing skills required for NDEC implementation.
- Establishment of a local governance structure.
- RN training and credentialing in the NDEC Model of Care (MoC) nursing skills.
- Review and local endorsement of Nurse Management Guidelines (NMG).
- Endorsement of Standing Orders by Local Health District (LHD) Drug and Therapeutic Committee.
- Adaption of the paper based NDEC documentation to FirstNet electronic medical record (eMR) if applicable/
- Authorisation and communication of the NDEC "go-live" decision.

1.6 Credentialing of Registered Nurses for NDEC

Operating the NDEC model is within the scope of practice of a Registered Nurse. To be credentialed to practice NDEC, RNs must fulfil the requirements of the NDEC Education and Accreditation Framework, including satisfactory completion of the education and competency assessment. Qualification or endorsement as an Advanced Practice Nurse or Nurse Practitioner is not required.

Credentialing requires NDEC RNs to demonstrate ongoing evidence of recency of practice using NDEC, and ongoing safe use of NDEC through clinical practice audits.

In addition to specific training requirements, the following mandatory education must be completed:

- Emergency Triage Education Kit program (or equivalent).
- NSW Ministry of Health Acute Paediatric Clinical Practice Guidelines on-line.
- Between the Flags, D.E.T.E.C.T. & D.E.T.E.C.T Jnr.
- NDEC mapped core skills review.

Further information can be found in the NDEC Education and Accreditation Framework: **http://www.ecinsw.com.au/sites/default/files/field/file/NDEC%20RN%20Education%20and%20Accreditation%20Framework.PDF**

1.7 Review Process

The ECI will conduct regular reviews of the NDEC clinical practice materials through its Clinical Advisory Committee, and NDEC Steering Committee, in line with its standard review schedule for clinical tools. Implementation sites can initiate review or revision of NDEC materials through ECI clinical governance processes. NDEC Patient Care Resources have been reviewed by the:

- ECI Executive Committee.
- NDEC Steering Committee.
- CEC Medication Safety Expert Advisory Committee.
- LHD Drug and Therapeutics Committees.

The ECI will provide NDEC sites with appropriate resources and education as reviews and updates occur. Individual sites will be responsible for updating local resources and completing reviews of local Standing Orders in accordance with **PD2013_043** *Medication Handling in NSW Public Health Facilities*.

2 IMPLEMENTATION OF STATEWIDE STANDING ORDERS FOR NURSE DELEGATED EMERGENCY CARE

When a state-wide Standing Order is applied, Public Health Organisation Executives are to ensure:

- A Registered Nurse operating under this standing order is aware of their responsibility to:
  - Comply with the requirements of the NDEC Education and Accreditation Framework.
  - Determine whether the patient meets the criteria for the standing order.
  - Recognise patients who do not meet inclusion criteria for NDEC and refer them to a medical officer for clinical care.
  - Determine any known allergies, hypersensitivity to the medication or contra-indications to treatment, and where these are identified, contact the medical officer to discuss appropriate management.

- Explain the medication and its purpose to the patient (or guardian).
- Obtain patient/guardian consent for treatment as appropriate.
- Document all assessments and details relating to the supply of medication as detailed below.
- Attend yearly training in cardio-pulmonary resuscitation, including review of the protocol for the administration of adrenaline.

- Medications are supplied by the Pharmacy Department to the Emergency Department pre-labelled in accordance with **PD2013_043** Medication Handling in NSW Public Health Facilities.
- All medication that is supplied for dosing at a later time is pre-prepared and labelled by a pharmacist, or, in circumstances where pre-prepared packs are not available, is labelled by the clinician supplying the medication to the patient. Labelling must include the name(s), strength(s), and active ingredient(s) of the medication and the directions for use, including duration of use, ancillary labels and other required information. The patient's name and date of supply must be hand-written on the label by the nurse at the time of supply. Any pre-prepared label must be initialled by the nurse supplying the medication to the patient. Additional information that must also be supplied includes the relevant medication factsheet.
- A Medical Officer is able to be contacted to provide advice to the Registered Nurse who is providing medication under the standing order.
- A Medical Officer will review, sign and date records within 24 hours to confirm that medications were administered or supplied in accordance with the standing order.
- All records relating to the administration of medication are retained in accordance with the State Records Authority General Retention and Disposal Authority for Public Health Services: Patient/Client Records (GDA 17).
- Where possible, medications are stored as Imprest stock Schedule 2, 3 and 4 (but not Schedule 4D) in ED or ED after-hours store – see sections 6.3.3 and 6.8 of **PD2013_043**.

3 MEDICATIONS FOR THE MANAGEMENT OF SYMPTOMS ASSOCIATED WITH MINOR INJURIES/ILLNESSES DEFINED IN THE NURSE DELEGATED EMERGENCY CARE PATIENT CARE MODEL

3.1 Purpose

This standing order authorises a registered nurse, who has demonstrated compliance with requirements set out in Section 2, to administer and/or supply specified medications for the purpose of treatment of defined low-risk conditions specified under the Nurse Delegated Emergency Care patient care model. It also sets out procedures for ordering, storing, administering and supplying the medications.

If the Registered Nurse applying the standing order has any concerns regarding patient safety for provision of the medication (e.g. people with significant chronic illness or immunosuppression), the nurse should arrange for the responsible Medical Officer, whether in the hospital or on call, to assess the patient so appropriate administration of medication can occur as soon as possible. Where no medical officer is on call, the usual procedure designated by the hospital executive for obtaining medical officer advice will apply.

3.2 Scope

The following Standing Orders are to be used within the framework of the Nurse Delegated Emergency Care (NDEC) patient care model. These Standing Orders are not approved for use outside of the NDEC model of care, even if such use may be covered by other NSW Ministry of Health or LHD specific policy or protocol.

These Standing Orders are not intended to replace clinical judgement and expertise.

3.3 Additional points to be noted for all standing orders:

- Note on drug Trade Names: where applicable, every attempt has been made to list Australian available unique trade names that do not articulate the primary medication within the trade name (e.g. Heron Paracetamol is not listed). To confirm specific constituent components, consult medication packaging, product information such as MIMS Online® or pharmacological resource such as the Australian Medicines Handbook (**https://amhonline.amh.net.au.acs.hcn.com.au** .
- Note on listed Indications: The listed indications are for the NDEC context only. No attempt has been made to present a full scope of indications for each drug. For full medication information, consult an appropriate pharmacological resource like MIMS Online®.
- Note on listed Contraindications: Any RED FLAG listed within a specific Nursing Management Guideline is a contraindication for medication administration under NDEC. In addition, for the purpose of nurse administration of medication within NDEC, relative contraindications are treated as absolute contraindications; and a medical review will be required prior to medication administration.
- Note on listed Side Effects: The management of side effects from administration of any medications under the following Standing Orders should occur as per usual practice. For severe reactions, including anaphylaxis, care should be in accordance with NSW Rural Adult or Paediatric Emergency Clinical Guidelines. Should a patient develop any concerning side effects, a medical officer should be contacted.

3.3 Standing Order for supply of Amethocaine Hyrochloride eye drops

TITLE	Standing order for Amethocaine Hydrochloride eye drops
Trade Name(s)	Minims Amethocaine Eye Drops
Presentation [1]	Clear, colourless sterile eye drops 0.5% (5mg/mL), or 1% (10mg/mL) Single patient, single use
Indication	Production of local anaesthesia in the eye. Reduces pain to facilitate adequate eye exam.
Contraindications[1]	Current use of sulphur based antibiotics (sulphonamides)
Precautions[1]	Instruct patient not to rub or touch the affected eye while anaesthesia persists. Should be used with caution in children, as this group is more susceptible to drug effects.
Dose	1 drop into affected eye/s, repeated every 5 minutes if necessary. Up to 3 drops may be used for foreign body removal.
Dose frequency[1]	Single dose
Administration[1]	**To be administered in hospital only.** Ensure contact lenses are removed Instil dose into affected eye/s (see Emergency Eye Manual pg. 26 for eye drop instructions) **http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0013/155011/eye_manual.pdf** Instruct patient not to rub or touch the affected eye while anaesthesia persists
Storage	Refrigerate and store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	• On instillation an initial burning sensation may be experienced. This may last for up to 30 seconds. • Blurred vision, lacrimation (watery eyes) • Persistent use may result in corneal damage Never give patient anaesthetic drops to take home
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Eye Problems **http://www.ecinsw.com.au/node/270** NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

Local Standing Order Authorisation:

Date approved by XXX LHD Drugs and Therapeutics Committee: **Review Date:**	**Medical Officer Name:** **Signature:**

[1] The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

3.4 Standing Order for supply of Cephalexin

TITLE	Standing order for Cephalexin
Trade Name(s)	Cefalexin, Cephatrust, Cilex, Ialex, Ibilex, Keflex, Rancef
Presentation [1]	Tablet/capsules containing 250mg; 500mg Oral suspension for reconstitution 125mg/5mL; 250mg/5mL
Indication	Antibiotic treatment for suspected UTI by clinical history and positive U/A (positive leukocytes and/or nitrites)
Contraindications[1]	Known allergy to cephalosporin group of antibiotics or previous history of a major allergy to penicillins
Precautions[1]	Nil specific
Dose and frequency[1]	**Adults** 500mg first dose only* **or** 500mg every 12 hours for 5 days* **Children > 12 years** 12.5mg/kg up to 500mg first dose only* **or** 12.5mg/kg up to 500mg every 6 hours for 5 days* ***Refer to local facility NDEC guidelines regarding administration of first dose versus dispensing a full course of antibiotic via this Standing Order.**
Administration and Supply[1]	**May be administered in hospital and full course of medication may be supplied via pre-labelled stock for use outside the hospital.** Oral tablet/capsule Oral suspension – consult product information for reconstitution instructions. Store in fridge once reconstituted (discard unused portion after 14 days).
Storage	Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	Gastrointestinal symptoms Hypersensitivity reactions
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator,* in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration and supply record is to be documented by the administering nurse. Document first dose and supply of the full course in the "once only" section of the medication chart. The record of administration and supply must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Urinary Symptoms **http://www.ecinsw.com.au/node/278** NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

Local Standing Order Authorisation:

Date approved by XXX LHD Drugs and Therapeutics Committee: **Review Date:**	**Medical Officer Name:** **Signature:**

[1] The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

3.5 Standing Order for supply of Chloramphenicol eye drops

TITLE	Standing order for Chloramphenicol eye drops Minims Chloramphenicol 0.5% Eye Drops
Trade Name(s)	Chloromycetin Eye Drops; Chlorsig Eye drops; Minims Chloramphenicol 0.5% Eye Drops
Presentation [1]	Clear to slightly hazy, colourless, sterile eye drops 0.5% (5mg/mL).
Indication	Prophylactic antibiotic coverage against bacterial infection in superficial ocular injuries including corneal foreign body and "welder's flash" burn
Contraindications[1]	• Known allergy to chloramphenicol • Restriction of eye movement/abnormal pupils cloudy cornea • Chronic eye disease (e.g. glaucoma) • Recent (within 6 months) eye surgery, including laser surgery
Precautions[1]	Patients should be instructed to cease using contact lenses during treatment and seek GP or optometrist advice prior to recommencing use.
Dose[1]	1 drop into affected eye/s
Dose frequency[1]	Every 2–4 hours for 2 days; then 1 drop 4 times daily for 5 days
Administration and Supply[1]	**May be administered in hospital and full course of medication may be supplied via pre-labelled stock for use outside the hospital.** Single patient use (discard after 1 month of opening) Ensure contact lenses are removed Instil dose into affected eye/s (see Emergency Eye Manual pg. 26 for eye drop instructions) **http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0013/155011/eye_manual.pdf**
Storage	Refrigerate and store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	Local ocular irritation; burning or itching. Allergic type reactions. Unpleasant taste. Blurred vision.
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator,* in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration and supply record is to be documented by the administering nurse. Document first dose and supply of the full course in the "once only" section of the medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Eye Problems **http://www.ecinsw.com.au/node/270** NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

Local Standing Order Authorisation:

Date approved by XXX LHD Drugs and Therapeutics Committee: **Review Date:**	**Medical Officer Name:** **Signature:**

[1] The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

3.6 Standing Order for supply of Fluorescein eye drops

TITLE	Standing order for Fluorescein eye drops
Trade Name(s)	Minims Fluorescein Eye Drops
Presentation [1]	Sterile ophthalmic solution 2% (20mg/mL) or 1% (10mg/mL). Single patient, single use.
Indication	Diagnostic aid during eye exams.
Contraindications[1]	Nil recorded
Precautions[1]	Ensure single use/single patient regime maintained; significant risk of iatrogenic ocular infection if solution reused. Advise patient to avoid rubbing eyes and avoid expose to dust. Advise patient may temporarily stain skin, urine, tears, nasal secretions yellow; may permanently stain soft contact lenses and clothing.
Dose[1]	Use sufficient solution to apply stain to damaged area – generally 1-2 drops in each eye. Excess can be washed away with sterile saline solution.
Dose frequency[1]	Single dose
Administration[1]	**To be administered in hospital only.** • Ensure contact lens are removed • Instil solution into affected eye/s • (see Emergency Eye Manual pg. 26 for eye drop instructions **http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0013/155011/eye_manual.pdf**) • Use cobalt blue light source for assessment • Stain does not show up on a normal cornea. Corneal abrasions or ulcers are stained a bright green. Foreign bodies are surrounded by a green ring. Conjunctival abrasions are also stained.
Storage	Refrigerate and store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	May cause blurred vision – caution driving.
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator,* in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Eye Problems **http://www.ecinsw.com.au/node/270** NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

Local Standing Order Authorisation:

Date approved by XXX LHD Drugs and Therapeutics Committee: **Review Date:**	**Medical Officer Name:** **Signature:**

[1] The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

3.7 Standing Order for supply of Ibuprofen

TITLE	Standing order for Ibuprofen
Trade Name(s)	Advil, Brufen, Bugesic, Dimetapp, Heron Blue, Nurofen, Panafen, ProVen, Rafen
Presentation [1]	Tablets/capsules containing 200mg Suspension • 200mg/5mL • 100mg/5mL • 100mg/100mL (Note: Some ibuprofen preparations contain codeine, phenylephrine or pseudoephedrine combinations – this Standing Order is for ibuprofen only. Other preparation combinations are not covered).
Indication	Analgesia for the treatment of mild to moderate pain (any cause). Corresponding pain score may range from 1 – 6.
Contraindications[1]	• History of allergy to aspirin or other NSAIDs • Concurrent antiplatelet (including low dose aspirin) or anticoagulant use • History of, or likelihood of, active peptic ulcer disease or GI bleeding • History of, or likelihood of, liver, kidney or cardiovascular disease, including hypertension, heart failure, stroke, myocardial infarct • History of asthma or hypertension • Current or possible pregnancy • Breast feeding mothers • Patients >65yrs with multiple comorbidities and on multiple medications • Dehydration • Concurrent use of diuretics, ACE inhibitors or angiotensin receptor blockers
Precautions[1]	Nil specific – assess effectiveness by repeating pain assessment 30 – 60 minutes post administration
Dose[1]	**Elderly – 200mg per dose** **Adults – 200 -** 400mg per dose **Children -** 10mg / kg up to 400mg per dose
Dose frequency[1]	**Adults -** 4-6 hourly (maximum 3 doses/24hrs) **Children -** 6-8 hourly (maximum 3 doses/24hrs)
Administration and Supply[1]	**May be administered in hospital and supplied via pre-labelled stock for use outside the hospital in a take-home pack of no more than 10 tablets. Advise patient to consult a doctor about using for more than 2 days.** Oral tablet/capsule or suspension syrup
Storage	Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	• Gastrointestinal symptoms • Hypersensitivity reactions • Longer term use may exacerbate cardiac or renal disease
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record and supply is to be documented by the administering nurse. Document first dose and supply (if applicable) on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

Local Standing Order Authorisation:

Date approved by XXX LHD Drugs and Therapeutics Committee: **Review Date:**	**Medical Officer Name:** **Signature:**

[1] The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

3.8 Standing Order for supply of Lignocaine 1%

TITLE	Standing order for Lignocaine 1%
Trade Name(s)	Lignocaine, Xylocaine (Plain)
Presentation [1]	Ampoule containing clear, colourless, sterile liquid. Specific ampoule type depends on manufacturer however, contains either **50mg/5mL** **200mg/20mL**
Indication	To facilitate the removal of a crawling insect from the ear canal by gentle aural instillation.
Contraindications[1]	Known perforation, bleeding or obvious trauma to external auditory canal Inability for patient to stay still/immobilised during instillation
Precautions[1]	Nil specific
Dose	Single dose (1% lignocaine) for adults and children > 10kgs. Maximum dose (based on 3mg/kg) • ≥ 10kg 3mL
Dose frequency[1]	Single dose
Administration[1]	**To be administered in hospital only.** The aim of administration is to cover/drown the insect. Gently instil into the ear to achieve desired outcome. Note if the insect is still alive, it may rapidly crawl out of the auditory canal upon commencement of instillation.
Storage	Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	If instilled in an ear with a perforated membrane, middle ear type symptoms may develop (vertigo etc.)
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Earache **http://www.ecinsw.com.au/node/269** NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

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3.9 Standing Order for supply of Loratadine

TITLE	Standing order for Loratadine
Trade Name(s)	Alledine; Allerdyne; Allereze; Claratyne; Lorano; Lorapaed; Lorastyne
Presentation [1]	**Tablet** containing 10mg **Syrup** containing 1mg/mL (Note: Some loratadine preparations contain a pseudoephedrine combination – this Standing Order is for loratadine only. Other preparation combinations are not covered.)
Indication	Minor urticarial rashes of probably allergen origin
Contraindications[1]	• Allergy to sodium benzoate (preservative in syrup form) • Severe liver disease
Precautions[1]	Nil specific
Dose[1]	**Adults/children aged ≥ 12 years** • 10mg (1 tablet) orally, daily **Children** • 2 – 12 years o Body weight > 30kg; 10mg (10mL or 1 tablet) orally, daily o Body weight ≤ 30kg; 5mg (5mL) orally, daily • 1 – 2 years o 2.5mg (2.5mL) orally, daily
Dose frequency[1]	Daily
Administration[1]	**To be administered in hospital only.** Oral tablet/syrup
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	May rarely cause drowsiness, fatigue, headache, nausea, dry mouth especially in the elderly.
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator,* in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Rash **http://www.ecinsw.com.au/node/268** NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

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3.10 Standing Order for supply of Metoclopramide

TITLE	Standing order for Metoclopramide
Trade Name(s)	Maxolon; Pramin
Presentation [1]	**Tablets** containing 10mg **Parenteral solution** containing 5mg/mL, 2mL (Note: Some metoclopramide preparations contain a paracetamol combination – this Standing Order is for metoclopramide only. Other preparation combinations are not
Indication	Relief of nausea and/or vomiting
Contraindications[1]	• Age < 20 years • Hx epilepsy • Previous reactions to metoclopramide (including dystonic reactions) • Impaired renal or hepatic function
Precautions[1]	Nil specific
Dose[1]	Adults ≥ 20 years • 10mg oral tablet/OR by intramuscular injection If patient weighs 30-60kg • 5mg oral tablet/OR by intramuscular injection
Dose frequency[1]	Can be given three times a day (every 8 hours)
Administration[1]	**To be administered in hospital only.** Oral tablet OR by intramuscular injection
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	Dystonic type reactions (involuntary muscle contractions and abnormal postures of the trunk, neck, face, or extremities), akathisia, drowsiness, dizziness, headache.
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Vomiting and Diarrhoea **http://www.ecinsw.com.au/node/279**

Local Standing Order Authorisation:

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3.11 Standing Order for supply of Ondansetron

TITLE	Standing order for Ondansetron
Trade Name(s)	Ondaz; Zifojim Zofran, Zondan
Presentation [1]	**Wafer (fast dissolving) or oral tablet** containing 4mg or 8mg
Indication	Relief of nausea and/or vomiting
Contraindications[1]	• Concomitant use with apomorphine • Children < 2 years • Cardiac disease, particularly conduction anomalies • Hypokalaemia
Precautions[1]	Nil specific
Dose[1]	Adults and children ≥ 2 years • 4mg single dose (tablet or wafer)
Dose frequency[1]	Single dose
Administration[1]	**To be administered in hospital only.** Wafer is placed on top of the tongue where it dissolves within seconds and is swallowed Or Tablet orally
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	Headache, sensation of warmth or flushing, dizziness, hypotension, hiccups, arrhythmias, chest pain, seizures.
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Vomiting and Diarrhoea **http://www.ecinsw.com.au/node/279**

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3.12 Standing Order for supply of Oral Rehydration Solution

TITLE	Standing order for Oral Rehydration Solution
Trade Name(s)	E-Lyte; Gastrolyte; Gold Cross Gluco-lyte; HYDRAlyte, O.R.S.; Pedialyte; Repalyte; Restore O.R.S.
Presentation[1]	Oral Rehydration Solutions are generally available in 4 forms; • Soluble powder • Effervescent dissolvable tablet • Pre-made solution • Ice blocks. Composition of the available Oral Rehydration Solutions vary. For an overview comparison see NSW Health Infants and Children – Acute Management of Gastroenteritis. **http://www0.health.nsw.gov.au/policies/gl/2014/GL2014_024.html**
Indication	Oral correction of fluid and electrolyte loss in infants, children and adults as a result of vomiting and/or diarrhoea
Contraindications[1]	Possible surgical intervention and/or a requirement to remain 'nil by mouth'
Precautions[1]	Strict fluid balance record. Input should exceed output. Further vomiting ≠ failed trial of fluid – worsening dehydration assessment status = failed trial of fluid
Dose[1]	0.5mL/kg
Dose frequency[1]	Every 5 minutes
Administration[1]	**To be administered in hospital only.** If required, reconstitute specific Oral Rehydration Solution as per manufactures instructions. Instruct patient/carer to administer Oral Rehydration Solution in small, frequent amounts (0.5mL/kg every 5 minutes). Provide patient/carer with appropriate measuring/administration equipment; syringe, measuring cup etc.
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	No clinically significant side-effects
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator,* in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Vomiting and Diarrhoea **http://www.ecinsw.com.au/node/279**

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3.13 Standing Order for supply of Paracetamol

TITLE	Standing order for Paracetamol
Trade Name(s)	APO, Dimetapp, Dymadon, Febridol, Lemsip, Panadol, Panamax, Paralgin (Note: Some paracetamol preparations contain combinations of caffeine, chlorpheniramine, codeine, dextromethorphan, dextropropoxyphene, doxylamine, metoclopramide, orphenadrine, phenylephrine, pseudoephedrine, and/or triprolidine. This Standing Order is for paracetamol only).
Presentation [1]	Tablets/capsules/chewable tablets/soluble tablets or soluble powder: containing 120mg, 250mg, 500mg, 600mg, 1000mg Suspension: • 50mg/mL • 100mg/mL • 120mg/5mL • 240mg/5mL (Note: paracetamol is available as modified/sustained release (665mg) tablets, suppositories and intravenous infusions. This Standing Order is for oral non-modified release preparations only).
Indication	Analgesia for the treatment of mild to moderate pain (any cause). Corresponding pain score may range from 1 – 6
Contraindications[1]	• Known allergy to paracetamol or specific preparation components • Impaired liver function including current alcohol dependence • Previous dose 15mg/kg (1g adult dose) of paracetamol within 4 hours • Cumulative dose 60mg/kg (4g adult dose) of paracetamol within preceding 24 hours • Avoid soluble preparations (due to high sodium content) in heart failure/ hypertension/where low sodium intake is indicated
Precautions[1]	Nil specific – assess effectiveness by repeating pain assessment 30 – 60 minutes post administration
Dose[1]	**Adults and children > 12 years** • 1g **Children > 1 month** • 15mg / kg (maximum 1g) (maximum 60mg / kg / 24 hours – not more than 4g per 24 hours)
Dose frequency[1]	**Adults and children > 12 years** • every 4 – 6 hours (maximum 4g per 24 hours) **Children > 3 months** • every 4 – 6 hours (maximum 60mg/kg/24 hours – not more than 4g per 24 hours)
Administration and Supply[1]	**May be administered in hospital and supplied via pre-labelled stock for use outside the hospital in a take-home pack of no more than 10 tablets.** Prepare and administer appropriate oral dose based on product concentration, product instructions and intended dose.
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	Rare – though hypersensitivity/allergic type reactions are possible
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration and supply record is to be documented by the administering nurse. Document first dose and supply of take home pack (if applicable) on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.

Related Documents	NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

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3.14 Standing Order for supply of Paracetamol 500mg/Codeine 8mg

TITLE	Standing order for Paracetamol 500mg/Codeine 8mg **(adults only)**
Trade Name(s)	Codapane, Panamax Co, Panadeine, Panalgesic (Note: Paracetamol/codeine preparations are available in multiple dose ratios. Some preparations also contain combinations of doxylamine. This Standing Order is for paracetamol 500mg/codeine 8mg only.)
Presentation [1]	Tablet/soluble tablet containing 500mg paracetamol/8mg codeine
Indication	Analgesia for the treatment of moderate pain **in adults** (any cause). Corresponding pain score may range from 4 – 6.
Contraindications[1]	• Known allergy to paracetamol, codeine or specific preparation components • Breastfeeding mothers • Impaired liver function including current alcohol dependence • Impaired renal function • Decreased respiratory reserve • Previous paracetamol dose (≥ 1g) within last 4 hours • Cumulative dose of paracetamol ≥ 4g within last 24 hours • Avoid soluble preparations (due to high sodium content) in heart failure/ hypertension/where low sodium intake is indicated
Precautions[1]	Nil specific – assess effectiveness by repeating pain assessment 30 – 60 minutes post administration.
Dose[1]	2 tablets (paracetamol 500mg / codeine 8mg)
Dose frequency[1]	4 – 6 hourly up to 8 tablets (4g paracetamol total) per 24 hours
Administration[1]	**To be administered in hospital only.** Tablet or soluble tablet orally
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	• Drowsiness and mental impairment • Gastrointestinal symptoms • Rare – though hypersensitivity/allergic type reactions are possible for both paracetamol and codeine
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Pain **http://www.ecinsw.com.au/node/275**

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3.15 Standing Order for supply of Sodium Citrotartrate

TITLE	Standing order for Sodium Citrotartrate **(adults only)**
Trade Name(s)	Citralite, Citravescent, Ural
Presentation[1]	Powder for reconstitution containing 3.7g or 4g sodium citrotartrate
Indication	Symptom management of dysuria **in adult patients only**
Contraindications[1]	• Renal failure/renal impairment • Hypernatraemia/heart failure/hypertension / peripheral or pulmonary oedema/ where low sodium intake is indicated • Pregnancy • Breastfeeding mothers
Precautions[1]	Nil specific
Dose[1]	1 – 2 reconstituted sachets (3.7 – 8g)
Dose frequency[1]	3 – 4 times a day
Administration[1]	**May be administered in hospital and supplied via pre-labelled stock for use outside the hospital. (Patient information sheet must be included.)** Reconstitute powder as directed by product packaging.
Storage	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	• Mild laxative effect • Prolonged use may cause systematic alkalosis and/or hypernatraemia
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	NDEC Nurse Management Guideline: Urinary Symptoms **http://www.ecinsw.com.au/node/278**

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3.16 Standing Order for supply of Tetanus Toxoid

TITLE	Standing order for Tetanus Toxoid
Trade Name(s)	*Tetanus toxoid is only available in combination with other antigens.* Adacel (Diphtheria toxoid + Tetanus toxoid + Pertussis vaccine), ADT (Diphtheria toxoid + Tetanus toxoid), Boostrix (Diphtheria toxoid + Tetanus toxoid + Pertussis vaccine), Tripacel Injection (Diphtheria toxoid + Tetanus toxoid + Pertussis vaccine)
Presentation [1]	0.5mL in needleless prefilled syringe for injection
Indication	• All wounds in patients that have not had a booster in the last 10 years • All wounds <u>other than clean minor cuts</u> in adults who have not received a booster in the last 5 years • All wounds where <u>vaccination history is uncertain or less than 3 doses of tetanus toxoid.</u> *Ensure this is noted on discharge paperwork. The patient will require further immunoglobulin as part of routine follow-up*. (see table below)
Contraindications[1]	Previous anaphylaxis following a previous dose of tetanus-containing vaccine or any vaccine. Consider Tetanus Immunoglobulin (TIG) TIG for tetanus prone wounds for persons with history of severe adverse event following tetanus vaccination
Precautions[1]	Observe patient until at least 15 minutes post administration for development of allergic type reactions. Notify medical officer immediately if allergic type symptoms develop.
Dose[1]	0.5mL of a tetanus-containing vaccine in combination with diphtheria toxoid. Refer to medication packaging for specific dosages
Dose frequency[1]	Once only
Administration[1]	**To be administered in hospital only.** Shake thoroughly before use. 0.5mL given as a slow intramuscular injection
Storage	Refrigerate, store between +2^{0}C to +8^{0}C and according to *The National Vaccine Storage Guidelines Strive for 5 (2013)*. Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see **PD2013_043**.
Adverse effects[1]	Pain, redness and swelling at the injection site are common. Headache, malaise, myalgia and fever are uncommon. Anaphylaxis, urticaria and peripheral neuropathy are rare. Brachial neuritis is very rare.
Nursing Accreditation Requirements	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a *Local Facilitator*, in accordance with the NDEC Education and Accreditation Framework.
Documentation	*Record specific medication trade name and batch number in notes and in discharge letter (will allow GP to update Patient Healthcare Record)* Administration record is to be documented by the administering nurse. Document on the "once only" section of the appropriate medication chart The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
Related Documents	Guide to tetanus prophylaxis in wound management (The Australian Immunisation Handbook, 10th Edition, 2013) (see Table 1 below) NDEC Nurse Management Guideline: Foreign Body **http://www.ecinsw.com.au/node/271** NDEC Nurse Management Guideline: Insect Bites and Stings **http://www.ecinsw.com.au/node/272** NDEC Nurse Management Guideline: Marine Creatures **http://www.ecinsw.com.au/node/283**

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Table 1: Guide to tetanus prophylaxis in wound management *(Australian Immunisation Handbook)*

Time since vaccination	Type of wound	Tetanus toxoid vaccine [NB1]	Tetanus immunoglobulin
History of 3 or more doses of tetanus toxoid vaccine			
less than 5 years	all wounds	no	no
5 to 10 years	clean minor wounds	no	no
	all other wounds	yes	no
greater than 10 years	all wounds	yes	no
Uncertain vaccination history or less than 3 doses of tetanus toxoid vaccine			
	clean minor wounds	yes	no
	all other wounds	yes	yes
NB1: Tetanus toxoid is available only in combination with other antigens.			

[1] The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

SAFE ASSESSMENT ROOMS (GL2020_001)

PURPOSE

The purpose of this Guideline is to outline the requirements for the design and use of Safe Assessment Rooms (SARs) in NSW Emergency Departments (EDs). A SAR is designed to accommodate the needs of patients with, or at risk of developing, acute severe behavioural disturbance (ASBD) who require assessment in a therapeutically supportive environment.

KEY PRINCIPLES

- All NSW Health Organisations with a SAR should have local processes in place which comply with this Guideline and support the principles detailed here.
- The SAR is a staffed clinical area for the purposes of ED staffing allocation, staff establishment and clinical governance
- ED capacity relies on the flexible use of treatment spaces, and no individual patient group is identified as being the sole user of the SAR. The room may be used for a variety of clinical purposes.
- SARs have a number of design features which allow the patient to be managed in a safe environment while also optimising the safety of other patients and staff.
- The use of co-design methodology is a key principle to inform and support development, design and use of the SAR.
- SARs are not intended to be used for seclusion
- SARs should not be the default pathway in the ED for people presenting with mental health conditions.
- A collaborative approach between the ED and mental health (MH), drug and alcohol, and security services on the governance, safe practice, and use of SARs is beneficial for good patient outcomes.
- Police and NSW Ambulance are key stakeholders.

USE OF GUIDELINE

This Guideline should be used as a resource to support NSW Health organisations to co-design clinical spaces and local guidelines and policies to support management of patients with or at risk of developing ASBD.

To download the complete guideline go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_001

EARLY EVIDENCE COLLECTION (GL2022_010)

GUIDELINE SUMMARY

Early evidence collection is the process of supporting a patient who has or may have experienced a recent sexual assault to self-collect early forensic and/or toxicology samples to support the criminal justice process.

The Guideline provide clinicians with guidance for facilitating, storing, and documenting early evidence collection.

KEY PRINCIPLES

Early evidence collection is offered as part of an integrated crisis response when a person has or may have experienced a recent sexual assault.

Early evidence kits are to be offered to adults, young people and children who are able to self-collect samples.

Early collection of forensic and toxicology samples is to be offered in all sexual assault services and Level 3-6 Emergency Departments. This may also be offered in other NSW Health settings at the discretion of Local Health Districts (districts) and Specialty Health Networks (networks).

A person's physical and emotional health, safety and wellbeing must be prioritised even when particular time frames exist in the gathering of forensic evidence.

When offering early evidence collection, NSW Health workers must provide responses that:

- are respectful, non-judgmental and validating
- assist the person to regain their sense of dignity and control
- help access information and resources
- promote choice and control over actions taken • increase safety
- support the person in reconnecting with the self and to those who provide safe support.

All settings offering early evidence collection must consult with the district or network's sexual assault service to draft local processes that follow the principles and processes within this Guideline. Local processes must include a pathway for involving a sexual assault service in the collection, storage, release and destruction of forensic and toxicology samples to ensure psychosocial support for the patient is prioritised.

To download the complete guideline go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_010

MANAGING NON-FATAL STRANGULATION IN THE EMERGENCY DEPARTMENT (IB2023_038)

PURPOSE

This Information Bulletin advises local health districts and specialty health networks of the publication of the Agency for Clinical Innovation Clinical Practice Guide **Managing non-fatal strangulation in the emergency department**.

The Clinical Practice Guide outlines the necessary assessment and clinical management of non-fatal strangulation, including medical imaging for patients presenting with non-fatal strangulation and mandatory reporting requirements along with addressing the psychosocial factors that need to be addressed as part of care in the emergency department.

KEY INFORMATION

The Clinical Practice Guide Managing non-fatal strangulation in the emergency department provides clinical support to those managing adult and paediatric patients presenting to the emergency department with non-fatal strangulation.

The Clinical Practice Guide has been developed to improve patient care by increasing healthcare workers' awareness of the potential risks and injuries resulting from non-fatal strangulation, and by outlining appropriate assessment and management or care coordination of an episode of non-fatal strangulation.

The Clinical Practice Guide emphasises the importance of follow up for people who have experienced non-fatal strangulation who are a population at high risk of poor outcomes.

The Clinical Practice Guide is supported by the **Non-fatal strangulation facility contact list** which is a document for facilities to populate with psychosocial support services, referral pathways, specialist advice and employee support details for staff.

CHAPTER 7 – EYE CARE

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CHAPTER 8 – POLICY ON SMOKING IN THE WORKPLACE

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NSW HEALTH SMOKE-FREE HEALTH CARE POLICY (PD2015_003)

PURPOSE

The aim of this Policy Directive is to reduce the risks to health associated with tobacco use by clients, staff and visitors to NSW Health facilities and the community's exposure to second-hand smoke. This policy applies to banning the use of cigarettes and other smoking products in NSW Health buildings, grounds and vehicles and also to the use of electronic cigarettes to eliminate the risks of exposure to particulate matter emitted by second-hand vapour. However, in the case of electronic cigarettes the smoke-free by-law and the *Smoke-free Environment Act 2000* do not apply.

MANDATORY REQUIREMENTS

Compliance with the NSW Health Smoke-free Health Care Policy means that all NSW Health buildings, grounds and vehicles are smoke-free with the exception of designated outdoor smoking areas determined by Local Health Districts (LHDs) and speciality network governed statutory health corporations that choose to provide such areas using a smoke-free by-law.

LHDs and speciality network governed statutory health corporations will ensure compliance with smoke-free by-laws where they are in place. Where appropriate and in line with the NSW Health Prosecution Policy and Guidelines, Penalty Infringement Notices (PINs) may be issued to staff, clients and visitors who fail to comply with the smoke-free by-law. LHDs will also enforce the *Smoke-free Environment Act 2000 (*the Act) in settings applicable to buildings and grounds regardless of whether a smoke-free by-law exists.

This includes:

- Enclosed public places.
- Within 4 metres of the pedestrian access point to buildings.
- Bus stops and cab ranks, where people queue or gather.
- Within 10 metres of children's play equipment.
- In commercial outdoor dining areas from 6 July 2015.

Staff, clients and visitors to NSW Health facilities will be informed about smoke-free requirements under this policy, the Act and smoke-free by-laws, where they exist.

All clients of LHDs, St Vincent's Health Network and speciality network governed statutory health corporations will be asked about their smoking status and those who smoke will be supported to manage their nicotine dependence and quit, through:

- Provision of brief intervention to clients including the option of nicotine replacement therapy (NRT), where clinically appropriate.
- Provision at discharge of at least three days' supply of any NRT product the client has been using in hospital.
- Referral to Quitline 13 78 48 and/or a smoking cessation advisor for ongoing advice and support to quit.

All staff of LHDs, St Vincent's Health Network and speciality network governed statutory health corporations who smoke will be able to access from their organisation, at least four weeks' supply of free NRT per year (including a variety of NRT product choices).

IMPLEMENTATION

NSW Ministry of Health responsibilities

- Develop model smoke-free by-laws and Instrument of Appointment for use by LHDs and speciality network governed statutory health corporations.
- Develop and distribute a state-wide guide on smoking cessation and brief intervention.

Chief Executive responsibilities

- Ensure the requirements and standards of the Policy are implemented, monitored, reviewed and acted on accordingly.
- Determine whether to implement a smoke-free by-law to allow smoking bans in NSW Health buildings, vehicles and grounds not already covered by the Act to be enforced, designated smoking areas to be established and PINs to be issued (relevant for LHDs and speciality network governed statutory health corporations only).
- Enforce the Act as it applies to NSW Health buildings and grounds and the smoke-free by-law, where this is in place.
- Support managers and staff to implement the policy, including following up on reported breaches.
- Report implementation progress of the policy to the Ministry on a regular basis.
- Ensure a system is in place to support staff to quit or manage their nicotine dependence including access to brief intervention, at least four weeks of free NRT per year, where clinically appropriate and referral to NSW Quitline 13 78 48 and/or smoking cessation advisor (relevant to LHDs, St Vincent's Health Network and speciality network governed health corporations only).

Manager responsibilities

- Support staff to implement and comply with the policy and monitor staff compliance.
- Implement an appropriate strategy to inform clients, staff and visitors of the policy.
- Support all relevant staff to obtain smoking cessation training and ensure clinical staff provide brief intervention to all clients who smoke, where applicable.
- Ensure cessation support is available to staff to quit or manage their nicotine dependence, including provision of at least four weeks free NRT per year where clinically appropriate and referral to NSW Quitline 13 78 48 and/or smoking cessation advisor (relevant to LHDs, St Vincent's Health Network and speciality network governed health corporations only).

Staff responsibilities

- Implement and comply with the policy.
- Access smoking cessation training and provide routine brief intervention to clients who smoke, including assessment and documentation of clients' smoking status and support to manage nicotine dependence including provision of NRT, where clinically appropriate, referral to NSW Quitline 13 78 48 and/or smoking cessation advisor (relevant to LHDs, St Vincent's Health Network and speciality network governed health corporations only).

NOTIFICATION OF AMENDMENT TO THE NSW HEALTH SMOKE-FREE HEALTH CARE POLICY PD2015_003 (IB2018_026)

PURPOSE

The Information Bulletin is to notify the NSW Health system that the *Smoke-free Environment Amendment Act 2018* will commence on 1 July 2018. This means that in the case of electronic cigarettes that the *Smoke-free Environment Act 2000* will apply and will also cover Local Health District smoke-free by-laws that refer to the *Smoke-free Environment Act 2000*.

KEY INFORMATION

The NSW Health Smoke-free Health Care Policy bans the use of cigarettes and other smoking products in NSW Health buildings, grounds and vehicles and also the use of electronic cigarettes to eliminate the risks of exposure to particulate matter emitted by second-hand vapour.

The Smoke-free Environment Amendment Act 2018 will commence on 1 July 2018. The Act amends the Smoke-free Environment Act 2000 to prohibit the use of e-cigarettes in public places where the Smoke-free Environment Act 2000 currently bans smoking. This Act will also affect the smoke-free by-laws. Local health districts smoke-free bylaws that refer to the Smoke-free Environment Act 2000 will automatically cover ecigarette use in the same way they cover smoking cigarettes. This means Penalty Infringement Notices (PINs) may be issued for using e-cigarettes where a PIN could be issued for smoking

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CHAPTER 9 – HEALTH RECORDS AND INFORMATION

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NSW Health Privacy Internal Review Guidelines	GL2019_015
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MENTAL HEALTH CLINICAL DOCUMENTATION (PD2021_039)

PD2021_039 rescinds PD2010_018

POLICY STATEMENT

NSW Health organisations must ensure that all mental health services use available electronic medical record (eMR) systems for the documentation of clinical practice and care. This is required in all service settings, for all service types and age groups, and enables integrated health services and clinical information systems across NSW.

Digital documentation facilitates the recording, retrieval and sharing of medical record information in an accessible, standardised and structured format. This is important at all points in the cycle of mental health care from triage through to transfer or discharge.

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy.

SUMMARY OF POLICY REQUIREMENTS

Electronic health systems are to be supported by Local Health Districts (Districts) and Specialty Health Networks (SHNs) by implementing products and functionalities as they become available. Local systems, processes and procedures are to be maintained, including those required for downtime when needed. There must also be training and education provided for clinicians in the areas of mental health clinical documentation, and related eMR systems and processes.

eMR systems must include available electronic mental health (MH) documents, including notes, forms, measures and reports.

Clinical care and information must be documented and are to be recorded within the eMR, with paper records used only where there is no current alternative.

Documentation must occur at appropriate clinical points of care, including triage, assessment, care planning, review, transfer and discharge. It must be made as soon as practically possible in the eMR clinical document(s) relevant to the clinical point of care and needs of the person accessing the service.

Structured documentation is to be used to aid functionalities that auto-populate fields, and transfer information between documents and systems. This is critical to clinical care and support across services and systems within NSW Health. Only relevant fields need to be completed. There are no requirements that all fields or areas of a document are to be completed.

9. HEALTH RECORDS AND INFORMATION 9.2

All persons registered to a mental health service must have the following recorded in their documentation: Designated Carer(s) and/or Principal Care Provider information; Diagnosis (issues that are the focus of the current admission or encounter); Legal Status; and Alerts (for care and safety of the person, carer(s) and health workers).

There must be clinical reasons to use non mental health or alternative documentation or free text. In these circumstances, the clinician must be aware that auto-population and transfer functions will not be enabled. The clinician is to ensure that documentation reflects the content of the standardised eMR document, and the format of documentation is legible and locatable by other clinicians involved in care.

For information on Mental Health resources and updates
http://ehnsw.sharepoint.nswhealth.net/apps/ClinP-eMedsHub/Pages/Mental-Health.aspx

PRIVACY MANAGEMENT PLAN (IB2023_012)

IB2023_012 replaced PD2015_036

PURPOSE

The NSW Health Privacy Management Plan has been published on the NSW Health website Patient privacy.

All NSW Health organisations are required to adopt and implement the NSW Health Privacy Management Plan within their organisation and promote it to their staff and the public, including through publication of the Plan on their public facing websites.

KEY INFORMATION

Key actions for NSW Health organisations

All NSW Health organisations must ensure the collection, use, management and disclosure of personal and health information complies with the Information Protection Principles and with the Health Privacy Principles, as detailed in the *Privacy and Personal Information Protection Act 1998* (NSW) and *Health Records and Information Privacy Act 2002* (NSW), respectively.

NSW Health organisations are required to have a Privacy Contact Officer (or a designated staff member), whose role includes to facilitate compliance with privacy laws and NSW Health privacy policy in their organisation.

New staff members in NSW Health organisations are to complete mandatory privacy training as part of their induction and orientation process.

Where staff have access to large data sets of personal and health information in their roles, NSW Health organisations must ensure that, in addition to privacy training, appropriate privacy undertakings have been signed, prior to these systems being accessed.

Appropriate collection notices are to be used to satisfy privacy requirements when personal and health information is being collected, particularly when new programs or systems are being developed.
A request for a privacy internal review must be completed as soon as practicable, and within 60 calendar days.

Any wilful act of unauthorised access to, use, or disclosure of, personal or health information by a staff member is to be referred to human resources for advice regarding appropriate disciplinary action. In consultation with the NSW Ministry of Health, the chief executive must give consideration for referring the matter to the police, and/or informing persons affected by a breach, of the option of referral to prosecution.

NSW Health organisations have privacy-related statutory reporting obligations, including obligations under the *Independent Commission Against Corruption Act 1988* (NSW), the *Privacy Act 1988* (Commonwealth), the *My Health Records Act 2012* (Commonwealth), and the *Security of Critical Infrastructure Act 2018* (Commonwealth). Mandatory reporting obligations include privacy breaches involving inappropriate use/ disclosure of Tax File Numbers, My Health Record data breaches, other privacy matters related to corrupt conduct, and for notifying cyber security incidents to the Australian Cyber Security Centre.

Each NSW Health organisation is to provide a submission to the NSW Ministry of Health by 31 July each year, that outlines the actions it has undertaken in relation to privacy management and compliance, and details of privacy statistics, for the financial year immediately prior.

All NSW Health organisations are to publish their own privacy management actions and statistics (as included in the submission to the NSW Ministry of Health) on their own websites after the NSW Health Annual Report has been published on the NSW Health website, and by no later than 30 November of that same year.

Further information on privacy-related matters is available in the *NSW Health Privacy Manual for Health Information*.

About the NSW Health Privacy Management Plan

The NSW Health Privacy Management Plan:

- Demonstrates to members of the public and other third parties how NSW Health meets its obligations under the *Privacy and Personal Information Protection Act 1998* (NSW)
- Provides an overview of how personal information is managed appropriately and in accordance with the law, and provides advice about the management of staff members' personal information
- Demonstrates NSW Health's commitment to respecting the privacy rights of staff, members of the public, and other third parties together with a Privacy Information Sheet for Personal Information
- Sets out how individuals, whether they are staff or members of the public, can access their personal information, seek to amend their personal information, submit a privacy complaint, and request a privacy internal review and how possible breaches of privacy in relation to personal information will be managed by NSW Health
- Outlines limits on access to personal information and legislative exemptions (including Public Registers, Public Interest Directions and Codes of Practice)
- Sets out the remedies available to individuals, if they have a concern that the privacy of their personal information has been breached.

PHOTO AND VIDEO IMAGING IN CASES OF SUSPECTED CHILD SEXUAL ABUSE, PHYSICAL ABUSE AND NEGLECT (PD2015_047)

PURPOSE

The purpose of this Policy Directive is to:

- Define the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect
- Guide NSW Health staff when capturing, storing and managing images for the purpose of documenting health and clinical features and informing possible future judicial proceedings that require medical opinion.

MANDATORY REQUIREMENTS

This policy requires that:

- The immediate and longer-term physical and emotional needs of the child and their parent(s) / guardian(s) are identified and taken into account when considering photo and video imaging.
- Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and limited other relevant purposes, and is not excessive or unreasonably intrusive.
- Imaging is only captured where informed consent is sought and obtained for each purpose for which it may be used.
- Capture, recording and storage of images is limited to LHD / SCHN owned memory devices.
- Images are stored securely and are stored separately from the principal health care record, to maintain patient privacy.
- Limited access is provided to images, to maintain patient privacy.
- Capture, use and management of photo and video images in cases of suspected child abuse is conducted in accordance this Policy Directive, in conjunction with:
  Child Wellbeing and Child protection Policies and Procedures for NSW Health (PD_2013_007)
  Current Standards and Practice Guidelines for NSW Health Sexual Assault Services
  Child Wellbeing and Child Protection – NSW Interagency Guidelines,

- Consent, privacy, confidentiality, management and retention is preserved in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005, NSW Health Privacy Manual for Health Information, 2015, NSW Health Care Records – Documentation and Management Policy (PD2012_069), NSW Health Electronic Information Security Policy (PD2013_033), NSW Government Digital Information Security Policy M2012-15, NSW Health Subpoena policy (PD2010_065) and NSW Government General Retention and Disposal Authority policy (GDA17; 2011).

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- Establishing mechanisms to ensure the directives and requirements of this policy are applied, achieved and sustained
- Ensuring that NSW Health staff understand and are aware of their obligations in relation to this policy and related policies and procedures
- Ensuring resources are available to deliver and meet the directives and requirements of this policy
- Ensuring that NSW Health staff are trained to operationalise and implement this Policy
- Ensuring NSW Health staff are advised that compliance with this policy is part of their patient / client care responsibilities
- Ensuring that procedures for capture, storage, access and security are subject to risk analysis reassessment over time.

Facility managers are responsible for:

- Ensuring the requirements of this policy directive are disseminated and implemented in their service / department / hospital
- Establishing local validated processes for image preparation, capture, processing, storage, transmission, archiving, retention and disposal
- Monitoring implementation and compliance with this policy.

NSW Health workers are responsible for:

- Implementing and complying with the directives and requirements of this policy
- Ensuring that their knowledge of consent, privacy and documentation management processes is maintained, consistent with the requirements of this policy directive.

1 INTRODUCTION

1.1 Rationale

Clinical evaluation of a child or young person who is suspected of having been abused or neglected involves a holistic assessment of their physical needs, psychosocial needs, medical history, and any social or familial risk factors. NSW Health practitioners are required to document and report suspicion of harm and may use clinical photo and video imaging to supplement and enhance the detail in written notes and diagrams. Imaging can assist the physician to review the facts associated with clinical examination and history as part of their clinical diagnosis: in an attempt to ensure the accuracy of a diagnosis this may include professional peer review. Diagnoses in cases of suspected child abuse have an impact on the safety, welfare and wellbeing of a child or young person. Clinical photo and video imaging is an important tool in the achievement of accurate clinical conclusions to support the needs of children and young people.

This policy defines the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect. It will guide NSW Health workers to know what actions to take when capturing, storing and managing images for the purpose of documenting health and clinical features, and informing possible future judicial proceedings that require medical opinion. A development group was convened to inform the development of this policy. Details of membership appear at Appendix 5.5.

1.2 Who this policy applies to

This policy applies to NSW Health workers in Local Health Districts (LHDs) and the Sydney Children's Hospitals Network (SCHN) who are employed or contracted to capture or manage imaging in cases of suspected child abuse, including:

- Medical practitioners or other specialist staff undertaking medical and forensic examinations of children and young people aged under 18 who are suspected of having been sexually abused, physically abused or neglected
- Psychosocial, sexual assault and child protection practitioners, coordinators and managers
- Medical photographers, Joint Investigation Response Teams (JIRTs), Aboriginal health services and other clinical and allied health staff
- Managers or officers who support the capture, viewing, accessibility, transmission or management of photo and video imaging. This includes data custodians, IT technical and support staff, health information managers and staff in medical records departments.

The policy may also be of interest to:

- NSW Health interagency child protection partners
- Those who work in the wider criminal justice setting and child health and advocacy settings
- Networks that support children and young people who have experienced sexual abuse, physical abuse or neglect and their non-offending family members
- Those who work in private health settings who wish to adopt minimum standards for the use and management of photo and video imaging in cases of suspected child abuse.

1.2.1 Exclusions

This policy does not apply to:

- Sexual abuse examinations utilising clinical colposcopic equipment without capture of imaging
- Photo and video imaging taken in other types of medical examinations (i.e. those that do not relate to suspected child abuse)
- Medical imaging such as Magnetic Resonance Images (MRIs), Computerised Tomography (CT) scans, skeletal surveys, radioisotope scans or post-mortem imaging.

1.3 Service users

Children or young people who use NSW Health services in relation to suspected sexual abuse, physical abuse and/or neglect and, depending on the age of a young person, this may include parent(s), carer/(s) or guardian(s).

1.4 Context for practice

1.4.1 Interagency context

Medical and forensic examinations and associated photo and video imaging take place in the context of an interagency response to child protection. Interagency roles and responsibilities are outlined in the Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013, current standards and guidelines for NSW Health Sexual Assault Services and NSW Interagency Guidelines.

1.4.2 NSW Health context

The psychosocial and medical needs of a child or young person are a priority and need to be responded to appropriately. NSW Health's role is to provide an integrated psychosocial and medical response to all suspected child abuse presentations including assessment, crisis intervention and counselling. The medical response will potentially include a medical and forensic examination.

Medical and forensic examinations are critical to the crisis response required on presentation of: a child victim of sexual abuse to a Sexual Assault Service or Emergency Department; or a child with suspected physical abuse or neglect to a medical practitioner, Emergency Department, or other health service.

Related child protection and violence prevention, privacy, security and document management policies are listed in Appendices 5.1 to 5.4.

1.4.3 Clinical context

Clinical photography has assisted in the development of medical knowledge and skills within the NSW Health workforce over the last two decades, and aided the interpretation and evaluation of injuries, for the benefit of examiners and their patients. Medical and forensic assessment of children suspected of having been abused occurs within a framework that responds to the immediate psychosocial and medical needs of a child and their family – who are often traumatised and distressed.

This context includes:

- Identification of children at risk who require a medical and forensic assessment
- Recording of medical history and examination findings complemented by appropriate clinical photo or video imaging
- Forensic specimen collection where relevant (as in recent sexual abuse)
- Medical treatment of injuries or other sequelae of the abuse, such as the risk of exposure to sexually transmitted diseases or pregnancy
- Interpretation of clinical findings, with a reference to any allegation of abuse.

Anatomical diagrams are useful for recording certain features of an injury, such as the number of injuries, the type of injuries, their overall size and shape and the general location of the injuries on the body. It is difficult for a doctor to record adequately sufficient information for detailed medical and forensic assessment of many injuries with diagrams and words alone. Medical illustration is a specialised career. It takes both skill and time to produce an accurate and useful medical drawing. The extra detail provided by a photo or video record is of particular relevance when a medical and forensic examiner is asked to comment, sometime after the medical examination, on whether a particular account of accidental injury, provided by a caregiver, might reasonably account for the clinical findings.

Several advantages of photography can be summarised as below:

- Photo and video images allow review of injuries or other clinical findings, such as evidence of dermatological conditions or malnutrition, in a more comprehensive manner. Indeed there are many reasons why a child's injuries may need to be reviewed. The original examining doctor may review photos when preparing an expert certificate and/or prior to appearing in court. Photo and video imaging can assist the examining doctor when they review the patient for ongoing clinical care, or if the police provide additional information and ask for a clinical opinion, in regards injury causation. Photo and video imaging is useful for gaining a second opinion by a senior colleague as to the significance of the injury and also helps determine if specialist referral is necessary. It may also prevent the need for a child to travel long distances to a specialist centre
- Imaging can overcome the difficulties presented by children and young people having to lie still for extended periods of time. Children can naturally wriggle and not want to lie still – especially if they have experienced sexual abuse or if there is injury or recent assault. This is particularly relevant to examining the ano-genital regions, especially in pre-pubertal females where there is a need to assess in detail the significance of small anatomical structures which may be a normal variant or an indicator of recent or earlier injury

- Sexual abuse assessment in pre-pubertal children is complex. Paediatric genital anatomy is variable and accurate observation and interpretation is difficult. Forensic colposcopic imaging allows the examination to proceed with the knowledge that a child or young person can benefit from subsequent specialist review of the imaging as a record of the complex clinical findings
- Photo and video imaging may enable the medical examiner to capture a clear picture of an area that was only exposed for a few seconds. The use of photo and video imaging can in many cases prevent the need for a child or young person to return for a repeat examination, or undergo examination under anaesthesia.

It is best practice in Forensic Medicine to rigorously separate the observation and recording of findings from the interpretation of those findings. Photo and video imaging enables the examiner to concentrate on observation, which is demanding, and then to later consider all possible causes.

1.4.4 Intimate images, sensitive evidence and retention

Photo and video imaging captured as part of a medical and/or forensic assessment may include intimate images.

Intimate images are defined as depicting the genitalia, anus or post-pubertal female breast (Faculty of Forensic & Legal Medicine, 2014) and may also include other parts of the body, such as the buttocks or chest of a pre-pubertal child.

These images are considered as 'sensitive evidence' under the *Criminal Procedure Act 1986* (Section 281B). Where they are held by the NSW Police Force and Office of the Director of Public Prosecutions (ODPP) access to them is restricted. These restrictions do not extend to images held by NSW Health. Where a subpoena has been validly lodged, the court is not obliged to restrict access to intimate images held by NSW Health.

In accordance with health care record retention policies, once an image is captured as a medical record it can be subpoenaed, shown in court and remains on a medical record file for at least 30 years (NSW Government General Retention and Disposal Authority policy, 2004, revised 2011).

2 NSW HEALTH MINIMUM STANDARDS

When use of photo and video imaging is being considered during medical and forensic examinations in cases of suspected child sexual abuse, physical abuse and neglect, NSW Health will ensure that:

1. The immediate and longer-term physical and emotional needs of the child and their parent(s)/guardian(s) are identified and taken into account. (Section 2.1)
2. Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and other directly related purposes, and is not excessive or unreasonably intrusive. (Section 2.2)
3. Imaging is only captured where informed consent is sought and obtained for the specific purposes for which it may be used. (Section 2.3)
4. There are standardised procedures for capturing and documenting images to reduce variation across statewide services. (Section 2.4)
5. Capture, recording and storage of images is limited to LHD/SCHN owned memory devices. (Section 2.5)
6. Images are stored securely and separately from the principal health care record, to maintain patient privacy. (Section 2.6)
7. Restricted access is provided to images, to maintain patient privacy. (Section 2.7)
8. The integrity of images is maintained in the longer-term. (Section 2.8)

2.1 Physical and emotional needs of the child or young person

Standard: The immediate and longer-term physical and emotional needs of the child and their parent(s)/guardian(s) are identified and taken into account when considering photo and video imaging

In accordance with the Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013 and current standards and guidelines for NSW Health Sexual Assault Services:

- In cases of suspected physical abuse and neglect, optimally, assessment should be conducted by the medical officer with a social worker or other health professional colleague, e.g. a nurse, present to facilitate a holistic assessment (Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014).
- In cases of suspected sexual assault a joint response by the medical practitioner and counsellor from the Sexual Assault Service or Child Protection Unit provides the professional response required in these circumstances (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).

When deciding whether and how to capture images in this context, NSW Health workers must:

- Identify and take into account:
  - Factors arising from the life circumstances of the child or young person, their psychosocial development, vulnerability to particular risks and their linguistic, cultural and religious needs
  - The circumstances in which the child or young person was alleged to have been assaulted, abused or neglected
    - The need for an appreciation and understanding of Aboriginal people and communities' inter-generational trauma legacies, the impact of power dynamics, the importance for understanding an Indigenous world-view, including cultural practices and protocols, the multiple and inter-related factors that contribute to the poorer health status of Aboriginal people, and the limitations of Western approaches in the assessment and treatment of trauma (see http://www.health.nsw.gov.au/aboriginal/pages/default.aspx).
- Ensure that children, young people and their parent(s)/guardian(s) have:
  - Access to health information relative to their wellbeing
  - The opportunity to participate in decision making
  - Access to an interpreter if required (see Interpreters – Standard procedures for working with Health Care Interpreters)
  - Access to an Aboriginal Health worker if desired. It is important to determine at the beginning the most appropriate person or people to communicate with in relation to the patient.

2.2 Purpose of imaging

Standard: Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and other directly related purposes, and is not excessive or unreasonably intrusive

In accordance with the NSW Heath Privacy Manual for Health Information, 2015:

- The primary purpose for collecting photo and video imaging is to document a clinical finding for the medical record
- Imaging must be relevant to the purpose, not excessive, accurate, up to date, complete and must not be unreasonably intrusive
- Collection of photo and video imaging must supplement, not replace, other methods of documenting findings

- Other directly related purposes for collecting photo and video imaging may include:
  - Peer review to assist diagnosis
  - Providing an aide-memoire for potential future legal proceedings
  - Teaching, research and quality improvement activities (sections 2.3.3, 2.7.1, 2.8 and 2.9).

LHDs/SCHN must ensure that images are only captured and used for relevant purposes in accordance with the NSW Heath Privacy Manual for Health Information, 2015.

2.3 Seeking consent

Standard: Imaging is only captured where informed consent is sought and obtained for the specific purposes for which it may be used

LHDs/SCHN must ensure that NSW Health workers act in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Health Privacy Manual for Health Information, 2015 and comply with 2.3.1 to 2.3.3 below. Additional advice may be sought from NSW Health Legal and Regulatory Services.

2.3.1 Who should seek consent

An examiner must ensure that valid consent has been obtained. An examiner may ask another health care practitioner to seek consent, however the examiner maintains responsibility and may be held responsible in some circumstances if consent is not sought correctly (NSW Health Privacy Manual for Health Information, 2015).

2.3.2 Who can provide consent

Where a child or young person is less than 14 years of age, consent given by a parent or legal guardian is generally necessary. In some circumstances, consent can be given by the young person if he or she is considered by the treating health care practitioner to be mature enough, and if this would be appropriate in the circumstances. See '*Gillick* competence' in the 'Glossary'.

Where a young person is aged 14 or 15 they are generally able to consent, however an assessment of their maturity and understanding will still need to be made. Effort should be made to seek the consent of a parent or legal guardian unless the young person indicates a strong objection, and this is reasonable in the circumstances. Alternatively a parent or legal guardian can provide consent, however it would be exceptional to proceed on the basis of parent or guardian consent without the acquiescence of the young person aged 14 or 15.

Where the young person is 16 years of age or over they should generally be capable of consenting themselves (NSW Health Consent to Medical Treatment - Patient Information policy, 2005; NSW Heath Privacy Manual for Health Information, 2015).

For guidance on capacity to consent see the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Heath Privacy Manual for Health Information, 2015.

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child, to another adult. This may occur in certain cultures, for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, might be responsible for giving consent on their behalf. Where NSW Health workers require advice about who is able to provide consent for imaging they should consider the following options:

- Refer to policy relating to:
  - The broader context of consent for the examination (NSW Health Consent to Medical Treatment - Patient Information policy, 2005; NSW Heath Privacy Manual for Health Information, 2015)
  - Child Wellbeing and Child protection Policies and Procedures for NSW Health, 2013 and current standards and guidelines for NSW Health Sexual Assault Services
- Contact NSW Health Legal and Regulatory Branch or NSW Kids and Families during business hours
- Contact the Guardianship Division of the NSW Civil and Administrative Tribunal.

2.3.3 The consent process

Where child sexual abuse, physical abuse or neglect is suspected and the capture and use of photo and video imaging is considered as part of a medical and forensic examination, informed consent must:

- Be sought in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Health Privacy Manual for Health Information, 2015 and
- Address consent for the capture of the image(s) and the separate specific purposes for which image(s) may be used.

The consent process must include:

- Patient/parent/guardian access to culturally appropriate information
- Seeking written informed consent for the capture of photos to document a clinical finding
- An explanation to the child or young person and/or their parent(s)/guardian(s)
  - What the procedure for capturing imaging will involve
  - That imaging may include ano-genital and breast/chest areas of the body and that they may opt to exclude imaging of these or other specific body areas
  - That any records of examinations, findings, photos, videos, samples/specimens taken in accordance with the consent/s given
    - Will be stored in accordance with NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Government General Retention and Disposal Authority policy, 2004 (revised 2011) for a minimum of 30 years
    - May be referred to another clinician for a second opinion and peer review
    - May be forwarded to the NSW Police Force, ODPP, and by the court under subpoena, including the judge, the jury, the defendant, counsel for both prosecution and defence and any other people whom the judge considers relevant
    - May be produced to comply with a request to a NSW Health organisation under the legislation set out in the *Children and Young Persons (Care and Protection) Act* 1998
    - May be forwarded to parties in Family Court proceedings under subpoena

For the purpose of this policy the consent process must also include:

- Seeking separate informed consent for the use of copies of photo and video imaging for a) teaching and/or b) approved research. All such copies must be de-identified, the teaching and research activities must be compliant with the NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies and research must be approved by a Research Ethics Committee (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics2.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf).

Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW can help to determine whether an activity constitutes a research or quality improvement activity.

- An explanation that consent for the future use of images for a) teaching and/or b) approved research activities may be withdrawn by the person who provided consent or the person depicted in the image(s) once they are Gillick competent.

An interim NSW Health consent form is located in Appendix 5.6.

2.4 Procedures for capturing and documenting imaging

Standard: There are standardised procedures for capturing and documenting images to reduce variation across statewide services

LHDs/SCHN must support NSW Health workers to comply with 2.4.1 and 2.4.2 below.

2.4.1 Capturing imaging

Capture of imaging in cases of suspected child abuse must be conducted in accordance with the NSW Health Privacy Manual for Health Information, 2015, and must be restricted to NSW Health workers with suitable training and experience in the procedures required to comply with this photo and video imaging policy.

At a minimum, NSW Health workers must:

- Carefully explain to the child or young person, and where appropriate their parent(s)/guardian(s), what the procedure is going to involve in advance of the examination
- Provide the opportunity for the child or young person, and/or parent(s)/guardian(s) to ask questions and receive answers in a way that takes into consideration the person's level of development and understanding as described in section 2.1 of this policy
- Seek informed consent as described in section 2.3 of this policy directive via a process that:
  - Explains what consent means in relation to the separate specific purposes for which images may be used (as described in section 2.3 of this policy directive) and the implications that may arise for the child, young person or their parent/guardian providing consent
  - Provides options for providing or refusing consent at any time during the course of the examination for:
    - The capture of images of specific areas of the body
    - The specific purposes for which images may be used.
- Consider whether the child or young person and their parent(s)/guardian(s) would find it helpful if the practitioner or other NSW Health worker demonstrated the use of the video colposcope and observation monitor. This could be achieved by displaying real time magnified images of objects and/or non ano-genital body parts on a monitor placed in a location easily seen by the child or young person and examiner
- Ensure that images of a child or young person's face are not captured, unless it is required to document a clinical finding
- Capture the minimum number of images required to adequately document a clinical finding
- Adopt the following good practice techniques:
  - Use a RAW (digital negative that requires processing), TIFF or JPEG format for capturing still images
  - Use a procedure that will allow reliable identification of the recording(s) in relation to the particular child or young person and the time that the image(s) was taken. For example, include the child's hospital ID label for identification purposes

- Include some form of further visual identification on the first and last image, including the child's name or initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID) and the date
- Include a scale in the image, where possible
- Consider anterior, posterior and lateral images of the patient and document the anatomical location of each image (an example 'Request for medical photography services' form is located in Appendix 5.7).

When conducting telehealth NSW Health workers must:

- Consider the professional capacity of the host and remote site examiners as either the supervising or the supervised clinician based on their relevant and appropriate training and experience
- Act in accordance with the requirements of this policy directive
- Consider using the good practice techniques set out in the Agency for Clinical Innovation Guidelines for the use of telehealth for clinical and non-clinical settings in NSW, 2015.

NSW Health does not support recording of an entire telehealth consultation with a patient or any audio recording.

2.4.2 Documenting imaging

NSW Health workers must:

- Act in accordance with NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015
- Reference images using an individual health care patient identification system including a child or young person's name or initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID), date of birth (DOB), the date the images were captured and the name of the treating physician
- Document consent and the existence of images in the patient's medical records. For physical abuse and neglect the Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014 may be used, unless this is being assessed in conjunction with suspected sexual abuse when the Child Sexual Assault Medical Protocol in the Sexual Assault Investigation Kit (SAIK) may be used. Details must include:
  - Any refusal of consent for capturing photo and video imaging
  - Any withdrawal of consent for the capture or use of photo and video imaging before and during the examination
  - The name of the photographer, the date and time, and the location of where the images were taken to maintain integrity in the event of legal action or issuing of a subpoena
  - The number and type of images that were taken
- Note that child abuse and neglect images must be stored securely and separately from a child or young person's principal health care record (see section 2.6.2) and a reference placed on the health care record where the images are located to identify the existence of any principal health care record or other relevant health related documents. Index or patient administration systems must reference the existence of satellite/decentralised health care records that address a specific issue and that are kept separate from the principal health care record
- Document authorised permission for release/transmission in the patient's medical records (see section 2.6.3 of this policy directive).

Where telehealth is used, document at both sites that the consultation has occurred and ensure that this documentation concurs.

It is good practice to disclose the existence of images to NSW Police Force on the Expert Certificate.

2.5 Devices used to capture, record, store and transmit images

Standard: Capture, recording and storage of images is limited to LHD/SCHN owned memory devices

LHDs/SCHN must ensure that:

- In cases of suspected child abuse, medical and forensic imaging is captured on dedicated LHD/SCHN owned:
  - Clinical camera imaging devices used for the sole purpose of documenting suspected sexual abuse, physical abuse, and neglect;
    - or where the sole purpose of a clinical camera is not restricted to documenting abuse or neglect, such as in an Emergency Department, the clinical camera must accommodate an LHD/SCHN owned removable memory device and images must be captured onto the removable device and not the camera, using one removable device per patient
  - Clinical colposcope imaging equipment, preferably used for the sole purpose of documenting sexual abuse
  - Portable or removable memory devices, such as DVDs, memory sticks and external hard drives
- Single Lens Reflex (SLR) clinical camera equipment is the preferred option and:
  - Includes a flash
  - Includes a lens with a close up facility
  - Has at least six megapixels.

  A 'stand-alone' personal camera (i.e. one that is not part of a mobile telephone or ipad) may be used in exceptional circumstances and only where:
  - No LHD/SCHN owned equipment is available and
  - The personal camera can accommodate an LHD/SCHN owned removable memory device and use is restricted to capturing images onto the removable device and not the personal camera, using one removable device per patient.
- All equipment complies with NSW Health Electronic Information Security Policy, 2013 and NSW Health Privacy Manual for Health Information, 2015
- Imaging equipment is:
  - Capable of producing an accurate representation of any evidential clinical finding being recorded
  - Appropriately maintained and managed, such as updating date and time settings recharging/replacing batteries
  - Strictly governed and controlled and adequately secured using lockable facilities
  - Monitored in respect of who accesses and uses it.
- Any equipment or devices used for remote access to NSW Health networks from an external location must be authenticated and authorised by the LHD/SCHN and connectivity must be protected by approved controls. This includes mobile devices, smartphones, tablets, netbooks, notebooks, palmtops, handheld personal organisers, laptops, modems, PDAs, wireless access points, portable or removable storage devices, CD/DVD burners and printers
- All imaging is protected and managed according to NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, and NSW Health: Health Care Records – Documentation and Management policy, 2012.

NSW Health does not support:

- The use of any other personal equipment or devices for the purpose of capturing or storing images in relation to suspected child abuse. Examples include cell phones, smartphones, tablet devices, netbooks, notebooks, palmtop, handheld personal organisers, laptops, USB drives, DVDs and removable memory cards and sticks
- Use of Skype or other insecure software/platforms in NSW Health care settings.

2.6 Security and storage of images

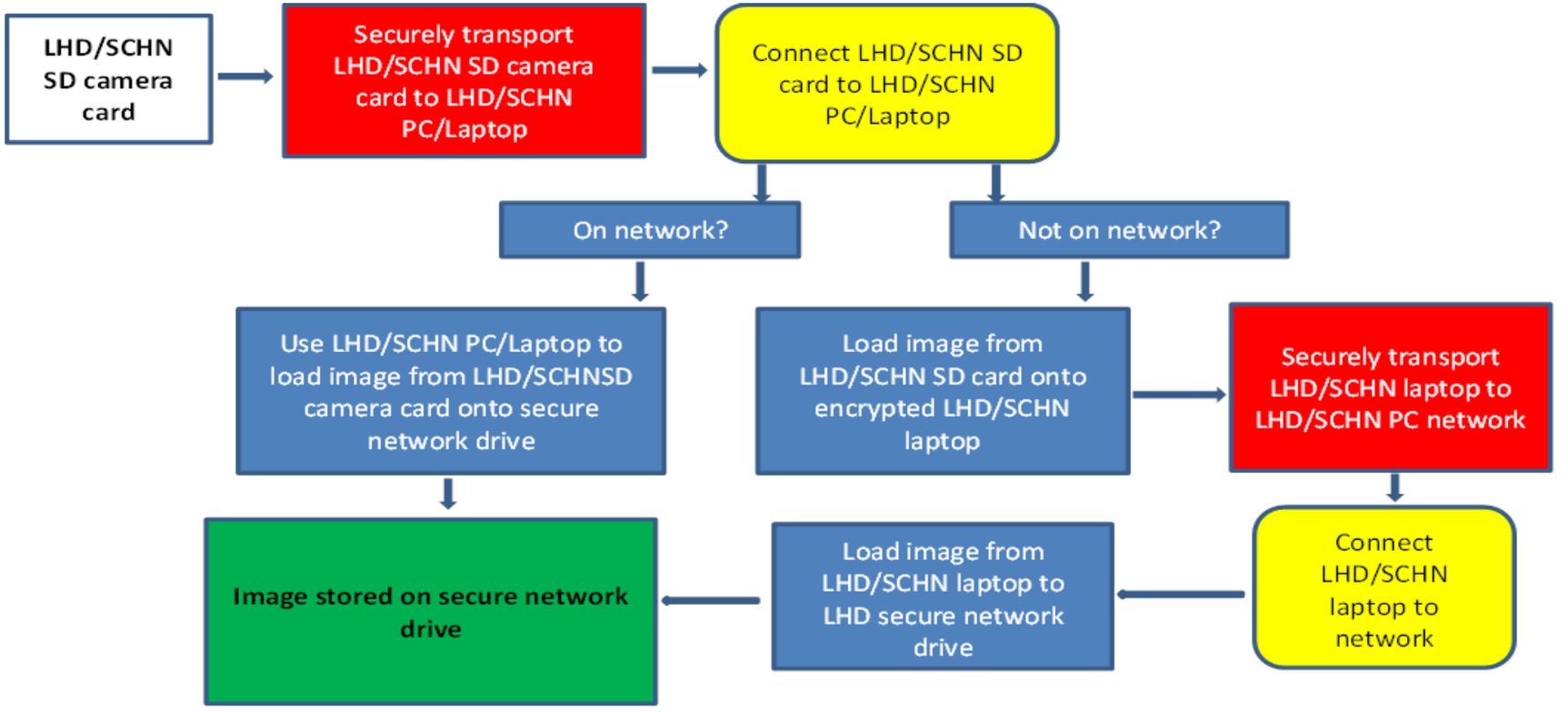
Standard: Images are stored securely and separately from the principal health care record, to maintain patient privacy

LHDs/SCHN must support NSW Health workers to comply with 2.6.1 to 2.6.6 below.

2.6.1 Transfer of images from the capture equipment to secure storage

NSW Health workers who capture and/or support the management of medical and forensic photo and video imaging in cases of suspected child abuse must:

- Check the original images on the camera equipment/LHD removable memory device and:
  - Consider deleting those where at the time the examiner first views the image(s), in the opinion of the practitioner, it is not usable. For example, the image depicts surrounding context rather than the patient or the lighting or exposure impedes what is depicted. Caution must be exercised and where the practitioner is unsure the image must be retained
  - Delete those where the person that provided consent for imaging withdraws consent before completion of the examination
  - Where images are deleted, document the number of images that were deleted and for each image, the reason why it was deleted
- Transfer the retained original image/s from the capture equipment/LHD removable memory device to LHD/SCHN secure network storage facilities as soon as possible and usually within one working day (see Figure 1)
- Archive retained original image/s. A ’read only' format or the equivalent facility is preferred to ensure the integrity of the original image/s and restrict the potential for editing
- Use a separate working copy of an original image for any editing that might be required
- Check images have successfully transferred to LHD/SCHN secure network storage facilities and then delete images that are left on the camera equipment/LHD removable memory device
- Periodically format capture camera equipment/LHD removable memory devices to ensure data recovery processes cannot be used to recover deleted images: Where a removable memory device per patient is used, such as in personal or non-dedicated cameras, formatting must occur as soon as possible after transfer to LHD/SCHN secure network storage facilities and usually within one working day
- Act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015.


LHD/SCHN SD camera card
Securely transport LHD/SCHN SD camera card to LHD/SCHN PC/Laptop
Connect LHD/SCHN SD card to LHD/SCHN PC/Laptop
On network?
Not on network?
Use LHD/SCHN PC/Laptop to load image from LHD/SCHNSD camera card onto secure network drive
Load image from LHD/SCHN SD card onto encrypted LHD/SCHN laptop
Securely transport LHD/SCHN laptop to LHD/SCHN PC network
Image stored on secure network drive
Load image from LHD/SCHN laptop to LHD secure network drive
Connect LHD/SCHN laptop to network

2.6.2 Storage of images

NSW Health workers who capture and/or support the storage and management of medical and forensic photo and video imaging in cases of suspected child abuse must act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015.

Photo and video imaging in cases of suspected child abuse, together with the medical records associated with the imaging, must be stored securely and separately from a child or young person's principal health care record.

LHD/SCHN secure storage facilities may be within a Child Protection Unit, Sexual Assault Service, an Emergency Department or other LHD/SCHN facility offering medical and forensic examinations.

All original photo and video images and any separate working copies used for editing must be stored on LHD/SCHN owned restricted secure network drives. Such restriction(s) to be determined by the Chief Executive Officer, or officer delegated responsibility for the security of LHD?SCHN medical records relating to cases of suspected child abuse.

Where LHD/SCHN owned restricted, secure network drives are not immediately available, in some remote areas for example, electronic/digital photo and video imaging must be:

- Transferred from the camera equipment/removable memory device to an LHD/SCHN owned laptop using appropriate safeguards, such as password or PIN codes, together with encryption technology (see Figure 1)
- Kept in lockable facilities with restricted access.

It is preferred that original images are stored using a 'read only' format, or equivalent, and images must be maintained in an original state and not subject to processes that cause permanent alteration.

All hard copy images must be stored securely in LHD/SCHN owned lockable facilities with restricted access. Such restriction(s) to be determined by the Chief Executive Officer, or officer delegated responsibility for the security of LHD/SCHN medical records relating to cases of suspected child abuse.

To maintain the integrity of the images in the event of legal action, images must be stored with:

- A copy of the consent form and documentation that includes the name of the photographer, the date and time the image/s were taken, and the location where the images were taken (see section 2.4.2)
- Accompanying documentation that includes a child or young person's initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID), date of birth (DOB), the date the images were captured and the name of the treating physician
- A reference that identifies the existence of any other relevant health related records or documents that are kept separately from the images, such as the location of the principal health care record. The images can be linked to the principal health care record via a notation on the principal record that a 'confidential health record exists'.

The restricted access electronic and hard copy storage facilities must have an auditing or tracking procedure that documents:

- Who, other than restricted access workers, views an image
- When an image leaves the location where it is stored and its destination
- When an image is copied and by whom.

2.6.3 Transmission of images

For the purpose of security and patient privacy, NSW Health workers involved in the transmission of medical and forensic photo and video imaging in cases of suspected child abuse must act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015 and:

- Restrict access to images as described in section 2.7 of this policy directive
- Obtain authorised written permission to release/transmit a copy of an image from a senior member of NSW Health staff, such as the attending medical and forensic practitioner, health information manager or a senior medical records officer/manager. Archived original image(s) should be retained as described in section 2.6.1 of this policy
- Document the authorised permission for release/transmission in the patient's medical record and:
  - The details of the request for release, including the reason for release
  - The number and type of images released
  - The date
  - The person/recipient to whom the image/s have been released
  - Full details of the address/location that the image/s were sent to.

Within NSW Health

- Consideration must first be given to restricted party viewing of the images at the NSW Health source site.
- Where this is not possible and electronic transmission occurs, it must occur:
  - Within NSW Health email
  - From NSW Health email accounts to another recognised NSW Health address
  - Using appropriate safeguards such as encryption technology, password or PIN codes and delivery/receipt confirmations, where available
  - From LHD/SCHN owned computers, equipment or devices or those that are authenticated and authorised by the LHD/SCHN with connectivity protected by approved controls or, through NSW Health Secure File Transfer solutions.

In all cases consider whether it is feasible to remove or abbreviate patient identifiers on the image and in any subject lines whilst the image is in transit in liaison with the recipient.

External to NSW Health

Where it is necessary to release images to restricted parties outside NSW Health, such as the court or under rigorously restricted information sharing practices relating to Chapter 16A and Section 248 of the *Children and Young Persons (Care and Protection) Act* 1998 (see section 2.7.1 to 2.7.4 for details of permitted access):

- Consideration must first be given to restricted party viewing of the images at the NSW Health source site
- Where this is not possible:
  - Electronic copy/copies on a removable memory device under strict governance and control using appropriate security safeguards such as encryption technology, password or PIN codes, or where this is not possible
  - Hard copy/copies

should be transported sealed in an appropriately robust sealed envelope (or similar package) with a unique number allocated from a register held by the NSW Health source site.

The envelope/package should be delivered by hand by an employee of NSW Health, registered post or courier and a receipt should be obtained.

At no time must a portable or removable device be used if it is not securely encrypted and released using these safeguards.

- Where this is not possible it should be noted that electronic transmission of personal health information to destinations external to NSW Health are not considered secure (NSW Health Privacy Manual for Health Information, 2015) and where electronic transmission is necessary, the following must occur:
  - Appropriate safeguards must be used such as encryption technology, password or PIN codes and where available, delivery/receipt confirmations
  - LHD/SCHN owned computers, equipment or devices or those that are authenticated and authorised by the LHD/SCHN with connectivity protected by approved controls must be used.

In all cases consider whether it is feasible to remove or abbreviate patient identifiers on the image and in any subject lines whilst the image is in transit in liaison with the recipient. Images must never be emailed or uploaded via the internet to cloud services. Personal email accounts must never be used to transmit patient information.

- Communication using File Transfer Protocol (FTP), telnet, Mobile SMS, instant messaging and web traffic (HTTP) is not permitted by NSW Health as a secure process for sharing photo and video imaging (NSW Health Electronic Information Security Policy, 2013).

2.6.4 Ownership and copyright

Images, recordings and documentation produced by NSW Health workers in a NSW Health service facility remain the property of the health service, including those taken by visiting medical officers.

Copyright of all recordings is owned by the State of New South Wales through the Local Health District/Speciality Network.

2.6.5 Destruction of images and medical record information

An original image on the camera equipment/device may be deleted in accordance with section 2.6.1 of this policy directive.

In all other cases, NSW Health workers must act in accordance with the NSW Government General Retention and Disposal Authority policy, 2004 (revised, 2011) and retain images for a minimum of 30 years after legal action is completed and resolved (where known), *or* after last contact for legal access *or* 30 years after the individual attains *or* would have attained the age of 18 years, whichever is the longer.

2.6.6 Images received from external sources

With the exception of formal, professional clinical peer group requests, review of an image sent to a practitioner from any other source, for example, a family member, in the context of investigating allegations of child abuse needs to be carefully managed. Offering an opinion on such images needs to done with caution because the practitioner may be exposed to various risks, including difficulties arising from the quality of the image, uncertainties about the date and time it was captured, the identity of the person depicted in the image(s) and an inability to document a clear chain of evidence. In these circumstances:

- Where a person depicted in an image has not been examined by an appropriate practitioner, a NSW Health practitioner that receives the image must not provide advice based solely on the image
- The image should be retained as a record of a request for review, stored separately from images that the examiner has captured and include a notation with full details of the request (for example, the source and date) and any response.

2.7 Access to images for relevant purposes

Standard: Restricted access is provided to images, to maintain patient privacy

LHDs/SCHN must ensure that NSW Health workers comply with 2.7.1 to 2.7.5 below.

2.7.1 Permitted access

NSW Health workers who capture and/or support the management of medical and forensic photo and video imaging in cases of suspected child abuse must ensure that access is restricted to:

- Designated NSW Health workers providing treatment to children or young people or involved in their safety who have unique user identification, individual password authentication and permission controls
- Circumstances where:
  - It is reasonably necessary, and directly associated with the primary purpose/s of collection and
  - The patient/their parent(s)/guardian(s) would reasonably expect the information to be used for that purpose, or
  - Separate informed consent has been obtained for the purpose of a) teaching and/or b) research activities
- The patient or their parent(s)/guardian(s), unless release would affect the personal affairs of any person, including a request by a parent or guardian where such access may lead to child abuse or prejudice a child's physical or mental health. Caution must be exercised and an interpretation and explanation of the clinical findings is preferable to the provision of access to images
- Approved teaching and/or research activities (section 2.8) where:
  - the young person and/or their parent/guardian has provided separate informed consent, and
  - images are de-identified and anonymity of patients is maintained, and
  - the teaching and/or research activities are compliant with the NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies and the research has received ethical approval (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf), and
  - electronic and digital information is used in accordance NSW Health Electronic Information Security Policy, 2013 and NSW Government Digital Information Security Policy, 2015
- Quality improvement activities (section 2.9) where:
  - images are de-identified and anonymity of patients is maintained, and
  - Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW is used to help to determine the activity, and
  - the quality improvement activities are compliant with NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies.
- Information sharing under Chapter 16A and Section 248 of the *Children and Young Persons (Care and Protection) Act* 1998 (sections 2.72 and 2.7.3)
- Requests under a court subpoena (see section 2.7.4)
- The requirements of the Health Privacy Principles NSW Health Privacy Manual for Health Information, 2015.

Where access to images is deemed necessary, consideration must be given to viewing the images at the NSW Health source site.

Where release is deemed necessary it should be restricted to the above circumstances and integrity of security must be maintained in accordance with section 2.6.3 of this policy directive and NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, the NSW Health Privacy Manual for Health Information, 2015 and NSW Health: Health Care Records – Documentation and Management policy, 2012.

2.7.2 Information sharing under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998

Chapter 16A establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies.

All applications and requests for access to photo and video imaging under Chapter 16A must be forwarded to an appropriate Health worker, medical and forensic examiner involved in the case, manager of the relevant service that authorised the images to be taken (e.g. Sexual Assault Service, Child Protection Unit, Emergency Department or Paediatric Unit), or LHD/SCHN Central Contact Point, regardless of the author of the recording.

The LHD/SCHN will provide a medical report or Expert Certificate to summarise findings to support investigation, assessment, decision making and coordination of services. Access to images of ano-genital, breast/chest and other sensitive areas of the body must be rigorously restricted and considered in the context that such images can only be interpreted by qualified medical and forensic examiners.

Consideration must be given to the relevance of access to or release of photo and video imaging relating to suspected physical abuse and neglect to prescribed bodies for the purpose of the safety, welfare or wellbeing of the child or young person. Where a request is granted, accompanying interpretation or explanation of clinical findings must also be provided.

- Where a medical examination has taken place in accordance with Section 173 of the *Children and Young Persons (Care and Protection) Act* 1998 a medical report is provided for the Secretary of Family and Community Services (FACS). An existing Expert Certificate could also be provided.

2.7.3 Information sharing under Section 248 of the Children and Young Persons (Care and Protection) Act 1998

Section 248 governs the exchange of information relating to the safety, welfare and wellbeing of children and young people between the Department of Family and Community Services and prescribed bodies

Requests under Section 248 should be directed to the LHD/SCHN Central Contact Point and come from the Secretary, Family and Community Services (or delegate).

Under Section 248 FACS can request access to a child or young person's medical record, which includes the Child Sexual Assault Medical Protocol/SAIK and Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014. The LHD/SCHN will provide a medical report or Expert Certificate to summarise findings to support investigation, assessment, decision making and coordination of services. Access to images of ano-genital, breast/chest and other sensitive areas of the body must be rigorously restricted and considered in the context that such images can only be interpreted by qualified medical and forensic examiners.

Consideration must be given to the relevance of access or release of photo and video imaging relating to suspected physical abuse and neglect to the Secretary of the Department of Family and Community Services and prescribed bodies for the purpose of the safety, wellbeing and welfare of the child or young person. Where a request is granted, accompanying interpretation or explanation of clinical findings must also be provided.

Where a medical examination has taken place in accordance with Section 173 of the *Children and Young Persons (Care and Protection) Act* 1998 a medical report is provided for the Secretary of FACS. An existing Expert Certificate could also be provided.

2.7.4 Subpoenas

For the purpose of a subpoena, a 'document' includes 'an electronic medical record or information contained on a computer file, such as photos and/or video' (NSW Health Subpoenas policy, 2010) and

For the purpose of this policy directive a photo or video image captured in a case of suspected sexual abuse, physical abuse or neglect, constitutes a 'sensitive record' (section 4.3: NSW Health Subpoenas policy, 2010).

LHDs/SCHN must act in accordance with the NSW Health Subpoenas policy, 2010, and ensure that the LHD/SCHN designated officer (e.g. medical records health information manager or medico-legal officer or risk manager) is informed about the subpoena, as well as, where possible, the senior health care provider and treating health care provider.

NSW Health workers who manage subpoenas must:

- Be aware of whether any claim for privilege over the images can be applied and take appropriate action
- Follow the precautions for 'sensitive records' (see section 6.4: NSW Health Subpoenas policy, 2010)
- Where images are produced, provide only those that are captured under the schedule of the subpoena
- Retain a copy of the subpoena and the images that the Health service provided under the subpoena.

Where the patient whose records are subpoenaed are not a party to the proceedings before the court, the LHD/SCHN must notify the patient:

- That the subpoena has been received
- The date that the photo/video imaging must be provided to the court, so that the patient can arrange to attend court if they so wish.

2.7.5 Sexual assault communications privilege

Records relating to the counselling of victims of sexual abuse may be protected from production to the court. Photo and video imaging is not covered under this privilege (see Chapter 6 of the *Criminal Procedure Act* 1986).

2.8 Use of imaging for teaching and research

LHDs/SCHN must ensure that NSW Health workers comply with the following:

- Specific informed consent must be obtained from the young person or their parent(s)/guardian(s) for de-identified photo and video imaging to be used for a) teaching and/or b) approved research activities. This must include an explanation that consent for future teaching and/or approved research activities may be withdrawn by the person who provided consent or the person depicted in the image(s) once they are Gillick competent

  For this purpose, where consent is provided for de-identified images to be used for the purposes of teaching and/or approved research activities there must be a process to ensure that withdrawal of consent may be withdrawn. An example of good practice is described in Appendix 5.8

- Anonymity of patients must be maintained during case presentations, demonstrations, teaching, research and at seminars and conferences. Where possible, fictitious data must be used and identification of individuals must not occur. Use of images that would identify the child or young person must not occur. Images of the face must be de-identified and use of blocked sections or cropping, for example, could be used for this purpose

- Research must abide by relevant NSW Health policies and be approved by a Research Ethics Committee (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf)

- Act in accordance with the NSW Health Privacy Manual for Health Information, 2015.

9. HEALTH RECORDS AND INFORMATION

2.9 Use of imaging for quality improvement activities

LHDs/SCHN must ensure that NSW Health workers comply with the following:

- Quality improvement activities must:
  - use de-identified images and maintain anonymity of patients, and
  - be determined by reference to Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW, and
  - comply with NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies.

2.10 Maintaining the integrity of images in the longer-term

Standard: The integrity of images is maintained in the longer-term

The extent and range of digital image capturing devices, communication technologies and storage systems create a complex environment and significant challenges and opportunities for those that provide forensic science services and their patients (Australia New Zealand Policing Advisory Agency, 2013).

- LHDs/SCHN must use risk analysis and management techniques to reassess the procedures used for capture, storage, access and security for the purpose of maintaining the integrity of images in the longer term. (See, for example, NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, and NSW Health: Health Care Records – Documentation and Management policy, 2012.)

3 REFERENCES

ACI (2015). Agency for Clinical Innovation. *Guidelines for the Use of Telehealth for Clinical and Non Clinical Settings in NSW*. Chatswood, NSW.

Australia New Zealand Policing Advisory Agency (2013). *Australia and New Zealand Guidelines for Digital Imaging Processes*. National Institute of Forensic Science, Australia. Docklands, Victoria. Available at: https://www.anzpaa.org.au/corporate-news-and-publications/anzpaa-publications

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NSW Health (2015). *Privacy Manual for Health Information* (Version 3). NSW Ministry of Health. Sydney, NSW.

NSW Health PD2012_069. *Health Care Records – Documentation and Management policy*. Ministry of Health. Sydney, NSW.

NSW Health PD2010_065. *Subpoenas*. NSW Ministry of Health. Sydney, NSW.

NSW Health PD2005_405. NSW Health Consent to Medical Treatment - Patient Information policy, 2005.

NSW Health PD2013_007. *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*. NSW Kids and Families. Sydney, NSW.

9. HEALTH RECORDS AND INFORMATION

Glossary

Capture	Capture is the process of recording (acquiring) data, such as an image or video sequence (Australia New Zealand Policing Advisory Agency, 2013).
Child Sexual Assault Medical Protocol (the written protocol in the Sexual Assault Investigation Kit (SAIK))	A written record used by forensic examiners in NSW Health Sexual Assault Services to record all types of sexual abuse examinations for children 0-14 years of age and, where appropriate, may be used for young people 14 -17 years, otherwise an adult Medical and Forensic Examination Record (MFER) may be used. It is part of the Child Sexual Assault Investigation Kit (SAIK). The Adult Sexual Assault Medical Protocol may be used where a young person aged 14 or above attends an adult Sexual Assault Service. In young people aged 14 to 17, which Protocol is used is contingent upon consideration of the circumstances of the child or young person and whether a child or adult SAIK represents the most appropriate pathway. The Protocols provide guidance to facilitate the medical and forensic examination of victims of sexual abuse and ensure that laboratory specimens are collected correctly and legal requirements are fulfilled.
Children and young people	Child: A person who is under the age of 16 years. Young person: A person who is aged 16 years or above but who is under the age of 18 years. (Section 3. *Children and Young Persons (Care and Protection) Act* 1998).
Colposcope	A lighted, magnifying medical instrument used to examine the tissues of the genitalia. It allows an examiner to take a closer look at a child or young person's genitalia and check for abnormal areas. Some devices can be fitted with photographic or video equipment that can capture still (photographic) or moving (video) images.
Cultural competence	Violence, trauma and neglect occur in culturally diverse contexts. Cultural competence is the ability to identify and challenge one's own cultural assumptions, values and beliefs. It is about developing empathy and appreciating that there are many different ways of viewing the world, as this is influenced by culture.
FACS	Department of Family and Community Services
Gillick competence	Whilst parents, or those having parental responsibility rights, generally have the legal authority to provide consent for medical procedures for children and young people under the age of 16 years, the Gillick principle (1985 decision of the House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority and anor) provides that a child's competence to consent to medical procedures increases as they approach maturity, that is a minor under the age of 16 years may be capable of independently consenting to medical treatment when they have achieved a sufficient level of understanding and intelligence to enable them to fully understand what is proposed. Medical practitioners must decide on a case-by- case basis whether a minor has achieved this level of understanding and intelligence.
Guardian	A person with 'parental responsibility' as defined in Section 79A of the *Children and Young Persons (Care and Protection) Act* 1998.
HRIPA	*Health Records and Information Privacy Act* 2002. The Health Privacy Principles (or HPPs) contained in the HRIP Act establish 15 rules for the management of information.

9. HEALTH RECORDS AND INFORMATION

Intimate image	A photo or video image depicting the genitalia, anus or post-pubertal female breast (Faculty of Forensic & Legal Medicine, 2014) and may also include other parts of the body, such as the buttocks or chest of a pre-pubertal child.
JIRT (Joint Investigation Response Team)	JIRT is a collaborative partnership between the Department of Family and Community Services, the NSW Police Force and NSW Health workers that jointly manages statutory child protection matters that may require a criminal justice response and a health response.
JPEG	A digital compression and coding standard (Australia New Zealand Policing Advisory Agency, 2013).
JRU (JIRT Referral Unit)	JRU is comprised of professionals from the Department of Family and Community Services, the NSW Police Force and NSW Health and ensures that reports of risk of significant harm of children and young people to the Child Protection Helpline that require a child protection response, and may require a health and criminal justice response, are jointly assessed for a response by the three JIRT partner agencies.
LHD	Local Health District.
Medical and forensic examiner	A trained Medical Officer, Sexual Assault Nurse Examiner (SANE) or Forensic Nurse who has specialised education and clinical experience in the treatment of children and young people who may have experienced child sexual abuse, physical abuse or neglect and the collection of forensic evidence.
Medical and forensic examination	A medical and forensic examination is an examination of a patient for the purpose of providing medical care and collecting forensic documentation and evidence.
Neglect	Where a child or young person's basic needs (e.g. supervision, medical care, nutrition, shelter and education) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to have a significant adverse impact on the child or young person's safety, welfare or well-being. This lack of care could be constituted by a single act or omission or a pattern of acts or omissions such as failing to attend medical appointments or failing to ensure that a school age child attends school. (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).
ODPP	Office of the Director of Public Prosecutions.
Original image	The first image that is captured onto any media.
Peer review	The evaluation of work or performance by colleagues in the same field with the aim of maintaining or enhancing the quality of work or performance in that field (Faculty of Forensic & Legal Medicine, 2014a). It includes: • Discussion about clinical decision making and interpretation of examination findings and results of investigations • Meetings undertaken by and with peers with the aim of updating knowledge and improving practice through presenting of work to peers for review (Medical Board of Australia, 2014a).
Personal device	A personal device is one which is not owned by a NSW Health Public Health Organisation. Examples of a personal mobile device include a phone, camera, ipad or other tablet and laptop computer.

9. HEALTH RECORDS AND INFORMATION

Photo and video imaging	Photo and video imaging depicts an image that: Documents the findings of a medical or forensic examination Is captured, recorded and in some cases, transmitted for clinical or forensic purposes Exists in live 'real time' or is stored in hard copy or electronic form Can be transmitted in real time or stored and transmitted at a later point in time May become evidence in a legal proceeding. Photo and video imaging can be captured using a camera or video recorder. Both can be used in conjunction with a colposcope to enhance magnification and lighting. For the purpose of this policy, photo and video imaging constitutes part of a health care record.
Physical abuse	Physical abuse occurs if a child or young person sustains a non-accidental injury or is being treated in a way that may have or is likely to cause injury. The injury may be inflicted by a parent, carer, guardian, other adult or other child or young person. (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).
Prescribed body	Chapter 16A of the *Children and Young Persons (Care and Protection) Act* 1998 establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies. A 'prescribed body' is any organisation specified in Section 248 (6), *Children and Young Persons (Care and Protection) Act* 1998 or in clause 7, *Children and Young Persons (Care and Protection) Regulation*, 2000, or in clause 8, *Children and Young Persons (Care and Protection) Regulation*, 2012.
Public Health Organisation	A 'Public Health Organisation' is: A local health district, or A statutory health corporation, or An affiliated health organisation in respect of its recognised establishments and recognised services. Section 7. *Health Services Act 1997*.
SAIK	Sexual Assault Investigation Kit (see 'Child Sexual Assault Medical Protocol').
SCAN Protocol	Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014.
SCHN (Sydney Children's Hospitals Network)	The Sydney Children's Hospitals Network comprises The Children's Hospital at Westmead, Sydney Children's Hospital, Randwick, Bear Cottage, the Newborn and Paediatric Emergency Transport Service (NETS), the Pregnancy and Newborn Services Network (PSN) and the Children's Court Clinic.
Sexual abuse	The terms sexual abuse and sexual assault are often used interchangeably. For the purposes of this policy directive 'sexual abuse' is used to refer to sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).
Sexual assault	See 'sexual abuse'.

Sexual Assault Communications Privilege (SACP)	As set out in the Criminal Procedure Act 1986, the SACP allows courts to exclude evidence that would disclose confidential communications made in the course of a professional or sexual abuse counselling relationship. See Appendix A of the NSW Health Subpoenas policy, 2010, for further information.
Standard	A standard is a key principle that must be followed.
Subpoena	A subpoena is an order from a court or tribunal which directs someone that they must on a given date: a) Produce to a court certain (existing) documents for use in legal proceedings b) Attend a court on a particular date to be a witness in a hearing and give evidence, or c) Do both. A subpoena can only be issued if legal proceedings have been commenced. For the purposes of a subpoena a 'document' includes, 'an electronic medical record or information contained on a computer file, such as photos and/or video' (NSW Health Subpoenas policy, 2010).
Telehealth	Telehealth is the delivery of health care at a distance using information and communications technology (Wade (2014). Available at http://www.e-unicare.com.au/wp-content/uploads/2013/06/unicare_ebook.pdf

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Australia New Zealand Policing Advisory Agency (2013). *Australia and New Zealand Guidelines for Digital Imaging Processes*. National Institute of Forensic Science, Australia. Docklands, Victoria.

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Wade, V. (2013). *How To Make Telehealth Work: Defining Telehealth Processes and Procedures*. Unicare e-health. Available at: http://www.e-unicare.com.au/wp-content/uploads/2013/06/unicare_ebook.pdf

5 APPENDICES

5.1 List of relevant policy documents

Government of New South Wales, 2004, revised 2011	*General Retention and Disposal Authority policy*. Public health services: Patient/Client records. 2011. State Records Authority of New South Wales. ISBN 0-9750563-5-2.
NSW Health PD2013_033	*Electronic Information Security Policy*.
NSW Government OFS-2015-05	*Digital Information Security Policy*.
NSW Health PD2012_069	*Health Care Records – Documentation and Management policy*.
NSW Health PD2013_007	*Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.
NSW Health PD2010_065	*Subpoenas policy*.
NSW Health PD2005_405.	*NSW Health Consent to Medical Treatment - Patient Information policy*.
NSW Ministry of Health 2015	*NSW Health: Privacy Manual for Health Information* (Version 3). ISBN 978-1-76000-002-8.

5.2 Related policies and procedures

Child Sexual Assault Medical Protocol *(2002). (*Often referred to as the SAIK (Sexual Assault Investigation Kit)
Child Wellbeing and Child Protection NSW Interagency Guidelines (2011).
Guidelines for the Use of Telehealth for Clinical and Non Clinical Settings in NSW, (2015). Agency for Clinical Innovation.
JIRT Referral Unit (JRU) + Interim Procedures for NSW Health (2015).
Joint Investigative Response Teams (JIRT) Local Planning and Response Procedures (2013). NSW Health, Human Services – Community Services, and NSW Police Force.
Joint Investigation Response Teams (JIRT) Policy and Procedures (2001). NSW Department of Community Services, NSW Police Service and NSW Health.
Suspected Child Abuse and Neglect (SCAN) Medical Protocol, GL2014_12.
Sydney Children's Hospitals Network and Kaleidoscope Greater Newcastle (SCHN KGN) Clinical Guideline on Photography and Video Recording of Children and Young People under 18 years who are Suspected of Having Been Physically Abused, Neglected or Sexually Abused who Present to any of the Children's Hospitals in NSW (2012).

5.3 Key related policies and procedures to respond to adult sexual assault:

Sexual Assault Services Policy and Procedures Manual (Adult), PD2005_607.
NSW Police, NSW Health and Office of the Director of Public Prosecutions (2006). *Guidelines for Responding to Adult Victims of Sexual Assault*. NSW Department of Health, North Sydney.
Clinical Practices – Adult Sexual Assault Forensic Examinations Conducted by Nurse Examiners, PD2005_614.

5.4 Key Aboriginal health policies and procedures

Aboriginal Health Impact Statement and Guidelines, PD2007_082. NSW Health.
NSW Aboriginal Health Information Guidelines. State Health Publication No. (AHB) 980128. August 1998.
NSW Aboriginal Health Plan 2012-2023, PD2012_066. December 2012. NSW Health.

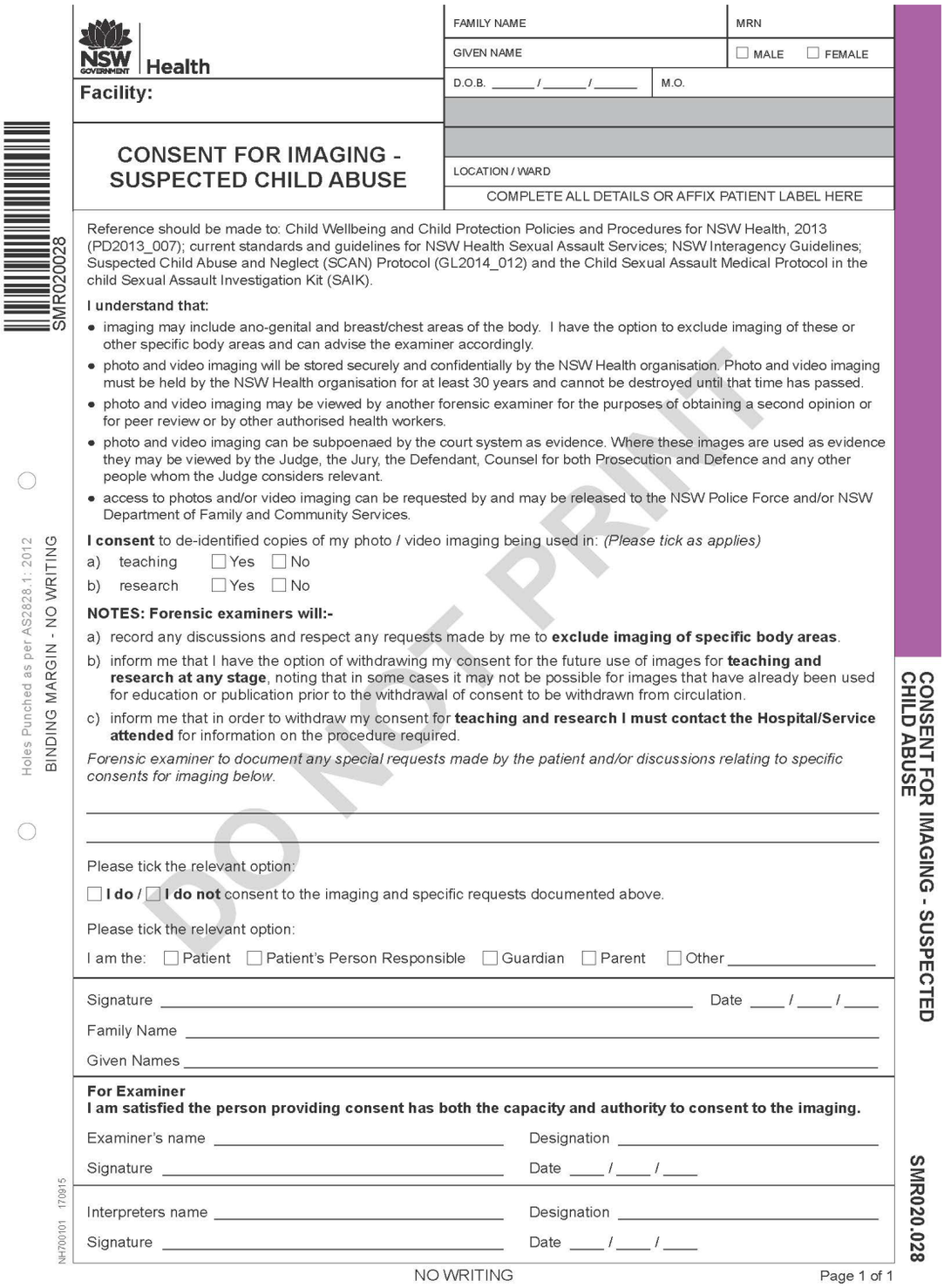
5.5 Membership of the Photo and Video Imaging Reference Group

Name	Title	Organisation	LHD/SCHN
Professor Graham Vimpani AM	Chair of the Reference Group Senior Clinical Adviser	Child Protection and Wellbeing	NSW Kids and Families
Mr David Bennett	JIRT Police Officer	NSW Police Force	N/A
Ms Sue Burke	District Manager, Sexual Assault Services and JIRT Health	Bloomfield Hospital	Western NSW LHD
Ms Danielle Clark	Manager	Violence Prevention and Response	NSW Kids and Families

9. HEALTH RECORDS AND INFORMATION

Name	Title	Organisation	LHD/SCHN
Ms Lisa Crawford	Senior Analyst	Violence Prevention and Response	NSW Kids and Families
Mr Paul de Sensi	Medical Photographer	Sydney Children's Hospital, Randwick	Sydney Children's Hospitals Network
Dr Rosemary Isaacs	Medical Director, Sexual Assault	Royal Prince Alfred and Liverpool Hospitals	Sydney and South West Sydney LHDs
Ms Robyn Lamb	Dept. Head (Allied Health), Child Protection	Sydney Children's Hospital, Westmead	Sydney Children's Hospitals Network
Ms Jenny Marshall	Acting Director	Child Protection and Violence Prevention	NSW Kids and Families
Ms Julia Martinovich	Telehealth Implementation Officer	NSW Agency for Clinical Innovation	N/A
Dr David McDonald	Senior Staff Paediatrician	Tamworth Rural Referral Hospital	Hunter New England LHD
Ms Lorna McNamara	Director Acting Director	Education Centre Against Violence Child Protection and Violence Prevention	NSW Health NSW Kids and Families
Ms Petra Milnes	Executive Officer	NSW e-health	N/A
Dr Louise Millward	Senior Analyst	Violence Prevention and Response	NSW Kids and Families
Ms Elena Mirenzi	Manager	Violence Prevention and Response	NSW Kids and Families
Ms Lynn Mitchell	Senior Analyst	Violence Prevention and Response	NSW Kids and Families
Ms Chloe Moddel	Telehealth Implementation Officer	NSW Agency for Clinical Innovation	N/A
Dr Maria Nittis	Department Head, Forensic Medical Units	Blacktown Hospital	Western Sydney LHD
Mr Hugh Percival	Legal Officer	Legal and Legislative Services	NSW Ministry of Health
Dr Anne Piper	Community Paediatrician/Training Adviser, Child Protection	John Hunter Children's Hospital	Hunter New England LHD
Detective S/Sergeant Ian Priest	Staff Officer, Child Abuse Squad	NSW Police Force	N/A
Dr Shanti Raman	Paediatrician/Medical and Forensic Practitioner	Liverpool Hospital	South West Sydney LHD
Dr Carol Stevenson	General Practitioner in Aboriginal Health, Medical Educator, Medical Coordinator	Lismore Sexual Assault Service	Northern NSW LHD
Dr Dimitra Tzioumi	Staff Specialist, Child Protection Unit	Sydney Children's Hospital, Westmead	Sydney Children's Hospitals Network

5.6 Interim NSW Health consent form



NSW GOVERNMENT Health

Facility:

CONSENT FOR IMAGING - SUSPECTED CHILD ABUSE

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020028

Reference should be made to: Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013 (PD2013_007); current standards and guidelines for NSW Health Sexual Assault Services; NSW Interagency Guidelines; Suspected Child Abuse and Neglect (SCAN) Protocol (GL2014_012) and the Child Sexual Assault Medical Protocol in the child Sexual Assault Investigation Kit (SAIK).

I understand that:

- imaging may include ano-genital and breast/chest areas of the body. I have the option to exclude imaging of these or other specific body areas and can advise the examiner accordingly.
- photo and video imaging will be stored securely and confidentially by the NSW Health organisation. Photo and video imaging must be held by the NSW Health organisation for at least 30 years and cannot be destroyed until that time has passed.
- photo and video imaging may be viewed by another forensic examiner for the purposes of obtaining a second opinion or for peer review or by other authorised health workers.
- photo and video imaging can be subpoenaed by the court system as evidence. Where these images are used as evidence they may be viewed by the Judge, the Jury, the Defendant, Counsel for both Prosecution and Defence and any other people whom the Judge considers relevant.
- access to photos and/or video imaging can be requested by and may be released to the NSW Police Force and/or NSW Department of Family and Community Services.

I consent to de-identified copies of my photo / video imaging being used in: *(Please tick as applies)*

a) teaching ☐ Yes ☐ No

b) research ☐ Yes ☐ No

NOTES: Forensic examiners will:-

a) record any discussions and respect any requests made by me to **exclude imaging of specific body areas**.

b) inform me that I have the option of withdrawing my consent for the future use of images for **teaching and research at any stage**, noting that in some cases it may not be possible for images that have already been used for education or publication prior to the withdrawal of consent to be withdrawn from circulation.

c) inform me that in order to withdraw my consent for **teaching and research I must contact the Hospital/Service attended** for information on the procedure required.

Forensic examiner to document any special requests made by the patient and/or discussions relating to specific consents for imaging below.

_____

_____

Please tick the relevant option:

☐ **I do** / ☐ **I do not** consent to the imaging and specific requests documented above.

Please tick the relevant option:

I am the: ☐ Patient ☐ Patient's Person Responsible ☐ Guardian ☐ Parent ☐ Other _____

Signature _____ Date ____ / ____ / ____

Family Name _____

Given Names _____

For Examiner
I am satisfied the person providing consent has both the capacity and authority to consent to the imaging.

Examiner's name _____ Designation _____

Signature _____ Date ____ / ____ / ____

Interpreters name _____ Designation _____

Signature _____ Date ____ / ____ / ____

NH700101 170915

NO WRITING

Page 1 of 1

DO NOT PRINT

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

CONSENT FOR IMAGING - SUSPECTED CHILD ABUSE

SMR020.028

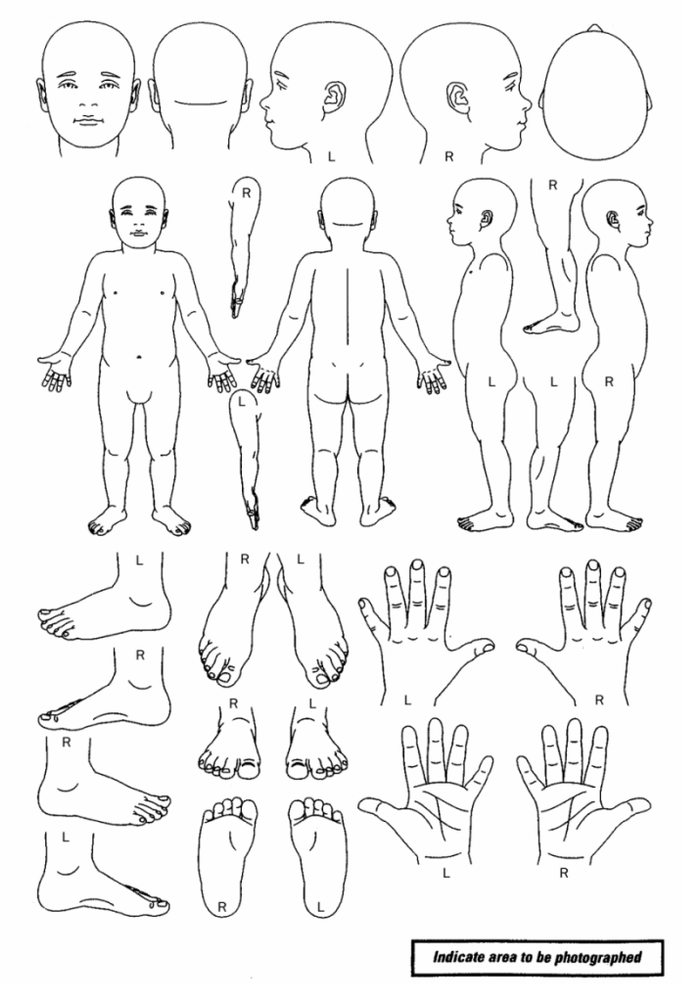
5.7 Request for Medical Photography Services

Consent must be sought before sending this form to the medical photographer.

Request for Medical Photography Services (to be completed by Health Professional requesting service)	
Requester	Diagnosis (If known/please print)
Designation/Department	Location of patient (Outpatient, Inpatient or Ward)
Signature (of Requester)	Date of Request

Type of request	Instructions to photographer (indicate area to be photographed below)
Case history print ☐	
Digital file ☐	
Colour prints ☐	
Black and white prints ☐	
Video/audio ☐	

Name of Reporter/Photographer:



5.8 Good practice example of a process for complying with a withdrawal of consent for de-identified images to be used for future a) teaching and/or b) research activities

For the purpose of complying with a withdrawal of consent for de-identified images to be used for future a) teaching and/or b) approved research activities:

On receipt of consent

- Each de-identified image should be assigned a reference notation
- The reference notation should be recorded in the patient's file
- A register should be:
  - Kept to document and link the reference notation of the de-identified image with the patient file and
  - Maintained for a minimum of 30 years (NSW Government General Retention and Disposal Authority policy, 2004, revised, 2011)
- A copy of the consent must be stored with the de-identified image(s).

On receipt of a withdrawal of consent, for the purpose of compliance and risk analyses, the de-identified image/s must be deleted from:

- Files that are kept and used for the purposes of future teaching and/or research
- Existing training materials, including Powerpoint files, where they are known to exist.

ADOPTION ACT 2000 – RELEASE OF INFORMATION (PD2016_036)

PD2016_036 rescinds PD2010_050

PURPOSE

This Policy Directive provides:

- Information regarding the rights of adopted persons and their families to access information held by Information Sources under the *Adoption Act 2000*
- NSW Health Information Sources with direction and guidance as to what information should be disclosed to adopted persons and their families and the circumstances in which it should be disclosed.

MANDATORY REQUIREMENTS

Each NSW Health Information Source must have effective systems and procedures in place to ensure adopted persons and their families can access information in accordance with the *Adoption Act 2000* and this Policy Directive.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure:

- The principles and requirements of this Policy Directive are applied, achieved and sustained
- Their medical record staff are made aware of this Policy Directive.

Medical record staff have responsibility to:

- Be aware of this Policy Directive
- Release information to adopted person and their families in accordance with this Policy Directive and the *Adoption Act 2000*.

BACKGROUND

About this document

The *Adoption Act 2000* is administered by the Department of Family and Community Services and sets out the information to which adoptees and their families are entitled to access and the manner in which a person may access that information.

Under the *Adoption Act 2000*, adopted persons, adoptive parents and birth parents are entitled to access prescribed information held by an "Information Source". An Information Source includes:

- The NSW Ministry of Health
- A public hospital under the control of a Local Health District
- A statutory health corporation
- An affiliated health organisation, and

- A private health facility.

This Policy Directive provides specific information on how information about adoptees and their families held by Information Sources should be disclosed.

1.2 Legal and legislative framework

Adoption Act 2000
Adoption Regulation 2015

2 GENERAL MATTERS

2.1 Persons making general enquiries

Telephone enquiries should be directed by switchboard to the medical records department. Persons making enquiries should be informed that the Adoption Information Unit of the Department of Family and Community Services offers services regarding past adoptions, including accessing information.

The Adoption Information Unit can be contacted on 1300 799 023 or via email at **adoption.information@facs.nsw.gov.au**.

Where an enquirer is seeking information held by the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation, this Policy Directive, in conjunction with the Adoption Act 2000 should be complied with.

2.2 Search fees

An Information Source may charge a fee for disclosing information held by the Information Source. Information Sources should refer to PD2006_050 Health Records and Medical / Clinical Reports - Charging Policy in respect of the fees to be charged.

2.3 Information to be provided

Adopted persons, adoptive parents and birth parents are entitled to a variety of information held by an Information Source. This policy only deals with the release of information most likely to be commonly held by NSW Health Information Sources that is health information. If there are further records relating to the adopted person, adoptive parents or birth parents held by an Information Source, you should contact your legal advisor to determine whether the information should be released.

2.4 Proof of identify

Before any information under the Adoption Act 2000 is released to an individual, that individual should provide proof of their identity and, in cases where the individual is seeking information about another person, the individual should provide proof of their relationship to the other person, such as adoption order and birth certificate(s).

2.5 Birth Parents and presumptive fathers

In this policy, a reference to an adopted person's birth parent includes a reference to the "presumptive father" of the adopted person. Under the Adoption Act 2000, the presumptive father of an adopted person means a man who claims to be the birth parent of the adopted person and who:

(a) Is shown on the adopted person's original birth certificate as the adopted person's father, or

(b) Is a person whom the Information Source is entitled to presume under any law to be the adopted person's father.

If you are unsure whether a particular person is the presumptive father of an adopted person, you should contact your legal advisor.

In some cases, an individual man will be named as the "father" in the medical records but will not be named as the father on the adopted person's birth certificate. In these cases, the individual man's identifying information cannot be disclosed to any person. However, in such cases, the medical records department of the Information Source should consider providing the individual man's details to the Department of Family and Community Services who can determine whether the man would like to exchange information with the adopted person.

2.6 General guidelines for the release of information

Under s142 of the Adoption Act, an Information Source must comply with any guidelines prescribed by the Adoption Regulation before releasing information under the Act. Under clause 105 of the Adoption Regulation, the guidelines below must be complied with.

2.6.1 Confirmation of identity

The Information Source must make reasonable inquiries to confirm the applicant's identity and relationship to the person to whom the information relates.

2.6.2 Sensitive information

The Adoption Regulation has special guidelines in relation to "sensitive information". Sensitive information means:

(a) Information indicating that an adopted person was conceived as a result of incest or the sexual assault of his or her birth mother, and

(b) Information indicating that an adopted person has an hereditary condition seriously affecting the current, or that could seriously affect the future, physical or mental health of the adopted person or any descendant of the adopted person, and

(c) Information that could reasonably be expected to be distressing in nature to the person receiving the information.

Before disclosing sensitive information, the Information Source must:

- Make appropriate counselling and support available to the person, and
- Check whether the birth parent's name is entered in the Reunion and Information Register. If the birth parent's name is entered on the Reunion and Information Register, the Information Source must not disclose the sensitive information unless the Information Source has taken reasonable steps to ascertain whether the birth parent wishes to provide the information personally.

2.7 Supply Authority

Information may only be disclosed to an individual if that individual provides the Information Source with a Supply Authority issued by the Department of Family and Community Services if:

- The adoption occurred prior to 1 January 2010, or
- The adoption occurred after 1 January 2010 where the applicant is a birth parent or non-adopted sibling.

In some cases, where a Supply Authority is required before information can be released to an individual, that individual may instead produce to the Information Source an original or amended birth certificate issued under the *Adoption Information Act 1990* prior to October 1998 by the Registrar of Births Deaths and Marriages stamped with the words "Not for Official Use".

If the Information Source is unclear whether the Supply Authority or birth certificate is valid, the Adoption Information Unit should be contacted.

3 RELEASE OF INFORMATION

3.1 Request to access information regarding adoptions occurring on or after 1 January 2010

If an adoption took place on or after 1 January 2010, an adopted person, their adopted parents and birth parents and non-adopted siblings have rights to access information held by an Information Source, including the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation.

3.1.1 Adopted person's rights

3.1.1 (a) Rights to access information by an adopted person who is over the age of 18

An adopted person who is over the age of 18, and was adopted on or after 1 January 2010, is entitled to receive:

- Information regarding the adopted person's birth details (including the time of birth and weight and length at birth) and other medical records about the adopted person, and
- Any non-identifying background information about the adopted person's birth parents, siblings, grandparents, aunts or uncles that will give the adopted person knowledge of his or her origins.

3.1.1 (b) Rights to access information by an adopted person who is under the age of 18

An adopted person who is under the age of 18, and who was adopted on or after 1 January 2010, is entitled to receive information only with the consent of the person's adoptive parents or the Secretary of the Department of Family and Community Services.

If the adopted person produces a written consent of their adoptive parents or the Secretary of the Department of Family and Community Services, the following information should be provided to the adopted person who is under the age of 18:

- Information regarding the adopted person's birth details (including the time of birth and weight and length at birth) and other medical records about the adopted person, and
- Any non-identifying background information about the adopted person's birth parent, sibling, grandparent, aunt or uncle that will give the adopted person knowledge of his or her origins.

3.1.2 Adoptive Parents' rights

An adoptive parent of an adopted person who was adopted on or after 1 January 2010 is entitled to receive the following information held by an Information Source:

- Information regarding the adopted person's birth details (including the time of birth and weight and length at birth), and
- Any non-identifying background information about the adopted person's birth parent, sibling, grandparent, aunt or uncle that will give the adoptive parent knowledge of the adopted person's origins.

3.1.3 Birth Parents' rights

3.1.3 (a) Rights to access information by a birth parent where the adopted child is under the age of 18

A birth parent of a person, under the age of 18, who was adopted on or after 1 January 2010 is entitled to receive information held by an Information Source only if the birth parent produces to the Information Source a Supply Authority issued by the Secretary of the Department of Family and Community Services authorising the disclosure of the information. Where a birth parent provides such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any non-identifying background information about an adopted person or his or her adoptive parents that will give the birth parent knowledge of the adopted child's life, and
- Birth details of the adopted person (including the time of birth and weight and length at birth).

If the birth parent does not have a Supply Authority, information can be released if the head of the Information Source, that is the Health Secretary or the Chief Executive Officer of the relevant Information Source, is of the opinion that the information cannot be used to identify the adopted person or their adopted parents.

3.1.3 (b) Rights to access information by a birth parent where the adopted child is over the age of 18

A birth parent of a person, over the age of 18, who was adopted on or after 1 January 2010 is entitled to receive any of the following information held by an Information Source:

- Any non-identifying background information about an adopted person or his or her adoptive parents that will give the birth parent knowledge of the adopted child's life, and
- Birth details of the adopted person (including the time of birth and weight and length at birth).

3.1.4 Non-adopted sibling's rights

A non-adopted sibling, of a person adopted on or after 1 January 2010, is able to access any non-identifying background information held by an Information Source about the adopted person or his or her adoptive parents and adoptive family that will give the non-adopted sibling knowledge of the adopted person's life. However, if the non-adopted sibling is under the age of 18, information can only be released with the written consent of the non-adopted sibling's parents or the Secretary of Family and Community Services.

3.2 Request to access information regarding adoptions occurring before 1 January 2010

If an adoption took place before 1 January 2010, an adopted person, their adopted parents and birth parents have rights to access information held by an Information Source, including the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation.

3.2.1 Adopted person's rights

3.2.1 (a) Rights to access prescribed information by an adopted person who is over the age of 18

An adopted person who is over the age of 18, and was adopted before 1 January 2010, is entitled to receive information held by an Information Source only if the adopted person produces to the Information Source a Supply Authority issued by the Secretary of the Department of Family and Community Services authorising the disclosure of the information. Where the adopted person provides such a Supply Authority, the adopted person is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any relevant non-identifying information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adopted person knowledge of his or her origins, and
- Copies of medical reports of examinations of the adopted person made before the date of the adoption order.

3.2.1 (b) Rights to access prescribed information by an adopted person who is under the age of 18

An adopted person who is under the age of 18, and who was adopted before 1 January 2010, is entitled to receive information only with the consent of the person's adoptive parents or the Secretary of the Department of Family and Community Services.

If the adopted persons produce a written consent of their adoptive parents or the Secretary of the Department of Family and Community Services, the following information should be provided to the adopted person who is under the age of 18:

- Any relevant non-identifying information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adopted person knowledge of his or her origins, and
- Copies of medical reports of examinations of the adopted person made before the date of the adoption order

3.2.2 Adoptive parent's rights

An adoptive parent of a child, under the age of 18, who was adopted before 1 January 2010 is entitled to receive any relevant non-information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adoptive parent knowledge of the adopted person's origins.

3.2.3 Birth parent's rights

3.2.3 (a) Where the adopted person is over the age of 18

A birth parent of an adopted person over the age of 18 adopted before 1 January 2010, is only entitled to receive information about the adopted person if the birth parent produces a Supply Authority from the Secretary of the Department of Family and Community Services authorising the disclosure of relevant information. If the birth parent produces such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any relevant information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of an adopted person or his or her adoptive parent and that will give the birth parent knowledge of the adopted child's life after adoption
- Birth details (including the time of birth and weight and length of the person at birth), and
- Copies of medical reports and examinations of the adopted person made before the date of the adoption order.

3.2.3 (b) Where the adopted person is under the age of 18

A birth parent of an adopted person under the age of 18 is only entitled to receive information about the adopted person if the birth parent produces a Supply Authority from the Secretary of the Department of Family and Community Services authorising the disclosure of relevant information. If the birth parent produces such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Birth details (including the time of birth and weight and length of the person at birth), and
- Copies of medical reports and examinations of the adopted person made before the date of the adoption order.

If the birth parent does not have a Supply Authority, information can be released if the head of the Information Source, such as the Chief Executive Officer of the relevant Information Source, is of the opinion that the information cannot be used to identify the adopted person or their adopted parents.

ELECTRONIC INFORMATION SECURITY (PD2020_046)

PD2020_046 rescinds PD2013_033

PURPOSE

All NSW Health Organisations must have appropriate systems and processes in place to adequately and appropriately protect their information systems and assets. This includes the fundamental responsibility to protect information from inappropriate, illegal or accidental misuse, modification, loss or release.

This policy applies to all users of NSW Health information systems and assets, including, but not limited to, employees, contractors, service providers and third parties, and all NSW Health information systems and assets, regardless of the media or location where information is stored, and the technology used to process the information.

SUMMARY OF POLICY REQUIREMENTS

All users of NSW Health information systems and assets have the responsibility to uphold confidentiality and protect information entrusted to them.

Information security measures and controls must be developed and implemented to ensure privacy of information is preserved, confidentiality of information is protected, integrity of information is maintained, and availability of information is assured.

NSW Health Organisations must identify and implement the appropriate scope of an Information Security Management System (ISMS) or Cyber Security Management System (CSMS) that is compliant with the relevant recognised standards.

A risk-based approach must be adopted to identify and prioritise information systems and assets security risks, ensure proper security measures are implemented and mitigate security risks to an acceptable level. These measures may be preventative, detective, responsive or recovery in nature.

A continual improvement process must be adopted to respond to, monitor, review and improve the effectiveness and efficiency of information security measures and controls in a changing environment.

NSW Health Organisations must ensure a consistent and effective approach to the management and where relevant, the escalation of information security incidents.

Electronic Information Security: Procedures

1. BACKGROUND

Any persons having access to NSW Health information have a responsibility to maintain the security and confidentiality of critical and sensitive information, including personal and health information.

NSW Health is committed to the provision of appropriate levels of security across all information systems and assets.

Confidentiality, Integrity and Availability are the security objectives that must be applied to NSW Health Organisations' information systems and assets. These objectives will uphold authorised restrictions on access to, and the use and disclosure of, information, to ensure data is protected against unauthorised alteration or destruction and to ensure authorised users are provided with timely and reliable access to information systems and assets.

NSW Health Organisations are required to assure the privacy of information systems and assets that include records containing personal and personal health information about employees and members of the public. This will uphold the individual's expectation and legal right that personal, health and any other identifying information will not be unlawfully disclosed.

Implementation of information security controls to mitigate the risks to sensitive information must be based on a risk management approach to ensure suitable and appropriate information protection.

All information must be classified in accordance with the NSW Government Information Classification, Labelling and Handling Guidelines. The guideline outlines how NSW Government agencies, such as NSW Health, must securely share, handle and protect information according to its sensitivity. Information which needs increased protection is to be either security classified and identified by a protective marking or assigned a Dissemination Limiting Marker (DLM). For NSW Health Organisations, information that has been classified and labelled using any of the six 'OFFICIAL: Sensitive' NSW DLMs or above, must be securely managed to ensure privacy and confidentiality is preserved. This includes the DLMs 'OFFICIAL: Sensitive – Health information' and 'OFFICIAL: Sensitive – Personal'.

The release of information must comply with NSW and Commonwealth legislation and relevant NSW Health policies.

1.1 About this document

This document establishes the provision of appropriate levels of security across all NSW Health Organisations' information systems and assets. It supports the governance of information security and dictates the principles to manage information security.

The security requirements in this document apply to all NSW Health information systems and assets regardless of the media storage location and the technology used to process the information. All security requirements are designed to be technology neutral. The requirements focus is on the fundamental objectives and measures to protect information.

1.2 Key definitions

Availability

Ensuring timely and reliable access to and use of information.

Confidentiality

Handling of information to ensure that it will not be disclosed in ways that are inconsistent with authorised use and its original purpose.

Cyber Security

Cyber Security is the prevention of damage to, unauthorised use of, exploitation of, and - if needed - the restoration of electronic information and communications systems, and the information they contain, in order to strengthen the confidentiality, integrity and availability of these systems.

Electronic information

Electronic information is information that is electronically created, processed, held, maintained and transmitted by NSW Health organisations. It also refers to information held electronically for or on behalf of other government agencies or private entities.

Information systems and assets

Refers to any information or communication infrastructure used by NSW Health Organisations and all personnel that work with it. This includes computer hardware and software, to create, process, hold, maintain or transmit electronic information.

Integrity

To protect information against unauthorised alteration or destruction and prevent successful challenges to its authenticity.

Personal health information

Personal health information is personal information or an opinion which concerns an individual's health, medical history or past or future medical treatment. It also includes other personal information collected in the course of providing a health service or information collected in relation to donation of human tissue.

Personal information

Personal information is information or an opinion (including information or an opinion forming part of a database and whether it is recorded in a material form) about an individual whose identity is apparent or can be reasonably ascertained from the information or opinion.

1.3 Legal and legislative framework

NSW Health Organisations that hold records containing either personal information or personal health information must meet the requirements of the:

1. *Health Records and Information Privacy Act 2002* (NSW); and
2. *Privacy and Personal Information Protection Act 1998* (NSW).

2. PROTECTION OF INFORMATION SYSTEMS AND ASSETS

To safeguard information systems and assets, NSW Health Organisations must have an Information Security Management System (ISMS) or Cyber Security Management System (CSMS) that is compliant with recognised standards and implement the relevant controls based on the organisation's requirements and risk tolerance.

Each organisation's security management system must include the following components:

1. Governance;
2. Risk Management;
3. Allocation of Resources and Training;
4. Evaluation; and
5. Continuous Improvement.

2.1 Governance

NSW Health organisations must have an executive-level governance committee accountable for the effective and efficient management of information security risks, associated plans and implementation of controls.

NSW Health organisations must implement security controls locally according to their needs.

2.2 Risk methodology

NSW Health organisations must use a structured approach to information security risk management, consistent with approaches for assessing and treating all types of risk, at all levels and for all activities within NSW Health.

Information security risk management involves identifying the types of risk exposure within NSW Health, measuring those potential risks and proposing means to mitigate them. While it is impossible to remove all risk, it is important to understand the risks and manage and identify the level of risk NSW Health Organisations are willing to accept in the overall context of effective operation and service provision.

2.2.1 Enterprise Risk Management Framework

NSW Health Organisations must assess and manage information security risks in line with the *NSW Health Enterprise-wide Risk Management Policy and Framework (PD2015_043).*

This framework provides a structure for a consistent risk management approach and for embedding risk management across all operations.

The risk management process includes the following steps:

1. Communication and Consultation;
2. Establish the context;
3. Risk Identification;
4. Risk Analysis;
5. Risk Evaluation;

6. Risk Treatment; and
7. Risk Monitoring, Review and Governance.

2.2.2 Risk assessment

Risk identification, analysis and evaluation are taken together and described as 'risk assessment'. Information security risk assessments are performed to allow NSW Health Organisations to assess, identify and modify their overall security. This process is required to obtain management's commitment to allocate resources and implement the appropriate security controls. All risk assessments must conform to the NSW Health Risk Matrix tool in terms of the relationship between likelihood and consequence.

2.2.3 NSW Health Risk matrix

The NSW Health Risk Matrix provides a tool to apply a severity rating to each risk, by assessing the potential consequence of the risk and its likelihood of occurring. The NSW Health Risk Matrix is required to be used for assessment and management of information security risks, development of risk registers and reporting of risks.

2.2.4 Risk treatment

Information security is a combination of preventive, detective, responsive and recovery security measures. Preventive measures avoid or deter the occurrence of an undesirable event. Detective measures identify the occurrence of an undesirable event. Responsive measures refer to coordinated actions to contain damage when an undesirable event (or incident) occurs. Recovery measures are for restoring the confidentiality, integrity and availability of information systems to their expected state.

Once the risks have been identified, analysed and evaluated; treatments are considered. Risk treatment involves selecting one or more options for addressing the identified information security risk(s) and implementing and managing those options. Risk treatment options include:

1. Risk Management / Reduction - The level of risk is to be reduced through the implementation of some or all recommendations made from the risk assessment. Appropriate and justified controls should be selected to meet the risk acceptance criteria as well as legal, regulatory and contractual requirements. When selecting controls, NSW Health Organisations must weigh up the cost of acquisition, implementation and maintenance of the control(s) against the 'value' of the information being protected;
2. Risk Transfer - This decision requires the risk to be transferred to another party that can effectively manage costs associated with the particular risk;
3. Risk Avoidance - Stop the activity that would give rise to the risk, thus eliminating the risk. Risk avoidance is not commonly selected as it typically results in not being able to exploit the associated opportunity; and
4. Risk Acceptance - This decision relies on the findings of the risk assessment and is applied when the level of risk is assessed within the business's defined risk tolerance level. However, the business may accept when it is not practical to avoid, treat or transfer the risk.

2.2.5 Selection and implementation of security measures

The appropriate security measures must be selected and implemented once security requirements have been identified. Security measures need to ensure risks are reduced to an acceptable level. The extent of the security measures required must be balanced against the potential business impact that may arise from security failures. Security measures can include local policies, standards, procedures, guidelines, practices, technological solutions and organisational structures. Measures will vary for different information systems and assets, depending on the criticality and sensitivity of the particular information asset.

2.2.6 Risk monitoring and review

Risks, threats and impacts will change over time and identified risks are to be reassessed to ensure the security measures selected remain appropriate and effective. Risks must be reviewed annually, or more frequently when major changes are made to information systems and assets.

2.3 Allocation of resources and training

Adequate resources (people, time, money) must be assigned to the operation of the ISMS/CSMS, including all security controls.

Information security training is required for all persons with access to NSW Health information to ensure procedures are followed to adequately protect information

2.4 Performance evaluation

NSW Health organisations must regularly collect and evaluate metrics on existing security measures: The evaluation of these metrics will lead to:

1. Improved information security processes – Quantify improvements in securing information and demonstrate quantifiable progress in information security objectives;
2. Increased accountability – By identifying specific security measures that are implemented incorrectly, not implemented or ineffective;
3. Greater support for decision making - Provide quantifiable information to the risk management process. Measure success/failure of investments and support resource allocation for future investments; and
4. Evidence of meeting requirements - Fulfilling ISMS/CSMS requirements and other applicable laws, rules and regulations.

2.5 Continual improvement

NSW Health Organisations must continually improve their ISMS/CSMS, including information security processes, techniques and controls. Continual improvement will be achieved through the ongoing processes of:

1. Risk assessment and treatment;
2. Evaluation of effectiveness of implemented security measures;
3. Corrective actions from internal audits and management reviews;
4. Reviewing and updating of information security documentation;
5. Training and awareness;
6. Review of information security incidents; and
7. Compliance reviews.

3. INFORMATION SECURITY INCIDENT RESPONSE PLAN

NSW Health Organisations must have an information security incident response plan that outlines the process for reporting and managing information security incidents, events and concerns from internal and external sources. Monitoring tools and processes must be in place for incident identification and response.

All users are responsible for reporting any information security concerns, events or incidents. Security events and incidents must be reported to eHealth NSW, Information Security Services within 48 hours and, to facilitate any investigation, as much relevant information as possible must be provided.

All reported information security concerns, events and incidents must be recorded in an appropriate register, which will be the official record and form the basis for evaluation and investigation. The register will be used to maintain the current status and the history of each incident as well as all decisions, recommendations and actions related to it.

The incident response plan must include the following steps:

1. Preparation;
2. Detection and Analysis;
3. Containment, Eradication, and Recovery; and
4. Post Incident Review.

3.1 Preparation

NSW Health Organisations must establish an information security incident response capability, separate to the security incident plan, so that they are ready to respond to incidents.

3.2 Detection and analysis

NSW Health Organisations must define the process for detecting and confirming an incident has occurred; categorising the nature of the incident and then prioritising the incident.

3.3 Containment, eradication, and recovery

NSW Health Organisations must identify the immediate response actions to deal with the information security incident. The primary objective is to confine any adverse impact to information systems and assets, followed by processes for the eradication of the threat and the return to the normal productive state of information systems and assets.

3.4 Post-Incident Review

NSW Health Organisations must compile a summary of actions and findings once the information security incident has been resolved. Any recommendations for changes to existing procedures or technology that will enhance the incident response plan must be documented.

4. ROLES AND RESPONSIBILITIES

Clearly defined roles and responsibilities ensure the proper protection of the information systems and assets of NSW Health.

4.1 Secretary, NSW Health

The Secretary, NSW Health must ensure all NSW Health Chief Executives establish, maintain and adequately resource an ISMS/CSMS. It is also the responsibility of the Secretary, NSW Health to ensure that the Chief Information Officer (CIO), NSW Health works with NSW Health Organisation Chief Executives and CIOs to implement this policy and that all NSW Health Organisations implement risk-based protections for information systems and assets.

The Secretary, NSW Health must ensure that all NSW Health Organisations comply with the NSW Cyber Security Policy. Reporting on compliance includes completing a yearly attestation report to be provided to Cyber Security NSW, which is completed by eHealth NSW on behalf of the Health Cluster. It is required that a copy of this report is included in the NSW Health annual report.

4.2 Chief Executives

Chief Executives must ensure that an ISMS/CSMS is established, adequate resources are allocated to implement the policy and associated framework, and there is appropriate resourcing and support of cyber security initiatives, including training and awareness and continual improvement initiatives.

It is also the responsibility of the Chief Executive, in collaboration with eHealth NSW, to ensure that their organisation complies with the *NSW Cyber Security Policy* and reports to the Secretary, NSW Health on compliance annually.

4.3 Chief Information Officer, NSW Health

The Chief Information Officer (CIO), NSW Health works with NSW Health Organisation Chief Executives and CIOs to implement this policy and ensures that all NSW Health Organisations implement risk-based protections for information systems and assets. This includes consideration of threats, risks and vulnerabilities that impact the protection of information systems and assets within their risk tolerance.

The CIO, NSW Health advises and guides NSW Health Organisation Chief Executives and CIOs on their responsibilities, which includes ensuring that all staff, including consultants, contractors, third parties and outsourced service providers, understand the cyber security requirements of their roles.

The CIO, NSW Health must also ensure a secure-by-design approach is in place for new initiatives and upgrades to existing systems and that all staff and providers understand their role in building and maintaining secure systems.

4.4 Director Information Security Services, eHealth NSW

The Director Information Security Services (ISS), eHealth NSW assists with defining and implementing risk-based protections for information systems and assets for NSW Health Organisations. Assistance and guidance is provided to NSW Health Organisations to implement policies, procedures, practices and tools that ensure compliance with this policy.

Responsibilities of the Director ISS, eHealth NSW include building an information security incident response plan that links NSW Health incident management and the whole of government cyber response plan. This allows the Director ISS, eHealth NSW to investigate, respond to and report on cyber security events within NSW Health and reports these incidents to the appropriate NSW Health governance forum and Cyber Security NSW.

The Director ISS, eHealth NSW must establish training and awareness programs to increase employees' cyber security capability and collaborate with NSW Health privacy, audit, information management and risk officers to protect NSW Health Organisation information systems and assets.

Other duties of the Director ISS, eHealth NSW include representing NSW Health Organisations on whole of government collaboration, advisory or steering groups, established by Cyber Security NSW as the central cluster Chief Information Security Officer (CISO) for NSW Health.

4.5 Data governance

The *NSW Health Data Governance Framework* outlines the roles and responsibilities involved in data governance and the structures in place to ensure effective and consistent management of the data assets of NSW Health.

The Framework facilitates data quality and comprehensiveness, appropriate access to data, information security, and standardisation of concepts.

Each data asset must have in place processes to protect the privacy and confidentiality of data through access management and security controls. This includes ensuring that the data is appropriately secured, backed up and disposed of according to agreed and documented protocols.

Data must only be disclosed for the purpose for which it is collected. Alignment of data and IT governance must enforce regulatory, architectural and security compliance requirements.

The Framework also provides the 'Principles of Data Governance for NSW Health' that support the structured and consistent management of data assets and outlines the essential components of data governance, including description of the roles of Data Sponsor, Data Custodian and Data Steward.

The Data Sponsor is responsible for the control of strategic direction and undertaking duties of ownership that includes:

1. Enabling strategic management, governance and operation of the asset;
2. Providing direction and guidance, and authorising appropriate resources for management of the data asset; and
3. Appointing a Data Custodian and ensuring the Data Custodian's duties are fulfilled.

The Data Custodian is responsible for the day to day management and oversight of the asset, approval of access to data and the overall quality and security of the asset. This includes:

1. Ensuring any use of the data aligns with the purpose for which it is collected;
2. Establishing a data quality framework that ensures the integrity, accuracy, completeness, timeliness, relevance, consistency and reliability of the data;
3. Controlling access to data in compliance with all relevant legislation, policies, standards and any conditions specified by the Data Sponsor;
4. Regularly reviewing users with access to data and the ongoing need and appropriateness of access; and
5. Appointing a Data Steward.

The Data Steward is responsible for the day to day management and operation of the data asset, its completeness and quality. This includes:

1. Managing the data asset in compliance with all relevant legislation, policies, standards and any conditions specified by the Data Sponsor;
2. Co-ordinating stakeholder engagement and input into the business requirements for the data asset; and
3. Providing advice to the Data Custodian and Data Sponsor on the management of the data asset.

4.6 System administrators

System administrators need to be aware of, understand and follow acceptable procedures for granting/revoking access, identifying and resolving known vulnerabilities, and monitoring system access. They are responsible for developing practices and procedures to support the policy and ensure compliance with the security requirements of information owners.

4.7 IT technical and support staff

IT support staff must manage confidentiality, integrity and availability of information systems. Staff are responsible for ensuring the appropriate access, delivery and ongoing support for systems, including applications, servers, networks, firewalls, routers and cloud services.

IT technical staff and system developers are responsible for delivering reliable software. Technical staff should understand the business use and risks associated with the technologies being used so that security solutions match the criticality and sensitive nature of the systems. They are responsible for developing practices and procedures to support the policy and ensure compliance with the security requirements of information owners.

4.8 Records and Information Managers

Records and Information Managers are responsible for maintaining a record and information management program in conformity with the standards and codes of best practice approved by NSW State Archives and Records. All disposal and destruction of records and information must be carried out in accordance with the relevant approved retention and disposal authority. They are responsible for developing practices and procedures to support organisation's records management policy and to ensure that records held in electronic (digital) or other technology dependent formats are accessible and protected for as long as they are required.

4.9 Users

Users of NSW Health information systems and assets play an important role in overall information security planning and risk management processes. Users must be aware of their responsibilities in relation to information security and privacy. Users have a role in identifying and reporting security concerns and incidents to management for investigation and review. Compliance with this policy and all relevant acts and regulations as they relate to information security is mandatory for all users.

4.10 Third party businesses and organisations, consumers and other agencies

The growing existence of inter-connected networks requires the extension of the 'boundaries' of NSW Health Organisations. All third parties must adhere to NSW Health and agency policies and procedures to ensure that adequate security controls are in place in the third-party environment.

4.11 Auditor

The role of independent reviewers and auditors is to assess the effectiveness and efficiency of implemented controls and whether controls are being adhered to. Independent reviewers and auditors must check compliance against policy and legislative requirements. Review and audit reports should be noted by executive management and, if appropriate, remedial action taken.

The internal auditor will regularly review NSW Health Organisations' adherence to this policy and cybersecurity controls, from a risk management perspective.

5. RELATED DOCUMENTS

5.1 NSW Health policy directives and guidelines

Reference	Policy Document Title
PD2009_076	Communications - Use & Management of Misuse of NSW Health Communications Systems
PD2015_037	Data Collections – Disclosure of Unit Record Data for Research or Management of Health Services
PD2015_036	Privacy Management Plan
PD2015_049	NSW Health Code of Conduct
GL2019_002	NSW Health Data Governance Framework
PD2015_043	Risk Management - Enterprise-Wide Risk Management Policy and Framework – NSW Health
Privacy Manual for Health Information	

5.2 Relevant legislation – NSW

- *Crimes Act 1900*
- *Defamation Act 2005*
- *Government Information (Public Access) Act 2009*
- *Government Sector Employment Act 2013*
- *Health Records and Information Privacy Act 2002*
- *Privacy and Personal Information Protection Act 1998*
- *State Records Act 1998*
- *Workplace Surveillance Act 2005*

5.3 Relevant legislation - Commonwealth

- *Cybercrime Act 2001*
- *Copyright Act 1968*
- *Privacy Act 1988*
- *Spam Act 2003*

5.4 NSW Government policies and directives

- Intellectual Property Management Framework for the NSW Public Sector
- Internal Audit and Risk Management Policy for the NSW Public Sector
- NSW Government Cyber Security Policy
- NSW Government: Information Classification, Labelling and Handling Guidelines

5.5 Standards

AS ISO/IEC 27001:2015. Information technology - Security techniques - Information security management systems – Requirements (this document is the same as ISO/IEC 27001:2013)
AS ISO/IEC 27002:2015. Information technology - Security techniques - Code of practice for information security management (this document is the same as ISO/IEC 27002:2013)
ISA/IEC 62443 - Series of standards, technical reports, and related information that define procedures for implementing secure Industrial Automation and Control Systems (IACS).

SUBPOENAS (PD2019_001)

PD2019_001 rescinds PD2010_065

PURPOSE

This Policy Directive outlines legislative provisions and procedures to be followed when the Ministry of Health and public health organisations are required to produce documents in response to a subpoena.

MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place in order to make sure that subpoenas issued on the agency are complied with appropriately.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure that:

- The principles and requirements of this policy and attached procedures are applied, achieved and sustained.
- All staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive.
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive.

Hospital Managers and Staff have responsibility to

- Understand the legislative requirements of a Subpoena.
- Provide only the documents which are requested under the schedule of the subpoena.
- To be aware of whether any claim for privilege over the documents can be applied and take appropriate action.

CONTENTS

1 BACKGROUND

1.1 About this document

The Ministry of Health and public health organisations are often required to produce documents on subpoena and a proper officer or staff member may be required to attend court and give evidence. This Policy Directive reflects current legislation and outlines procedures to be followed to assist public health organisations to comply with subpoenas issued by both NSW and interstate courts.

1.2 Key definitions

Approved form in relation to a document, means the form approved under Section 17 of the *Civil Procedure Act 2005* for the purposes of that document.

Care Proceedings are Court proceedings where an application for a "care order" is made for the protection of a child or young person.

Court includes tribunal. For a detailed list of Courts, refer to Appendix C.

Defendant or **Respondent** is the person against whom the action is brought by the Plaintiff/Applicant.

Document means any record of information and includes

(a) anything on which there is writing;

(b) anything on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them; or

(c) anything from which sounds, images or writings are capable of being reproduced with or without the aid of anything else.

Health record is a documented account, whether in hard copy or electronic form, of a patient's health, illness and treatment during each visit or stay at a health service. This may include electronic correspondence regarding the patient's treatment and records (such as x-rays or a community mental health record) that are stored separately from the patient's medical record.

Note: Health record holds the same meaning as: 'health care record', 'medical record', 'clinical record', 'clinical notes', 'patient record', 'patient notes', 'patient file', and so on.

Issuing Party means the person who has caused the subpoena to be issued.

Legal Privilege Protects certain documents being disclosed in court proceedings. These documents are protected from release under subpoena due to a special statutory or legal relationship that applies to the information.

Patient Any person who receives a health service and to whom, as a result, a health practitioner owes a duty of care. Also includes clients of PHOs.

PHO under the *Health Services Act* 1997, a public health organisation is a Local Health District or a statutory health corporation (including Specialty Health Networks), or an affiliated health organisation in respect of its recognized establishments and services.

Proper Officer is a person within the organisation who will have access to the records pertained in the subpoena.

Plaintiff or **Applicant** is the person who has commenced the proceedings.

Record includes any document or other source of information compiled, recorded or stored in written form or on film, by electronic process or in any other manner or by any other means.

Return Date is the last day the documents must be produced to the Court.

Subpoenaed Party or **Addressee** means the person who is the subject of the order expressed in the subpoena. A subpoena can only be addressed to a person, which may be the proper officer of an organisation.

1.3 Legal and legislative framework

* *Children and Young Persons (Care and Protection) Act 1998* (NSW)
* *Civil and Administrative Tribunal Act 2013* (NSW)
* *Coroners Act 2009* (NSW)
* *Commonwealth Service and Execution of Process Act 1992* (Cth)
* *Criminal Procedure Act 1986* (NSW)
* *Evidence Act 1995* (NSW)
* *Health Administration Act 1982* (NSW)
* *Interpretation Act 1987* (NSW)
* *Local Court Rules 2009* (NSW)
* *Uniform Civil Procedure Rules 2005* (NSW)
* *State Records Act 1998* (NSW)

2 INTRODUCTION

2.1 What is a subpoena?

A subpoena is an order from a court requiring the Addressee to:

(i) Produce to a court a copy of the subpoena and documents or things as directed by the subpoena;

(ii) Attend a court to give evidence as directed by the subpoena; or

(iii) Do both,

"***A subpoena to attend and give evidence*** means that the person to whom the subpoena is addressed is required to attend court and give evidence.

A subpoena to produce means that the person to whom the subpoena is addressed is required to provide documents or things. Producing documents to the court can also be done on behalf of the organisation by their legal representative."

Documents or things include written, printed or electronic material that provide information such as reports, emails, letters, photographs, video or audio recordings, diagnostic images, medical images or reports, laboratory results, cameras, phones, other electronic devices, CDs, USBs and so on.

A subpoena can only be issued if legal proceedings have been commenced.

In some courts and tribunals subpoenas are called "summons to produce documents", "orders to produce documents" or "notices for non-party or third party production". In coronial matters subpoenas may be called "section 53 Directions". The general principles that apply to these documents are the same in NSW courts, the Federal Court and the Family Court due to the harmonising of the subpoena rules.

2.2 What to do when you receive a subpoena

A subpoena cannot be ignored and must be dealt with promptly. Failure to comply with a subpoena without lawful excuse is a contempt of court and can result in an arrest.

When a subpoena is received by a PHO, it should be brought to the attention of the appropriate branch and the appropriate person within the PHO. All PHO's should have designated officers to coordinate responses to subpoenas, for example a medico-legal officer or medical records officer.

For particularly sensitive matters, the designated officer should notify the Chief Executive Officer or an executive officer of the PHO about the subpoena.

For matters where a PHO, a unit or employee of the PHO is a party, the subpoena should be brought to the attention of the solicitors acting on behalf of the PHO as soon as possible, and certainly before any documents are forwarded to the court.

3 GENERAL INFORMATION ON SUBPOENAES

3.1 Who is the subpoena addressed to?

A subpoena must be addressed to a person, or to "The Proper Officer" if directed to an organisation. If a subpoena to produce is addressed, for example to the Proper Officer a particular hospital or community health service within a PHO, only records held by that hospital or community health service will need to be produced.

If a subpoena to produce is addressed to the Proper Officer of PHO (i.e. "X Local Health District"), relevant records from all facilities within the PHO will need to be produced. If the subpoena is addressed to the Proper Officer of a PHO requesting all records relating to a particular patient, there are two options that can be considered:

(a) Contacting the issuing party and ask the solicitor to nominate which facilities within the PHO they require records from. Ask for this to be confirmed in writing.

(b) Search all facilities within the PHO for records relating to the patient. If this needs to be done, a separate fee may be charged for each facility searched. The issuing party should be told that fees will be payable for each facility searched. It is not necessary for the issuing party to issue separate subpoenas each addressed to separate facilities within the PHO.

3.2 Is the subpoena in the approved court form?

A subpoena must also be in the approved court form. If a subpoena is defective in this regard, the PHO should promptly inform the issuing party in writing and return any conduct money provided. The letter should explain how the subpoena is defective and be copied to the Clerk or Registrar of the court. A list of approved court forms can be found at www.ucprforms.justice.nsw.gov.au.

3.3 What if the PHO is a party to the proceedings?

If the subpoena lists the PHO or unit of the PHO as a party to the proceedings (for example as the Defendant), the subpoena should be referred to the appropriate person who will then forward it to the solicitor who has been instructed to act for the PHO (or unit) in those proceedings. If no solicitor has been appointed to represent the PHO (or unit) in the proceedings, the executive officer (or delegate) of the PHO (or unit) should be notified so that a solicitor can be appointed.
If a solicitor has been appointed, that solicitor should be instructed to respond to the subpoena. If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way set out in Part 33 of the UCPR.

3.4 What if the subpoena relates to a coronial inquest?

A subpoena to produce issued by the Coroner's Court needs to be signed by the Coroner or Assistant Coroner issuing it and provide a date and place where the document is to be produced. The Coroner may serve a subpoena by way of facsimile and is not required to provide conduct money.

The subpoena should be referred to the solicitor who has been instructed to represent the PHO's interests at the inquest, or in relation to the investigation to respond to the subpoena. If no solicitor has been appointed, the relevant medical administrator should review the medical records of the deceased and an assessment should be made as to whether the executive officer (or delegate) of the PHO should be notified so that consideration can be given to instructing a solicitor to represent the PHO. It may be appropriate for the relevant medical administrator to also consider notifying the PHO risk manager and the Treasury Managed Fund of the incident, if they have not already been notified.

If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way.

3.5 Has the subpoena been validly issued?

In most matters, subpoenas must be issued by a court or a tribunal. This means that they should include a court stamp or signature of a court officer.
If a party to the proceedings is represented by a solicitor, a subpoena may be filed electronically with the court except for some Local Court proceedings. If a subpoena is filed electronically, there will be an electronic court stamp. They are still valid subpoenas and should be complied with.
In some Local Court proceedings, Police Officers and Public Officers, rather than the Local Court can

issue subpoenas. These subpoenas do not need to be stamped. For more detail on these types of subpoenas, see Section 3.10.

In criminal, AVO and some civil proceedings, if the subpoena is seeking "counselling communications" for a victim of sexual assault, then the subpoena can only be issued with the leave or permission of the Court. Look for an attached court order or letter from the lawyer who issued the subpoena stating that leave was granted on a particular date. A subpoena issued without such leave will be invalid. For further information, see Appendix A – Sexual Assault Communications Privilege.

3.6 If you are uncertain about whether a subpoena has been validly issued, contact the court in which the proceedings have been commenced and ask for confirmation. What are the proceedings about?

From reading the subpoena you will be able to ascertain whether it is a civil or criminal matter and the identities of the parties. This information is contained within the Subpoena. Matters in the Family Court or Federal Circuit Court may involve children of the named parties.

In criminal matters, one of the parties will usually be the Director of Public Prosecutions, ("DPP"), or 'Regina' or 'R'. It is also possible (but less common) that one of the parties in a criminal matter will be a government department with the power to prosecute offences, such as the Australian Taxation Office or the Environmental Protection Agency.

As well as looking at the names of the parties, subpoenas should state what court, and sometimes what division of the court the matter is to be heard in, which might help ascertain what the proceedings are about. For a description of common courts, see Appendix C.

The Addressee of a subpoena to produce may request a copy of the appropriate Statement of Claim to assist them with determining the relevant documentation so that they are able to comply with the subpoena.

For more information on relevance, or legitimate forensic purpose, see Section 6.2.

3.7 Has the subpoena been properly served and in time?

The subpoena must be personally served on the person to whom it is directed, unless the subpoenaed party agrees to accept service by other means such as by post.

A subpoena to attend and give evidence must specify the date, time and place for attendance.
A subpoena to produce should be served in sufficient time to allow the collection of documents and delivery to court. The subpoena will say on it that you need not comply with it if it is served after the due date. The due date will not be less than five working days prior to the return date (ie. the date that the documents are required by the court) unless the court that issued the subpoena has shortened the time for serving it. If the court has made an order to shorten the period in which you must comply, the subpoena will be marked accordingly.

NB: The Federal Circuit Court requires the issuing party to serve the subpoena at least 10 clear working days before the date for producing documents, and 7 clear working days before giving of evidence. The Family Court is 7 clear working days for both giving of evidence and production of documents.

If the subpoena is served after the due date and there is no note or endorsement on the subpoena from the court stating that the time for service has been shortened, then the subpoena need not be complied with by the due date however you should contact the issuing party and ask that they obtain a further return date (an adjournment) so as to allow sufficient time for the documents to be collated.

Even where a subpoena to produce has been served in time, it may be possible to negotiate an extension of time within which to produce the documents with the issuing party. If the PHO has solicitors acting

on its behalf in the matter, those solicitors may be able to negotiate an extension of time on behalf of the PHO. If the PHO has not engaged solicitors, the person responsible for responding to the subpoena can contact the issuing party to negotiate an extension of time directly.

3.8 Does it make any difference if the subpoena is a facsimile, photocopy or a scanned copy?

As a general rule the original subpoena should be served to ensure it is authentic. Upon receipt of a facsimile, photocopy or scanned copy the issuing party should be contacted. All reasonable steps should be taken to ensure that an authentic subpoena is served. This will protect the PHO from claims by patients that their privacy and confidentiality have been breached by the production of the documents without an authentic subpoena.

However, this must be balanced against the requirements of the *Uniform Civil Procedure Rules* ("UCPR") which applies to all NSW Courts, the NSW Industrial Relations Commission and the Dust Diseases Tribunal only. The UCPR states that despite the requirement that a subpoena must be served personally on the subpoenaed party, the subpoenaed party must comply with the requirements of a subpoena even if it has not been served personally, even if the subpoenaed party has by the last date of service for the subpoena, actual knowledge of the subpoena and its requirements.

In some instances the Court may give approval to a party to serve a subpoena via electronic means, such as email.

Finally, the NSW Coroner's Court can serve a subpoena by way of facsimile (Section 105 *Coroner's Act 2009*).

3.9 What is the date the subpoena must be complied with?

Where a PHO has been ordered to produce documents, a 'return date' should be listed on the subpoena. If electing to send the documents or things via mail they should be received at the Court Registry at least 2 clear working (business) days before the date specified in the subpoena for production.

As noted in paragraph 3.6 above, it may be possible to negotiate an extension of time within which to produce the documents with the solicitor or person who issued the subpoena. This should be done prior to the original return date.

A failure to comply with a subpoena is a serious matter. The return date of each subpoena served on the PHO should be carefully noted as soon as it is received.

3.10 How can documents be produced to the court?

The subpoena allows the PHO to produce documents by attending the Court at the date, time and place specified and produce the subpoena or a copy of it and the documents or things to the court. Alternatively the PHO may deliver or send the subpoena and the documents or things requested in the schedule of the subpoena, via a courier or registered mail to the Registry at the address specified in the subpoena. As noted in paragraph 3.8 above, if documents are being posted, they should be received by the Court Registry at least 2 clear working days before the date specified in the subpoena to produce.

3.10.1 Providing documents electronically to Courts and Tribunals

Some Courts and Tribunals now accept subpoenaed material in an electronic format, such as on a DVD, CD or a USB device.
Sending information that is classified as 'sensitive' to destinations external to NSW Health, such as Courts and Tribunals, should be encrypted using approved encryption technologies or passwords in accordance with relevant regulations and Privacy Manual for Health Information.

Supreme Court of NSW

The Supreme Court of NSW accepts material in electronic formats. If the subpoena or covering letter from the issuing party does not specify that electronic formats are acceptable, you should contact the issuing party and see if they are agreeable to this. Documents should be provided as a PDF file. Electronic subpoena documents can be emailed to the Registry at supremecourt.enquiries@courts.nsw.gov.au. The subject line of the email should state "Producing subpoena documents" and include the case name and number. A scanned copy of the subpoena should also be attached.

District Court

Subpoenaed material may be provided in any electronic form that the issuing party has indicated will be acceptable. If the issuing party does not specify that electronic formats are acceptable and you would like to provide the material electronically, you should contact the issuing party and see if they are agreeable to this.

Tribunals

The NSW Civil and Administrative Tribunal and Administrative Appeals Tribunal generally do not accept subpoenaed material electronically, and require hardcopies to be produced to the Registry.

Local Court Criminal Matter

Police Officers and a Prosecutor who is a Public Officer have the power to issue subpoenas in the following types of Local Court proceedings:

- Local Court criminal summary and committal hearings;
- Local Court Application Notice proceedings;
- Children's Court criminal proceedings; and
- Apprehended Violence Proceedings.

Under the *Criminal Procedure Act*, ***prosecutor*** means the Director of Public Prosecutions or other person who institutes or is responsible for the conduct of a prosecution and includes (where the subject-matter or context allows or requires) an Australian legal practitioner representing the prosecutor.

Public Officer is defined as any of the following persons, if acting in an official capacity:

(a) an employee in the Public Service or the NSW Police Force;
(b) an officer or employee of a statutory body representing the Crown;
(c) an employee of a council within the meaning of the *Local Government Act 1993*;
(d) a member of staff of Local Land Services; or
(e) the Director of Public Prosecutions, Deputy Director of Public Prosecutions or Solicitor for Public Prosecutions.

Subpoenas issued by police officers or a Prosecutor who is a public officer will not have been signed and dated by a registrar of the Local Court. They will not have a court stamp. They are still valid subpoenas and should be complied with.

Children's Court

Any party to care proceedings in the Children's Court may seek leave to issue subpoenas in the proceedings. Subpoenas issued in care proceedings are issued by the Children's Court, Children's Magistrate or Registrar pursuant to Section 109C the *Children and Young Persons (Care and Protection) Act 1998*, and will therefore always be stamped with the seal of the Children's Court and/or signed and dated by the Children's Magistrate or Registrar.

A subpoena issued in care proceedings must be served on the recipient no less than five clear working days, or any such other date specified in the subpoena as endorsed by the Children's Magistrate or Registrar, before the return date. The issuing party is also required by s 108E of the *Children and Young Persons (Care and Protection) Act 1998* to tender conduct money at the time of service for the reasonable expenses of the person in complying with the subpoena.

3.11 What if an interstate court issued the subpoena?

It is common for some hospitals in NSW to receive subpoenas issued by interstate courts. For example, hospitals in northern NSW often receive subpoenas (known as notices of non-party disclosure) issued by courts in Queensland.
The Commonwealth *Service and Execution of Process Act* allows for interstate subpoenas to be validly served in NSW if they are accompanied by notice. The general rule is that subpoenas served interstate should be served 14 days prior to the return date. This time can be shortened by the court that issued the subpoena if a shorter time period is necessary in the interests of justice and there will be enough time for the subpoenaed party to comply without serious hardship or inconvenience. There may however be circumstances where further time is needed to produce the material of the subpoena. In such circumstances, it is generally best for the recipient of a subpoena to contact the party issuing the subpoena.
PHO's are entitled to request that the original subpoena (or a copy of the original) is served, rather than a faxed copy.

4 CONDUCT MONEY AND/OR COSTS OF COMPLIANCE

4.1 What is conduct money?

When a subpoena to give evidence is served on a person or a Proper Officer of an organisation, the person named is not required to attend and give evidence under the subpoena unless conduct money has been paid. This means an amount sufficient to meet the 'reasonable expenses' of attending (which are often prescribed). Conduct money must be provided at the time the subpoena to attend and give evidence is served.

In relation to subpoenas to produce, the Addressee is able to claim the 'reasonable expenses' of complying with the subpoena.

The court in the event of a dispute will determine what is 'reasonable' conduct money or costs of compliance. In reaching a decision the court is likely to take into account NSW Health policy when determining what is reasonable.

The rates to be applied for servicing a subpoena for production are advised annually by NSW Health in an information bulletin titled *Health Records and Medical/Clinical Reports – Rates* and the Policy Directive titled *Health Records and Medical/Clinical Reports – Charging Policy.*
Even if original documents are being produced to court, the photocopying charge will still apply. It will cover the cost of copying the records so that the PHO can maintain a copy whilst the originals are removed.

If a subpoena asks for records relating to more than one patient, the PHO has the discretion to charge separate fees for each patient.

If a subpoena requires searches for records to be undertaken at more than one facility of the PHO, the PHO has the discretion to charge separate fees for each facility searched.
Conduct money does not need to be paid in the following circumstances:
- NSW Civil and Administrative Tribunal
- NSW Coroner's Court
- Local Court proceedings where a Police Officer or Public Officer have issued the subpoena (as discussed in section 3.10)

4.2 What if the conduct money is inadequate?

If the record is lengthy, or will require a number of files to be searched or otherwise take up staff time so that it will cost more than the amount provided to produce the record, the issuing party should be contacted and advised of the estimated cost of compliance including staff time in searching and locating the relevant records, photocopy costs and mail or courier fees. Such contact may be by telephone but should be confirmed in writing.

In the event that the actual costs exceed the estimate, a further account should be raised against the issuing party. Information Bulletin 2017_035 is a useful guide that is updated each year to assist in determining costs of compliance.

If compliance with a subpoena involves a significant amount of work, consideration should be given to discussing with the issuing party whether they are prepared to narrow the scope of the subpoena (see Section 6.1 of this Policy Directive).

If the conduct money and/or amount paid for production expenses is inadequate, the PHO representative should:

(i) Call the issuing party to inform him or her of your requirements.

(ii) If there is still a refusal to provide additional conduct money or production expenses, or you consider it insufficient, contact the issuing party and attempt to negotiate some compromise on the amount.

(iii) In the event that conduct money was not provided by the issuing party and / or the amount of conduct money or amount paid for production expenses is considered to be 'unreasonable' the PHO or solicitor acting on behalf of the PHO should advise the Court on the day the documents are produced to the Court and request the Court make an order to the issuing party that they pay conduct money and/or the amount of any reasonable loss or expense incurred in complying with the subpoena.

4.3 What if too much conduct money has been provided?

The PHO is entitled to retain the minimum amount of conduct money and/or production expenses.

If more than the minimum amount is provided and the cost of producing the records is less than the amount provided, the records should be copied and delivered to the court and the excess amount should be refunded to the issuing party.

4.4 Can the PHO keep the conduct money if it has no documents to produce?

If the PHO receives a subpoena, conducts searches for the records requested, and has no records to produce, it may retain a reasonable amount to cover the cost of conducting the searches, and the cost of writing to the Court explaining that it has no records to produce.

If the records have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the amount paid should be refunded.

5 WHAT DOCUMENTS HAVE BEEN REQUESTED IN THE SUBPOENA TO PRODUCE

5.1 How do I determine the scope of the subpoena?

The schedule to the subpoena must be read very carefully to determine the scope and document required. This is critical because the PHO is under an obligation to produce only those documents covered by the description set out in the subpoena. A subpoena may call for the production of health and/or non-health related records. The applicable procedures are the same.

The next task is to undertake appropriate inquiries to determine whether the PHO is in possession of any records which fall within the scope of the subpoena, the likely location of the records and the number of files that may have to be searched.

The PHO should take care only to copy and produce documents that are within the scope of the subpoena. Do not provide any documents that are outside of the scope of the subpoena.

Documents that do not come within the scope of the subpoena should be removed from the medical record before it is copied and documents are sent to court. This may also mean redacting portions of documents if there is extraneous, irrelevant or privileged information contained within a document to be released. A clear record of which documents have and have not been produced and a copy of the subpoena should be kept by the PHO. This may involve keeping an additional copy of the records that were sent to the Court, if the records that were sent are a small extract from the medical record.

The schedule will generally address one patient, who is mostly a party to the proceedings. Care needs to be taken to protect the information of those parties who are not represented in the proceedings and would not anticipate their personal information being released to a Court without their knowledge.

Sometimes there may be letters from specialists, who state that the letter should not be released to a third party without the consent of the author, contained within the clinical record of a patient whose records have been subpoenaed. If the letters are included in the clinical record which has been requested in the schedule of the subpoena, the documents must be sent to Court. There is no need to obtain the permission of the specialist although the PHO should consider contacting the specialist as an interested party before producing those documents.
Only material specifically referred to in the schedule to the subpoena should be collated.

Examples

Scenario: A patient, Sara X, attends Chester Public Hospital on 28/9/2000 after being sexually assaulted. There are several later attendances to the hospital over the next three months. Some of these admissions being for surgical procedures unrelated to the sexual assault.

On 30/9/2000 Sara also visits the Chesterfield Sexual Assault Service, (a separate facility of the Chester Local Health District, located in Main St, Chester) in relation to the sexual assault, and there are several sessions with a sexual assault counsellor Jenny K, after this initial presentation.

Some months later, the defence in a criminal trial decide to issue a subpoena to the Chester Local Health District seeking access to documents held on Sara X. Some of the requests they consider putting in the subpoena include:

"All notes relating to the visit by Sara X to the Chester Hospital on 28/7/2000"

The Hospital holds no records relating to an admission of Sara X on 28/7/2000. The hospital is not required to, nor should it volunteer any information in relation to other visits Sara X may have made to the Hospital.

"All notes of the visit by Sara X to the Chester Hospital on 28/9/2000"

The only records caught by the subpoena are the actual notes which relate to the visit on 28/9/2000. No reference is made to other visits Sara X made to the Hospital, or the Community Health Centre at later dates, so these documents are not caught by the subpoena.

"All notes relating to the visit by Sara X to the Chester Hospital on 28/9/2000 or any time thereafter"

All notes included on Hospital records are captured, including notes on the unrelated surgical procedures. The subpoena does not, however, capture any records generated by the Sexual Assault Service which are not in the possession of or under the control of the Hospital. The Sexual Assault Service is a separate facility of the Local Health District, and is located outside the hospital campus. As such, the LHD is not required to, nor should it volunteer any information on visits made by Sara X to the Chesterfield Sexual Assault Service. Had the Sexual Assault Service been located within the hospital campus, and its records been in the possession of or under the control of the Hospital (and related to a visit to the Hospital), the result in this case would have been different.

"All notes and counselling records prepared by counsellor Mary G in relation to any counselling sessions conducted with Sara X."

The subpoena does not identify the records of a particular facility. As such, and as the subpoena is addressed directly to the Local Health District, all LHD records should be checked, including those held by the SAS. Note, however, that the subpoena names a specific counsellor, and only requests her notes. Mary G did not see Sara X, so the LHD does not hold any records covered by the subpoena. The LHD is not obliged to inform the court that another counsellor saw Sara X.

"Any records, notes reports or any other written material held by any facility of the Chesterfield Local Health District, including but not limited to the facilities at the Chester Hospital and the Chesterfield Sexual Assault Service relating to Sara X and dealing with an alleged sexual assault on 28/9/2000.

This is a more usual approach. The terms of the subpoena are broad, and clearly captures all the relevant documents held by the LHD on Sara X. The only documents not captured would be those dealing with the unrelated surgical procedures. Note however, the reference to "Chesterfield Local Health District", when the actual legal entity is the "Chester Local Health District". If the subpoena also wrongly names the LHD, arguments could be raised against complying with it.

5.2 What documents need to be produced?

This will depend on the scope of the subpoena to produce. It is important to read the schedule of the subpoena carefully in order to determine what documents are being requested. If this is not clear, contact the solicitor issuing the subpoena.
If the subpoena requests "*any records*" or "*all records*", this means the entire file relating to the patient, including correspondence and x-rays, including when the documents are stored separately to the medical record. For example, a patient's community mental health record, clinical record of sleep studies record would also need to be produced should a PHO receive a subpoena requesting all records within the PHO relating to that patient.
The definition of 'document' captures any electronically held documents and hard copy documents. Electronically held documents are those held, for example, in an electronic medical record, other clinical information systems or information contacted on a computer file, such as photos and / or videos. This would also include emails exchanged by clinicians regarding the particular patient along with any clinical records/reports from other PHO's or referring doctors.
With the continuing expansion of information technology systems across NSW Health, PHO's should keep in mind that a patient's health information may be stored on an electronic database that is an

extension of the patient's health record, for example the HealtheNet Clinical Portal. Depending on the scope of the schedule to the subpoena issued to a PHO, records from state-wide databases or databases that are in the possession of or under control of a particular PHO may need to be collated and produced if they form part of the patient's record at the PHO (whether they have been accessed by clinicians or not).

5.3 What if the subpoena captures reports to Family and Community Services?

Under Section 29 of the *Children and Young Persons (Care and Protection) Act 1998*, risk of harm reports made to the Secretary, Department of Family and Community Services are not produced in response to a subpoena, summons or notice to produce other than:

(i) Care proceedings in the Children's Court;

(ii) Proceedings in relation to a child or young person under the *Family Law Act 1975* (Cth);

(iii) Proceedings in relation to a child or young person before the Supreme Court or Civil and Administrative Tribunal;

(iv) Proceedings before the Civil and Administrative Tribunal that are allocated to the Guardianship Division of the Tribunal or are commenced under the *Victims' Rights and Support Act 2013*;

(v) Proceedings under the *Coroners Act 2009*.

Section 27A(7) of the *Children and Young Persons (Care and Protection) Act 1998* provides that a referral by a mandatory reporter to their relevant Child Wellbeing Unit is also protected from production under Section 29 of the Act.

Although risk of harm reports, or documents evidencing the contents of a risk of harm report, may be produced in response to subpoena, summons or notice to produce issued in certain proceedings, Section 29(f) of the *Children and Young Persons (Care and Protection) Act 1998* prohibits the disclosure of the identity of a person who made a report, except with:

(i) The consent of the person who made the report, or

(ii) With leave of the Commissioner.

Section 29AA of the *Children and Young Persons (Care and Protection) Act 1998* similarly prohibits the disclosure of the identity of a person who made a report to a Royal Commission, except in the circumstances described above.

It is possible for a court or other body before which proceedings relating to the report are conducted to grant leave to a party or a witness to disclose the identity of the mandatory reporter if the court or other body is satisfied that the evidence is of critical importance in the proceedings and that failure to admit the evidence would prejudice the proper administration of justice. If a court or other body grants leave for this to occur reasons must be provided as to why leave is granted, and the court or body must ensure that the holder of the report is informed that evidence as to the identity of the person who made the report, or from which the identity of that person could be deduced, has been disclosed.

5.4 What if the subpoena captures sensitive records?

For medical records, the prime criterion of sensitivity is whether the patient would consider the data sensitive. Records relating to people or patients who are not directly involved in the legal proceedings can also be classified as sensitive. Examples include where genetic counselling or medical records contain information relating to persons other than the patient.
The fact that records are sensitive does not itself mean that privilege can be claimed over them, or that they do not need to be produced. If a subpoena requests sensitive records and there are no grounds for challenging the subpoena or claiming privilege (see Section 6), the procedure set out in Section 7.4 may be followed.

5.5 What if there are no documents or information?

If there are no documents or information, a letter should be written to the court advising the court that there are no documents or information to be produced. This letter should be copied to the issuing party. The conduct money may be retained.

However, if there are no records but there is evidence that there once were relevant records that have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the conduct money should be refunded.

A file note should be created outlining efforts made to find the relevant records.

If records were destroyed in accordance with a disposal authority approved under Section 24 of the *State Records Act 1998*, a copy of the disposal authorisation should be included and the relevant disposal category cited. Disposal authorisation is the consent of public office that is required before records can be disposed of.

6 SUBPOENA TO PRODUCE – GROUNDS TO OBJECT OR SET ASIDE

In most instances, when a subpoena to produce is issued, the issuing party must also serve a copy of the subpoena on all active parties to the proceeding as soon as practicable after the subpoena has been served on the Addressee.

The court may, on the application of a party to the proceedings, or the Addressee, or any person having a sufficient interest, set aside a subpoena in whole or in part. If any party or person files a motion to set aside a subpoena issued to a PHO, the PHO must be notified.

If a subpoena issued to the PHO is set aside, the PHO is no longer required to comply with the subpoena.

The information provided below applies when the PHO itself seeks to set aside a subpoena or object to access to documents required to be produced under subpoena.

6.1 The subpoena is too wide and/or oppressive

A subpoena to produce may be set aside:

- where its terms are so wide and/or insufficiently precise that compliance (i.e. collation and production of documents) would impose an onerous obligation on the PHO; or
- where a subpoena is used for the purpose of "fishing" for information which a party hopes, but does not reasonably expect is in existence. This may apply particularly to broad requests for protocols and investigation documents.

Subpoenas which request the production of medical records relating to persons who are not parties to the proceedings, or which request records relating to multiple, unrelated patients may be an abuse of process or oppressive.
The subpoena may also be oppressive if it is not clear what documents are sought by a subpoena, or if it appears that the documents sought will have little or no relevance to issues in the proceedings. The scope of a subpoena can be narrowed in two ways:

(i) by agreement with the issuing party; and

(ii) by successfully challenging the subpoena in court (see Section 8 of this Policy Directive).

If you believe that the scope of the subpoena is too broad and calls for documents to be produced which are demonstrably not relevant to the proceedings, an option available is to approach the issuing party with a view to seeking a compromise on the range of documents that are required. If a compromise is reached, written confirmation should be obtained from the issuing party as to the terms of the amended schedule to the subpoena.

If the issuing party refuses to negotiate the scope of the subpoena as is suggested above and you still wish to set aside a subpoena on the basis that it is an abuse of process or oppressive, you should consult your immediate manager, who may need to consult the PHO Executive, and obtain advice from the PHO's solicitors if appropriate.
You should be aware that where a subpoena is challenged unsuccessfully, the PHO may be liable to pay the court costs (associated with argument over the subpoena) of the issuing party.

6.2 The subpoena is an abuse of process or lacks a legitimate forensic purpose

A subpoena to produce that has been issued for reasons other than for the purpose of obtaining relevant evidence for the proceedings may be set aside.

In criminal matters, an accused person must have an objective basis for demonstrating a real possibility that the subpoenaed material would assist his or her defence. Only documents that have a legitimate forensic purpose need to be produced. Legal advice is recommended in order to argue that records have no legitimate forensic purpose.

6.3 Public interest immunity

Where the public interest that would be served by withholding certain documents is so strong that it overrides the public interest in the following of due process, a subpoena may be set aside. A challenge on this basis applies only to very limited types of documents and will usually only be available to documents which may affect national security, the workings of the NSW Cabinet or some other extraordinary public interest.

NB: If you wish to challenge a subpoena on a public interest immunity basis, you should contact the Legal Branch on telephone (02) 9391 9606.

6.4 Client legal privilege

Client legal privilege can protect certain documents from being disclosed in court proceedings. This privilege applies to confidential communications between a client and another person, or between a lawyer acting for the client and another person, if the communication was for the dominant purpose of the client being provided with professional legal services relating to a court proceedings or an anticipated or pending court proceedings in which the client is or may be, or was or might have been, a party.
If a claim for legal professional privilege is contested, evidence will be required from the author of the documents and/or the person who requested that the document be created, that it meets this test; and/ or other investigations will need to be undertaken as to the document's dominant purpose.

If a PHO wishes to claim client legal privilege over documents it has created for legal proceedings, the lawyer that the PHO instructs in those proceedings will be responsible for claiming the privilege.

6.5 Qualified privilege

NSW qualified privilege legislation (Division 6B of the *Health Administration Act 1982*) applies to approved quality assurance committees. Qualified privilege operates to prevent committee members and documents produced by the committee from being used in any legal proceedings.
Qualified privilege applies to records that are under the control of an approved quality assurance committee, or a member of an approved quality assurance committee and were created at the request of or solely for the purpose of the committee. If documents were created by an approved quality assurance committee but have been disclosed to other units of the PHO, the privilege may be waived, however, if the committee has not waived privilege over the documents and a subpoena is received for these records, the PHO should write to the party who issued the subpoena and to the court stating that the records are protected by qualified privilege legislation and will not be produced.

If records relating to quality assurance activities and morbidity and mortality case reviews or committees are requested, the PHO Executive should be contacted to confirm whether the records are records created by an approved quality assurance committee.
In addition to approved quality assurance committees, the Minister has approved the following committees under Section 23 of *Health Administration Act 1982*, to be specially approved committees;

- Special Committee Investigating Deaths Under Anesthesia,
- Collaborating Hospitals Audit of Surgical Mortality Committee,
- NSW Maternal and Perinatal Mortality Review Committee,
- Mental Health Sentinel Events Review Committee, and
- Clinical Risk Action Group Committee.

These committees do not need to comply with subpoenas. If one of these committees is subpoenaed, it should not comply with the subpoena unless it has the approval of the Minister to do so, or the consent of the person from whom the information was obtained. A letter should be sent to the solicitor issuing the subpoena, as well as the Court, explaining the committee's special status and stating that records will not be produced

6.6 Sexual Assault Communications Privilege

Records relating to the counselling of victims of sexual assault (protected confidences) may be protected from production if they are covered by sexual assault communications privilege. Sexual assault communications privilege can be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders (AVOs) in NSW Courts. The sexual assault communications privilege may also be claimed in NSW Courts in civil proceedings, in limited circumstances, when the privilege was granted in criminal proceedings. The privilege may also be claimed in federal courts, such as the Family Court or Federal Circuit Court, if exercising jurisdiction in NSW and in the courts of other States and Territories of Australia.
PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

See **Appendix A** for further detail about the privilege.

6.7 Professional Confidential Relationship Privilege

This privilege may apply to a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication. The privilege can be claimed in NSW courts. The privilege may also be claimed in federal courts, such as the Family Court or Federal Circuit Court, if exercising jurisdiction in NSW and in the courts of other States and Territories of Australia.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records.

See **Appendix B** for further detail about the privilege.

7 COURT PROCEDURE FOR CHALLENGING ACCESS TO DOCUMENTS PRODUCED UNDER SUBPOENA

7.1 Subpoenas for records where the Addressee objects to inspection on grounds that they are privileged (other than sexual assault and confidential communications privilege)

A solicitor's assistance will be necessary depending on the complexity of the case. Discussion should be undertaken with the appropriate PHO Unit (e.g. CGU) to ensure that a solicitor is consulted or appointed if necessary.

If a PHO decides to challenge access to documents produced under subpoena without legal representation the following procedures will apply:

(i) Follow 7.1 – should I notify anyone of the subpoena?

(ii) Follow 7.3 – procedure for delivering subpoenaed documents to the court?

(iii) Place the records which are to be produced in a sealed envelope.

(iv) Place any records over which a claim for privilege will be made in a separate envelope and mark the word "privileged" on the envelope.

(v) Attach a copy of the subpoena to the outside of each envelope.

(vi) Place the envelope(s) marked "privileged" inside another envelope and send to the court with a letter to the Registrar notifying the court that the Addressee objects to the documents or things being inspected by any party to the proceedings and setting out :

(a) What type of privilege is claimed; and
(b) The reasons supporting the claim for privilege.

(vii) Consider attending in person on the return date, or instructing the PHO's solicitor to attend, in order to argue in support of the claim for privilege.

NB: For matters in NSW Civil and Administrative Tribunal (NCAT) (called a 'summons'), if the Addressee is unable to resolve the objection to the summons with the issuing party before the time for compliance, the Addressee who is objecting is required to:

a. Inform the registrar and the issuing party of the basis for the objection;
b. Attend NCAT on the date for compliance and be prepared to explain the basis for objection.
c. Objections that cannot be resolved by discussion and agreement will be referred to a Member for decision.

7.2 Steps to follow when a subpoena for sexual assault records or confidential communications records is received

7.2.1 Determine whether either privilege can be claimed in the proceedings

See **Appendix A** for a discussion of the types of proceedings in which sexual assault communications privilege must be considered and how the privilege operates.

See **Appendix B** for a discussion of the types of proceedings in which it is possible to claim professional confidential relationship privilege.

7.2.2 Family Court, Federal Circuit Court and Children's Court subpoenas

Sexual assault communications privilege and professional confidential relationship privilege are created by NSW legislation and apply in NSW courts, and may also apply in Federal Courts where a matter is heard in NSW and in the courts of other States and Territories of Australia.

If you receive a Family Court or Federal Circuit Court subpoena requesting a patient's sexual assault counselling communications records and the subpoena was not issued by the patient or the patient's legal representative, and you are concerned about producing the records, although privilege cannot be claimed, you could consider treating the records as 'sensitive records' (see Section 7.4).
Keep in mind that sexual assault communications records relating to children can be important evidence and highly relevant for the Family Court or Federal Circuit Court to have available when determining parenting orders for the care of a child.

You must file the 'notice of objection' form contained on the last page of the subpoena and serve copies of the notice of objection on each of the parties to the proceedings prior to the return date if you are objecting to the production of documents in response to a subpoena. The court will then assign a date for your objection to be heard and you will need to attend court on that day.
The Children's Court may take different approaches to objections to subpoenas depending upon the location of the court. However, if objecting to a subpoena you must ensure that the relevant Children's Court is given notice of your application to set aside the subpoena or to object to access either by mail, fax, email or in person prior to the return of subpoena. For example if the Children's Court at Parramatta receives notice of an application, the matter will be listed for directions.

7.2.3 Protected Confidence Notice

A protected confidence means a counselling communication that is made by a victim of a sexual assault. The counselling communication does not need to relate to the sexual assault and may predate the sexual assault. If a party wants production and access to a document containing a protected confidence, they must seek leave of the Court and give notice to the patient that production has been sought. Notice should also be given to the other parties. This is a requirement of the *Criminal Procedure Act 1986*.

This means that if the issuing party is aware that the documents sought contain protected confidences, the patient should have been made be aware that they can seek to appear in court on the return date to challenge the subpoena.

7.2.4 The view of the patient

Sexual assault communications privilege and professional confidential relationships privilege belong to the patient.

When a subpoena requesting sexual assault counselling records or records of a protected confidence is received the PHO should contact the patient and inform them that the subpoena has been served. The PHO should then:

(a) explain nature of the privilege which may apply;

(b) ask the patient whether s/he will consent to waive the privilege. If so, a consent to waive the privilege should be obtained from the patient in writing;

(c) if the patient does not want to waive the privilege, advise the patient of the steps (if applicable) that the PHO is taking to claim the privilege on the patient's behalf.

If the patient chooses to waive the privilege, the documents must be produced to the court.
Reasonable attempts should be made to contact the patient if a subpoena for sexual assault counselling records is received. What constitutes reasonable steps will vary depending on the individual circumstances of the patient. If the file shows that there is a potential that the patient will suffer serious harm if the records are disclosed, taking reasonable steps to locate the patient may involve doing more than attempting to telephone the patient or writing a letter, such as contacting the police for assistance. If the patient cannot be contacted, the PHO should write a letter to the court explaining this, and noting that the records contain confidential counselling material. This letter should be sent to the court with the records.
In proceedings where the patient is represented, the PHO will meet its obligation by referring the matter to the patient's legal representative.
Legal Aid NSW's Sexual Assault Communications Privilege Service (SACPS)is a state wide service that assists victims to protect the privacy of counselling notes and other confidential therapeutic records in criminal proceedings.

SACPS can assist the LHD and the victim by:

1. Providing information to health workers about privilege;
2. Advising sexual assault victims about using privilege; and
3. Providing representation in court for sexual assault victims to enforce the privilege.

SACPS can be contacted by phoning (02) 9219 5888 or emailing sacp@legalaid.nsw.gov.au.

7.2.5 Whether harm is likely to occur to the patient if the material is disclosed

The treating counsellor (or, if that person is not available, another qualified professional) should review the file and form a preliminary view as to whether harm is likely to occur to the patient from disclosure. This preliminary view will need to later be supported by the preparation of a harm statement or an affidavit. A harm statement or affidavit made by a professional with appropriate qualifications is an essential element to claiming the privilege. Before a decision is made to claim privilege, the professional/s involved should be comfortable they can adequately prepare a harm statement or affidavit for the court. If a decision is made to claim privilege, the most appropriate way to ensure the claim is argued effectively is for the PHO to obtain legal representation.

7.2.6 Determine whether the PHO should claim privilege on behalf of the patient

The following issues should be considered when deciding if the PHO should claim either sexual assault communications privilege or professional confidential relationships privilege:

- The views of the patient and whether the patient proposes to claim either privilege themselves. You may wish to refer the patient for independent legal advice. Legal Aid's SACP Service can be contacted by phoning (02) 9219 5888 or emailing sacp@legalaid.nsw.gov.au.
- Whether harm is likely to occur to the patient if the material is disclosed.

7.2.7 The harm statement or affidavit

In order to support a claim for privilege, it is necessary for the patient or the PHO to provide the court with evidence about the nature and extent of the harm that the patient would suffer if the documents were disclosed. However, specific details about the patient should not be provided – to do this would negate the purpose for the privilege claim.
If the PHO has instructed a lawyer to argue the privilege, the lawyer will advise staff on whether affidavits, or harm statements, or a combination of both, are required, and will assist staff in preparing these documents.

If the PHO does not instruct a lawyer, it may consider asking staff to draft a harm statement. When drafting harm statements, keep in mind that they are likely to be read by all parties to the proceedings.

A professional with appropriate qualifications should prepare a harm statement. It should include:

(a) the qualifications and experience of the professional preparing the statement;

(b) the employed position of the professional at the time of preparing the statement;

(c) if the person preparing the statement is the treating counsellor, the statement should state this, and explain for how long the counselling relationship has been established;

(d) if the person is not the treating counsellor, the statement should state that fact. It should explain why the treating counsellor is not available to make the statement and state that the person who is preparing the statement has read all the relevant counselling notes;

(e) a statement that the counselling notes that have been subpoenaed were made in confidence and relate to the impact of alleged sexual assaults.

(f) a statement to the effect that the symptoms, concerns, and worries of the patient would be seriously aggravated if the contents of the documents were disclosed.

(g) if applicable, a statement to the effect that the patient expected the counselling records to remain confidential.

(h) a statement that the writer of the harm statement claims sexual assault communications privilege in respect of the records.

7.2.8 Instructions to be given to lawyers engaged by the PHO to argue a privilege claim

If the PHO decides to engage lawyers to argue a claim for privilege, a letter of instruction setting out the following should be sent to the lawyers. The letter should include the following information:

- When the subpoena is returnable (attach a copy of the subpoena);
- The nature of the documents held;
- The patient's views on disclosure;
- If the patient does not wish to waive the privilege, an indication that the PHO is of the view that harm will occur to the patient if the documents are released;
- The name and contact details of the other party / parties to the proceedings (or their legal representatives);
- If the matter is a criminal matter, the name and contact details for the police officer in charge of the criminal investigation;
- The name of appropriate contact officer at the PHO;
- The date that the hearing starts. This information can be obtained from the issuing party. The date that the hearing starts will usually be a date sometime after the return date for the subpoena. This allows time for the return date for the subpoena to be adjourned by the court if the PHO wishes to put forward arguments objecting to disclosure. Where the subpoena is returnable at the start of the trial it is more difficult to negotiate additional time.
- Whether the documents have been subpoenaed before. This is important, as if the records were previously released, it will be more difficult to argue for their non-release in response to a later subpoena. Alternatively, the court may have prevented disclosure in earlier cases and made comments which may assist in arguing for non-disclosure in relation to the later subpoena.

8 PROCEDURES FOR RESPONDING TO A SUBPOENA TO PRODUCE

8.1 Should I notify anyone of the subpoena?

All subpoenas should be brought to the attention of the relevant person or branch with-in the PHO to whom the subpoena relates, for example the medical records department or, to medico-legal person or risk manager if the PHO has one. Where appropriate, the senior health care provider and the treating health care provider are to be advised (where possible) of subpoenas for health records, even if neither they nor the PHO are party to the proceedings.

Where a patient whose health record has been subpoenaed is not named on the subpoena as a party to the proceedings before the court, he or she should be notified by the PHO that the subpoena has been received and advised of the "return date" on the subpoena (i.e. the date the documents must be provided to the court) in sufficient time to allow the patient to arrange to attend the court if the patient wishes. Telephoning the patient, or writing to the patient's last known address is sufficient. A note should be made outlining measures taken to advise the patient of the subpoena.

NB: If you have concerns about the scope of a subpoena you should consult your immediate manager who may need to consult the PHO Executive and obtain advice from the PHO's solicitors if appropriate.

8.2 Are photocopies sufficient or must originals be produced?

Documents can be provided to the Court by way of:

(a) A photocopy;
(b) In PDF format on a CD-ROM;
(c) On a USB; or
(d) In any other electronic form that the issuing party has indicated will be acceptable.

Unless a subpoena specifically requires the production of the original document, photocopies of the records or a CD-ROM or USB should be provided. If the PHO is required to produce originals, it should ensure that a complete copy of the records remains with the PHO to ensure continuity of care.

8.3 What is the procedure for delivering subpoenaed documents to the court?

Documents produced under NSW subpoenas must be produced to the court at the address referred to in the subpoena and **not to** the issuing party. They should not be provided to the person who serves the subpoena, even if the matter is 'urgent'.

Documents produced on subpoena should be delivered to the Registrar or Clerk of the court in question. If the documents are produced to the court, the following procedures should be followed:

(i) The documents should be sealed in an envelope;

(ii) The PHO should allocate a unique number to the envelope from a register held by the PHO in which the name of the patient, the court to which the record is sent and the date of the hearing should be entered against the number;

(iii) a copy of the subpoena should be secured inside the envelope (if the Court requires the original subpoena, the PHO should make a copy for its records);

(iv) the PHO should keep a copy of the subpoena (and any original documents being sent to court with the subpoena); and

(v) the envelope should be delivered to the registry by hand by the return date by an employee of the PHO or by registered post, or courier not less than 2 clear working days before the return date specified in the subpoena.

On delivery, if practicable, a receipt should be obtained from the court which indicates the number of the record, the date the record was received at the court, the name of the court and the signature of the court official receiving the record.

If the PHO is a party to the proceedings in which the subpoena has been issued, or has sought legal advice in relation to the subpoena, the documents collated in response to the subpoena should be forwarded to the solicitor who is acting on behalf of the PHO. That solicitor will review the documents and arrange for them to be forwarded to the court on behalf of the PHO.

8.4 Can any additional precautions be taken for sensitive records?

A subpoena cannot be challenged merely because it requests sensitive records.

When responding to a subpoena that requests sensitive information (and where there are no grounds for setting aside the subpoena or claiming privilege over the documents), the following steps should be followed.

(a) Contact the issuing party and ascertain why the information is required. It may be possible to negotiate with the issuing party to either exclude these records from production, or produce copies of the records with the names of the affected people deleted.

(b) Request that the court limit access to the documents to certain people. For example, courts can give orders limiting access to the parties' legal representatives and independent experts on the condition that they give confidentiality undertakings. The responsibility for raising this issue rests with the subpoenaed party. A letter should be sent to the court setting out the concerns arising if the documents are provided in open court. The letter should not contain any sensitive information itself.

The documents to be produced, should be placed in a separate envelope marked "Sensitive – access restricted", however, this is no guarantee that the Court will treat these records differently.

9 WHAT HAPPENS AFTER THE DOCUMENTS HAVE BEEN PRODUCED

9.1 Who can see the documents after they have been produced to the court?

After documents have been produced to court, the court will make orders about who may access them. Usually, the parties to the proceedings and their legal representatives will be granted access to the documents.

If a patient's medical record has been produced to court, and the patient is also a party to the proceedings, his or her legal representative may ask for 'first access'. This means that the patient's legal representative can inspect the records before the other parties, in order to determine whether a privilege claim can be made to limit further access to the documents.

The question of who may have access, whether a party will have first access, or whether any other special access orders will be made, is often determined on the return date.

The following courts determine access issues in particular ways.

District Court – civil claims

The issuing party in a District Court civil matter is required to include a "proposed access order" on the subpoena. This is an order for access that the issuing party thinks is appropriate. For example, the proposed access order may be "plaintiff to have first access to the documents for 7 days". This type of access order may be appropriate if the plaintiff was the patient whose records had been produced, as it would allow the plaintiff/patient's solicitor to view the records and determine whether any claims for privilege should be made, prior to the other parties accessing the records.

If the PHO wishes to object to the proposed access order (for example, if a privilege is being claimed), the PHO should first notify the issuing party to attempt to negotiate an agreement as to what the proposed access order should be. If an agreement cannot be reached, a representative of the PHO, or the PHO's legal representative will be required to appear at Court on the return date and argue the question before the presiding registrar (see Section 8.1).

In any District Court civil case where there is no appearance at the return date, the proposed access order will be made automatically by default.

Supreme Court

A subpoena in the Supreme Court must include either a proposed access order for the documents to be produced and reasons for that order, or default access orders. Default access orders means general access to all parties, and includes permission to copy documents.

If a general access order allowing all parties access to the subpoenaed documents at the same time is not objected to, the Supreme Court will automatically make a default order for general access to the documents at the return date.

If PHO wishes to object to a general access order being made (for example, by claiming a privilege), it should notify the party that issued the subpoena and attend court, or arrange for a lawyer to attend court, on the return date and inform the Registrar of its position.

9.2 What if I receive a request for permission to 'uplift' documents?

Courts have photocopying facilities available on site; however, occasionally parties to litigation seek permission from the court to uplift, or temporarily remove the documents from the court to arrange for them to be copied externally, or reviewed in a more convenient setting. A party may request to uplift x-rays or scans which have been provided to the Court in order to obtain a copy to provide to a medical expert for an opinion. The documents are then returned to the court.

As the documents still belong to the subpoenaed party while they are at the court, some courts seek the consent of the subpoenaed party before they will allow the documents to be uplifted.

If a PHO is asked to consent to a party uplifting record, it is recommended that:

- If original documents have been produced, consent to uplift should generally be refused;
- If copies have been produced, consent can be granted on the basis that the documents do not leave the custody of the parties' legal representatives and/or the medical or other professional expert whom the parties' legal representatives have engaged to provide an expert opinion and the document/s are returned to the court in the same condition.

If a court allows documents to be uplifted, it will normally require the legal representative uplifting them to sign a receipt, accepting responsibility for the records whilst they are in the legal representative's possession.

9.3 Are subpoenaed documents returned?

Original documents should always be returned to the PHO.

Subpoenaed documents that are copies should be returned by the court at the conclusion of the matter, unless the PHO has informed the court that the documents may be shredded. If you have any queries contact the Clerk or Registrar of the court.

10 REQUESTS FOR INFORMATION UNDER THE CHILDREN AND YOUNG PERSONS (CARE AND PROTECTION) ACT

10.1 Requests for information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*

Chapter 16A of the *Children and Young Persons (Care and Protection) Act* provides a mechanism for NSW Health staff to exchange information with other human services and justice agencies, to ensure the safety, welfare and wellbeing of children and young people in NSW.

Please refer to the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* PD2013_007 where NSW Health's policy on child protection information exchange is set out in full.

10.2 Requests for information from Family and Community Services

Pursuant to Section 248 of the *Children and Young Persons (Care and Protection) Act*, PHOs may be required to provide information to Family and Community Services. Section 248 is designed to allow an exchange of information about the safety, welfare and wellbeing of children and young people between an agency and Family and Community Services.

Information can only be provided in response to a Section 248 request if it relates to the safety, welfare and wellbeing of a particular child or young person.

Once records have been provided to Family and Community Services in answer to a Section 248 request, Family and Community Services may use them as evidence in legal proceedings. If records are to be used in legal proceedings, they are usually annexed to an affidavit (a sworn statement) prepared by Family and Community Services staff in accordance with arrangements agreed upon between NSW Health and Family and Community Services. Family and Community Services staff are not to attach confidential information provided in response to a Section 248 request to affidavits without the consent of the person who provided the information.

If the document that Family and Community Services wish to attach to the affidavit is particularly sensitive, the PHO should refuse to consent (unless the patient's guardian does not object), and ask Family and Community Services to issue a subpoena seeking a copy of the document instead. Once a subpoena has been served, the PHO may consider whether production can be opposed, or whether any type of privilege can be claimed in respect of the document.

For more information regarding responding to S248 requests refer to to the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* PD2013_007.

11 PRIVACY

Compliance with a subpoena is required by law. Complying with a subpoena will not breach the PHOs obligations under the *Health Records Information Privacy Act 2002* and *Privacy and Personal Information Protection Act 1998* as it is a lawful excuse to release information as long as you provide documents within the scope of the subpoena. For further information about privacy obligations, see Privacy Manual for Health Information.

12 SUBPOENA TO GIVE EVIDENCE

12.1 What should I do if I receive a subpoena to give evidence?

A subpoena to give evidence will require the named person to attend a court on a particular date to be a witness in a hearing and give evidence. The subpoena will be addressed to a specific individual and will indicate the time and place the person will be required to give evidence as a witness.
A person who receives a subpoena should report that fact to his/her administrator/supervisor as soon as practicable.
A person who has been subpoenaed should contact the solicitor who requested the issue of the subpoena to:

(a) confirm that their attendance is still required;
(b) to obtain some better guidance as to when he or she might be required to give evidence; and
(c) confirm that if the solicitor who has issued the subpoena requires the witness to remain on 'standby' rather than come to Court, sufficient notice will be provided if the witness is to be called to Court so that alternative work arrangements can be made.

If the solicitor indicates that a person's attendance is not required, this should be confirmed in writing.

12.2 How much conduct money should I receive if I am required to attend court to give evidence?

Witnesses are entitled to receive conduct money and reasonable expenses from the solicitor or person who has issued the subpoena. Conduct money means a sum of money, or its equivalent, such as pre-paid travel, sufficient to meet the reasonable expenses incurred by the subpoenaed party in attending court as required by the subpoena, and returning from court after attending.

When a subpoena to give evidence is served on a person, the person named is not required to attend court unless conduct money has been handed or tendered to the named person a reasonable time before the date on which attendance is required.
If there is a dispute about conduct money the named person should contact the person who has issued the subpoena and negotiate further conduct money. If no agreement has been reached, but some conduct money has been provided at the time the subpoena was served, the person should still attend the court on the date specified in the subpoena, but advise the court that the conduct money provided is not reasonable and seek an Order from the court that additional conduct money be paid by the person who issued the subpoena.
For medical officers, the AMA has published guidelines relating to reasonable expenses.

13 APPENDIX A – SEXUAL ASSAULT COMMUNICATIONS PRIVILEGE

The Sexual Assault Communications Privilege is set out in the *Criminal Procedure Act 1986*. This privilege protects counselling communication made by, to or about a victim or alleged victim of a sexual assault offence. The Act does this by:

- Requiring the leave (permission) of the court prior to issuing a subpoena seeking access to this information;
- Requiring the leave (permission) of the court prior to accessing documents produced in response to a subpoena; and
- Requiring the leave (permission) of the court prior to this information being used in evidence.

The privilege applies to information regardless of whether it is in written form (for example, a client's file) or in oral form (for example, a health worker being subpoenaed to give evidence).

The privilege applies to criminal, Apprehended Violence orders and some civil proceedings in NSW and may also apply in the courts of other States and Territories of Australia.

13.1 What are counselling communications?

Counselling communications are defined in the Act to include communications made by a person in confidence to a counsellor who is counselling the person in relation to any harm the person may have suffered.

Counselling communications also include communications made in confidence by the counsellor, or by a parent, carer or other support person who is present in the counselling to facilitate communication or to otherwise further the counselling process.

The Act provides that a person counsels another person if the person has undertaken training or study or has experience that is relevant to the process of counselling persons who have suffered harm and the person:

(a) listens to and gives verbal or other support or encouragement to the other person, or

(b) advises, gives therapy to or treats the other person

whether or not for fee or reward.

This wide definition is likely to include counselling provided by a counsellor, health care worker, social worker or youth worker.

A counselling communication is a protected confidence even if:

(a) it was made before the relevant sexual assault offence occurred, or is alleged to have occurred, or

(b) was not made in connection with a sexual assault offence or alleged sexual assault offence.

This means that the privilege could apply to any counselling communications, and not just to counselling following a sexual assault (for example, the privilege could apply to drug and alcohol counselling provided prior to the sexual assault taking place).

13.2 A counselling communication may be made in confidence even if it was made in the presence of a third party if the third party was present to facilitate communication or to otherwise further the counselling process. Can the sexual assault communications privilege be claimed in all types of court proceedings?

The sexual assault communications privilege can be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders ("AVOs").

The privilege applies in any courts that exercises criminal jurisdiction, any may also apply in federal courts, such as the Family Court or Federal Circuit Court, and in the courts of other States and Territories of Australia. The federal court or courts of other States and Territories will consider the application of the privilege in the context of their local laws.

The sexual assault communications privilege can also be claimed in civil proceedings in NSW, but only if:

(a) substantially the same acts are in issue in the civil proceedings as were in issue in relation to previous criminal proceedings; and

(b) the evidence was found to be privileged in the previous criminal proceedings.

13.3 Principles applying to sexual assault subpoenas

In the first instance, where a subpoena is received for patient records that may contain sexual assault communications, attempts should be made to contact the patient and advise that a subpoena has been received for their records and indicate they should seek legal advice. If the patient is not a party to the proceedings (for example, in criminal proceedings) they may not be aware that their records have been subpoenaed.

PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

This obligation is most critical where the patient is a child, or where the disclosure is sought in relation to criminal proceedings and the victim of the assault does not have legal representation. In these cases, the PHO may consider obtaining legal representation to challenge the production of documents under the subpoena.

In cases where there is a high risk of serious harm such as, for example, a high likelihood of suicide or self-harm to the patient if the records are disclosed, the PHO should consider obtaining legal representation to challenge the production of material in response to the subpoena. Harm can be actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

In proceedings where the patient is represented, the PHO may meet its obligation by referring the matter to the patient's legal representative.

If the patient has legal capacity and chooses to waive the privilege, the PHO must respect that decision.

13.4 How does sexual assault communications privilege operate?

13.4.1 Preliminary Criminal Proceedings

Preliminary criminal proceedings are committal or bail proceedings (whether or not they relate to a sexual assault offence).
In preliminary criminal proceedings:

(a) a person cannot seek to compel any other person (whether by subpoena or any other procedure) to produce a document recording a protected confidence;

(b) a document recording a protected confidence cannot be produced; and

(c) evidence cannot be adduced if it would disclose a protected confidence or the contents of a document recording a protected confidence.

13.4.2 Criminal Proceedings

Criminal proceedings include those relating to the trial or sentencing of a person for an offence (whether or not they relate to a sexual assault offence) and also proceedings for an AVO.
In criminal proceedings, unless the court grants leave:
(a) a person cannot seek to compel any other person (whether by subpoena or other procedure) to produce a document recording a protected confidence;
(b) a document recording a protected confidence cannot be produced; and
(c) evidence cannot be adduced if it would disclose a protected confidence or the contents of a document would recording a protected confidence.
The court will not grant leave unless the court is satisfied that;

(a) the document or evidence will have substantial probative value; and

(b) other documents or evidence concerning the matters to which the protected confidence relates are not available; and

(c) the public interest in preserving the confidentiality of protected confidences and protecting the victim from harm is substantially outweighed by the public interest in admitting into evidence information or the contents of a document of substantial probative value.

The court is also required to take into account certain matters, including the need to encourage victims of sexual offences to seek counselling and the fact that disclosure is likely to undermine the relationship between counsellor and patient.

13.4.3. Civil Proceedings

The privilege can only be claimed in a civil proceeding where substantially the same acts are in issue as the acts that were in issue in relation to a criminal proceeding.
Where evidence was found to be subject to sexual assault communications privilege in the criminal proceeding, that evidence may not be adduced in the civil proceeding.
In civil proceedings where the *Uniform Civil Proceedings Rules 2005* apply, a party can also object to production of a document on the basis of the privilege in these circumstances, and cannot be compelled to produce the document until the objection is overruled.
If you have received a subpoena to produce in a civil proceeding where the documents cover sexual assault communications, you should make enquiries as to whether there were criminal proceedings in relation to the acts which are the subject of the communications.
If you are unable to make such enquiries, you should place the documents into a sealed envelope marked "**Sexual assault communications – may be subject to s 126H of the Evidence Act 1995**" when producing the documents to the court.

13.5 What happens if there is a dispute about whether a document or evidence contains a protected confidence?

If a party has requested leave to subpoena documents that contain a protected confidence or to adduce evidence that contains a protected confidence, notice must be given in writing to each other party and the patient. A patient who is not a party may appear in criminal proceedings if this occurs.

If you have received a subpoena that covers sexual assault communications and you are unsure if leave has been sought, you should contact the relevant Registry and object to production until such time as the Registry confirms leave has been granted.

If leave has been granted, objection to access may still be made.

Before a court can make a decision about the documents, they must be produced to court, with an objection to their production noted, so the court can rule on the objection. This means that the PHO must produce the documents to the court in a sealed envelope marked "**Sexual assault communications privilege claimed**". The court will inspect the documents in order to determine whether the claim for privilege will be upheld. Some courts will not uphold a claim for privilege without hearing legal argument from the issuing party and the subpoenaed party. PHOs should recognise that producing the documents marked privilege may not be sufficient for a claim for privilege to be successful. Legal argument may be necessary.

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard 'in camera' (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence, or the identity of the confider. The court may also make orders limiting who may inspect documents produced.

14 APPENDIX B – PROFESSIONAL CONFIDENTIAL RELATIONSHIP PRIVILEGE

14.1 What is a protected confidence for the purpose of claiming professional confidential relationship privilege?

A protected confidence is a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication. A communication may be made in confidence even if it is made in the presence of a third party if the third party's presence is necessary to facilitate communication.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records.

The aim of the privilege is to protect marginalised groups (other than victims of sexual assault in relation to whom the sexual assault communications privilege may apply) such as mental health patients and HIV positive patients, who may not seek medical treatment if they are concerned that professional confidentiality will not be maintained.

The rationale for the privilege is that some relationships between health professionals and patients will be severed, if trust and confidentiality are not maintained. This rationale may not apply to a patient's relationship with a Hospital or PHO, where the patient is treated by a team, and may not form a special relationship with a particular health professional.

14.2 Can the professional confidential relationship privilege be claimed in all types of court proceedings?

The privilege can be claimed in all NSW courts or federal Courts operating in NSW, such as the Family Court or Federal Circuit Court, and in the courts of other States and Territories of Australia. The federal court or courts of other States and Territories will consider the application of the privilege in the context of their local laws.

14.3 How does professional confidential relationship privilege operate?

The court may direct that evidence not be used in proceedings, if the court finds that using it would disclose a protected confidence, or the contents of a document recording a protected confidence.

The court can come to this decision on its own initiative, or on an application from the protected confider (the patient) or the confidant (the health professional).

The court must decide not to use evidence about a protected confidence if, it is likely that harm would be caused to the protected confider (the patient) if the evidence is used and if the nature and extent of the harm outweighs the desirability of the evidence being given. It is generally desirable, however, for the evidence to be given. The more important the evidence is, particularly if it is not available from an alternative source, the more desirable it is.

Harm includes actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard ‘in camera’ (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence.

The privilege can be waived if the confider consents.

14.4 What will the court take into account when deciding whether the privilege applies?

The court will consider a range of factors, including the following:

(a) the extent to which the evidence could affect the assessment of a fact in issue in the proceedings;

(b) the importance of the evidence in the proceeding;

(c) the nature and seriousness of the relevant offence, cause of action or defence and the nature of the subject matter of the proceeding,

(d) the availability of any other evidence concerning the matters to which the protected confidence or protected identity information relates,

(e) the likely effect of using evidence of the protected confidence, including the likelihood of harm, and the nature and extent of harm that would be caused to the patient,

(f) the means available to the court to limit the harm or extent of the harm that is likely to be caused if evidence of the protected confidence or the protected identity information is disclosed,

(g) if the proceeding is a criminal proceeding—whether the issuing party is a defendant or the prosecutor, and

(h) whether the substance of the protected confidence or the protected identity information has already been disclosed by the patient or any other person.

15 APPENDIX C – COMMON COURTS AND TRIBUNALS

15.1 The Family Court of Australia and Federal Circuit Court of Australia

The Family Court and Federal Circuit Court resolve and determine family disputes, including disputes about the care, custody and maintenance of children.

The Family Court also provides consent for special medical treatment (such as sterilisation, surgical gender reassignment and the harvest of bone marrow blood cells from a disabled child for transplantation into a relative) to be carried out on minors.

15.2 The Supreme Court of New South Wales

The highest court in the State is the Supreme Court of NSW. It has unlimited civil jurisdiction and handles the most serious criminal matters.

The Supreme Court also deals with Adoption matters and has *parens patri* jurisdiction which can include applications related to the care and protection of children and young persons, medical treatment, and secure detention.

The Court of Appeal and Court of Criminal Appeal hear appeals from decisions made in most of the Courts of New South Wales and from decisions made by a single judge of the Supreme Court.

15.3 The District Court of New South Wales

The District Court deals with criminal and civil cases. The District Court has jurisdiction to hear:

(a) all indictable criminal offences (except murder, treason and piracy); and

(b) civil matters with a monetary value up to $750,000, - or greater with the consent of the parties. The Court also has an unlimited jurisdiction in respect of motor accident cases and work injury damages cases.

The Court's judges hear appeals from the Local Court and also preside over a range of administrative and disciplinary tribunals.

15.4 The Local Court of New South Wales

The Local Courts are the courts of general access in New South Wales. There are 157 Local Courts in NSW. They have jurisdiction to deal with:

- the vast majority of criminal and summary prosecutions;
- civil matters with a monetary value of up to $100,000;
- committal hearings;
- family law matters;
- child care proceedings;
- juvenile prosecutions and care matters; and
- coronial inquiries.

In the Local Court, Magistrates hear criminal cases that do not need a judge and jury. These are called summary offences and include traffic matters, minor stealing, offensive behaviour, and some types of assault. Magistrates also hear applications for apprehended violence orders where one person is seeking a restraining order against another.

A Magistrate conducts committal proceedings to decide if there is enough evidence for a serious matter, such as armed robbery, or attempted murder, to go before the District Court or the Supreme Court.

Children's Courts deal with criminal matters involving children who are younger than 18 and care applications concerning children who are in need of care or protection.

15.5 The NSW Civil and Administrative Tribunal

The NSW Civil and Administrative Tribunal ("NCAT") was established on 1 January 2014 by the *Civil and Administrative Tribunal Act 2013* (NSW), consolidating the work of 22 former tribunals (including the Guardianship Tribunal, Administrative Decisions Tribunal and the occupational tribunals) into a single specialist tribunal service. NCAT is made up of four divisions:

- Consumer and Commercial;
- Occupational;
- Guardianship; and
- Administrative and Equal Opportunity.

NCAT deals with a broad range of matters including review of administrative decisions made by government agencies, discrimination matters, complaints concerning professional conduct and discipline and determining applications for guardianship.

15.6 Workers Compensation Commission

The Workers Compensation Commission deals with workers compensation disputes arising out of work related injury or disease suffered by a worker in New South Wales. In addition, the Commission administers medical panels which assess a worker's condition or fitness for employment in circumstances specified in legislation.

15.7 Coroner's Court of New South Wales

Coroners are situated around New South Wales in Local Courts. They inquire into the circumstances surrounding deaths that are reported to them.

The State Coroner's role is to ensure that all deaths, suspected deaths, fires and explosions which are under the Coroner's jurisdiction are properly investigated, and where the law requires an inquest to be held, or in cases whether the Coroner believes an inquest is necessary, a full inquest is undertaken.

15.8 Drug Court of New South Wales

The Local or District Court in the defined catchment area must refer offenders who appear to meet the Drug Court obligatory criteria, to the Drug Court.

The aim of the Drug Court is to protect the public by ensuring drug dependent offenders engage in longer term treatment. The Court works in collaboration with a number of other organisations. These include Corrective Services NSW and NSW Health.

15.9 Dust Diseases Tribunal

The Dust Diseases Tribunal hears and determines claims for dust related diseases suffered as a result of exposure to dust. Dust diseases include mesothelioma, asbestosis, silicosis and certain types of lung cancer. The Dust Diseases Tribunal follows the procedural rules of the Supreme Court of New South Wales.

15.10 Children's Court of New South Wales

The Children's Court is a specialist court to deal with criminal cases, applications for apprehended violence orders, applications for compulsory schooling orders and cases involving the care and protection of children.

15.11 Industrial Relations Committee

The NSW Industrial Relations Commission is the court which hears matters relating to the workplace. The role of the Commission is to regulate workplace affairs in NSW and arbitrate to resolve industrial disputes.

HEALTH RECORDS AND MEDICAL/CLINICAL REPORTS - CHARGING POLICY (PD2006_050)

PD2006_050 rescinds PD2005_235.

The contents of this policy directive are to be effective from the date of issue and replaces PD2005_235 (dated 14 February 2002).

The following relates to charges for health records and medical/clinical reports that are to apply unless specific legislation specifies a lesser rate or exemption from fees. Health Services should develop local policies, which detail the content of records and reports as they relate to these charges. These policies should take into account the function of the health facility, the type of report produced and the amount of information to be provided.

Rates are advised separately via Information Bulletin.

The decision to charge for requests for health records and medical/clinical reports from researchers is a matter for local determination depending upon the type of request and possible future benefit to the health system. Such charges should be determined on a cost recovery basis.

For the purposes of this policy directive a health record is defined as a documented account, whether in hard or electronic form, of a client/patient's health, Illness and treatment during each visit or stay at a health service (and includes a medical record).

Charges relating to categories A, B and C (below) are taxable supplies (ie subject to GST) unless deemed GST - free under the provisions of the '*A New Tax System (Goods and Services Tax) Act 1999*' (*GST Act*). The criteria to be followed by the Area Health Services/Hospitals in assessing the GST status are advised in the GST section of this circular. Please note that where the service is determined as being 'GST-free' the rates as advised by Information Bulletin apply. Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates as advised by Information Bulletin are to be grossed-up by 10%.

A CHARGES FOR MEDICAL/CLINICAL REPORTS apply based on the following categories:

1. Preparation of a medical report by a medical practitioner appointed to or employed by the health institution/hospital **requiring no further examination of the patient.** This applies to the treating medical practitioner or a medical practitioner who has not previously treated the patient.
2. A report made by a **treating** medical practitioner appointed to or employed by the health institution/hospital **where a re-examination of the patient is required.**
3. A report made by a medical practitioner appointed to or employed by the health institution/hospital **who has not previously treated the patient where an examination is required.**
4. Preparation of a report by an **allied health professional, other than a medical practitioner,** appointed to or employed by the health institution/hospital.

B OTHER CHARGES apply based on the following criteria:

1 (a) Charges for access to clinical notes requested by a patient/client, or by a person acting on behalf of the patient.

A patient/client can apply for access to their own personal health information held by a public health organisation, by contacting the medical records department for that organisation. In addition, the *Freedom of Information Act 1988* and the *Health Records and Information Privacy Act 2002* provide a statutory right for individuals to apply for access to information held about them.

These laws also allow for other persons to apply for access to a client/patient's personal health information. A person can apply for access on behalf of the patient/client with their consent, such as a solicitor, interpreter or employer. Alternatively, where the patient lacks the capacity to consent, or is deceased, a person who is the authorised representative for the patient/client can apply for access to the patient/client's personal health information.

NB. Further details are contained in NSW Health Privacy Manual Version 2, Sections 5.6 and 11.2.2.

Copies of clinical notes supplied in response to the above requests may typically include, as a minimum: patient registration/front sheet, consent to treatment, discharge summary, referral/transfer letters, ambulance report, continuation notes, operation reports (including anaesthetists and nursing reports), radiology and pathology reports, and nursing care plan. Where additional information is held by a hospital but not routinely released, the person making the request should be made aware that such additional information exists but has not been supplied. A further request for such additional information should be considered as forming part of the original request and no additional charge (other than photocopying, where appropriate) should be raised.

(b) Charges for information requested by an insurer.

Health facilities should not provide clinical notes or photocopies of notes to the insurer, but may supply a "Medical Report" or "Summary of Injuries" (Section A or C) if provided with a Statutory Declaration signed by the claimant on the insurer's claim form in respect of Compulsory Third Party (CTP) insurance or a declaration signed by the claimant on the insurer's claim form in respect of Workers Compensation Insurance. Such reports should only provide information **relevant to the claim.** This will necessitate the insurer detailing the nature of the claim. Health facilities will be required to exercise their judgement in determining what is relevant information. A photocopy of the CTP Statutory Declaration is acceptable irrespective of the date of signing.

If clinical notes, or part of the clinical notes, are requested by an insurer, the insurer should be requested to provide written consent from the patient stating that the patient:

- agrees to allow the insurer to have a copy of all or part of the clinical notes and
- the patient is aware that clinical notes, or part of the clinical notes, will inevitably include confidential medical information, which is irrelevant to the claim.

In the absence of clearly documented written consent, as detailed above, hospitals are not required to provide clinical notes to insurers.

The charge applicable in respect of 1(a) and 1(b) (above), which includes search fee, photocopying charges, labour costs, administrative charges and postage, is based on the following criteria:

- A set fee for the provision of a copy of the medical record, or part thereof, eg continuation notes, pathology reports, charts. (Maximum eighty pages.)
- An additional per page rate in excess of eighty
- An additional charge at cost recovery for the provision of other material (eg reproduction of X-rays, audiovisual tapes, copies of photographs & operation footage contained on DVD's).

Where a patient wishes to access her/his records under the *Freedom of Information Act*, the requirements of that Act (including charges) apply.

2 **Search Fees** - Other than requests made by a party concerned with a patient's continued treatment or future management.

The search fee should be charged:

- for searching for the health record, irrespective of whether the health record is found. If however, the Patient Master Index (PMI) or other indexes showed that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the fees should be refunded in full;
- where the applicant subsequently advises that a report/record is no longer required, or where a thorough search has ascertained that the patient has never attended that health institution for that particular episode of illness;
- for information on date or time of birth, including requests from the Registry of Births Deaths and Marriages in relation to enquiries on hospitals to verify birth details;
- for Motor Accident and Work Cover medical certificates completed at other than time of consultation;
- **NOTE** - The search fee is a component of the fees charged for the preparation of reports, summaries or the production of health records required by subpoena, ie additional fees should **not** be charged on top of those for the preparation of reports, summaries and the production of health records required by subpoena.

The fee covers processing time, which includes time for locating the information, decision-making and consultation where necessary.

C **SUMMARY OF INJURIES** charges apply based on the following:-

"Summary of Injuries" - this is generally requested by Compulsory Third Party Insurers for patients whose fees are covered by the Bulk Billing Agreement.

The "Summary of Injuries" should include:

- Identifying information (name, date of birth, medical record number)
- Date of first attendance,
- Whether patient was admitted. If so, specify dates,
- Positive findings on examination,
- Level of consciousness, if documented,
- Diagnosis, if known.

A standard form letter may be appropriate.

If a discharge summary, or appropriate correspondence that provides this minimum information, is available at the time of the request, a copy of this may be sufficient. Should further information be required, the appropriate report charge as applicable to Section A or B should be raised. There is no requirement to provide the full clinical notes to third party insurers.

The purpose of the "Summary of Injuries" in relation to the bulk-billing agreement is to establish that the admission occurred as a result of a motor vehicle accident.

If the information contained in the "Summary of Injuries" is insufficient or unavailable and a medical practitioner (or other treating health professional, where appropriate) is required to prepare a report, charges for a medical report (or report by a treating health professional) should be raised.

Health Information Managers should consult with the requesting solicitor/insurer/other party to determine which is required before a fee is raised or report is prepared.

Goods and Services Tax (GST) in relation to categories A, B & C (above).

In relation to categories A, B & C above the fees/charges set by NSW Health that are taxable supplies or that Health Services are to consider for GST implications are as follows:

- Where revenue derived from the preparation of Clinical Reports is in the context of the Medical Officers Rights of Private Practice the service is to be regarded as a taxable supply.
- Where the income derived is treated as public hospital revenue, consideration is to be given as to whether it satisfies GST-free status under section 38-250 of the '*A New Tax System (Goods and Services Tax) Act 1999*' (*GST Act*).
  ie. Supplies are GST-free if:-
  - the charge is less than 50% of the GST inclusive market value of the supply; or
  - the charge is less than 75% of the cost to the supplier of providing the supply.
- NB. Further details are contained in section 3.3 (pages 22 to 24) of the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" which is available on the NSW Health Intranet.
- All Area Heath Services need to ensure that documentation/systems exist to compare the costs (including overheads) of providing health records and medical reports, and being able to assess the GST status as detailed above.
- Where the service is determined as being 'GST-free' the rates advised by Information Bulletin apply,
  or
- Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates advised by Information Bulletin are to be grossed-up by 10%.

D HEALTH RECORDS REQUIRED TO BE PRODUCED BY SUBPOENA

This refers to the retrieval of all the information required by the schedule noted on the subpoena and forwarding it to Court.

Charges apply based on the following:

1. where at least 5 working days notice is given for the production of the record to Court
2. where less than 5 working days notice is given

plus a photocopying charge per page as advised by Information bulletin.

- Multiple requests on a subpoena should be charged on a fee-per-patient basis.
- In a situation where no record is found, it is appropriate to raise a Search Fee for each record, particularly in situations where incorrect details are given or "blanket" subpoenas are issued and considerable time is spent in locating the record. However, if the PMI or other indexes shows that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the search fee should not be charged.
- Charges under this category are not subject to GST as they are **'out of scope'** under a Division 81 Determination.
- Reference should also be made to **PD2010_065** headed 'Subpoenas', which outlines legislative provisions and procedures to be followed when public health organisations are required to produce documents on subpoena.

E ADMINISTRATIVE PROCEDURES

1 Policies and procedures regarding access to health records and disclosure of personal information should be made in accordance with the NSW Health Privacy Manual Version 2.

2 Applicants should be asked to put all requests in writing and to provide as much information as possible. A patient's solicitor should include consent by the patient for access to personal records as detailed in the Information Privacy Code of Practice.

3 Where the original of a health institution's health record leaves the institution (eg health records being tendered to a Court under subpoena), a copy of those records should generally be made beforehand and kept in the institution. Charges for photocopying should be charged at the appropriate per page rate as advised by Information Bulletin. This charge does not apply to Coroner's or Complaints Unit cases.

4 Charges should be collected in advance, where appropriate. For government departments, reimbursement may be sought subsequently from the relevant department or authority. Even where health records are required to be produced by subpoena, payment should still be sought in advance. It is emphasised that a hospital or organisation is expected to comply in due time with the requirements of a subpoena. Non-compliance may result in contempt of Court, which is punishable by fine or in certain cases imprisonment.

5 It may be decided that an examination of the patient (by either the treating medical practitioner or a medical practitioner who has not previously treated the patient) is required. Under such circumstances, the applicant should be asked to pay the balance of the money for the higher fee before proceeding with the request.

6 Fees collected are to be recorded as revenue in the General Fund.

7 Where there are disputes regarding fees or the amount of information, attempts should be made to resolve the matter between the parties involved. This would normally involve the Chief Health Information Manager and/or the General/Medical administration of the health facility.

F CIRCUMSTANCES UNDER WHICH A CHARGE SHOULD NOT BE RAISED

1 When the request has been made by a party concerned only with the patient's continued treatment and/or future management, no charge should be raised (eg where a medical practitioner requests information from a health institution to assist him/her with that patient's treatment);

2 The GIO or EML as Managers, Treasury Managed Fund or solicitors acting for the GIO or EML in such matters, in respect of claims for workers compensation for employees of Public Hospitals, Public Psychiatric Hospitals (former 5th schedule hospitals), the NSW Ambulance Service and the NSW Department of Health. Health facilities should ensure that solicitors acting for the GIO or EML specify in writing that this is the case;

3 Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing;

4 The Department of Community Services or the Police in respect of children suspected of being abused, or of a parent of a child so suspected;

5 The completion of medical certificates at the time of consultation - no charge should be made as the forms for motor accident and WorkCover certificates are in the nature of a certificate and not a report. If not completed at the time of consultation, a search fee may be raised.

G CIRCUMSTANCES UNDER WHICH CHARGES SHOULD BE RAISED

In all cases where the conditions in Section F have not been met including:

1 When medical reports/records are requested by individuals, solicitors, insurance companies, health professionals and government departments (with the exception of those indicated in Section F) for purposes other than the patient's continued treatment or future management.

2 The Department of Veterans' Affairs and Centrelink for the purpose of pension/benefits assessment;

3 Interstate Health Authorities in respect of the eligibility of candidates for appointment to the relevant Public Service.

4 NSW Compulsory Third Party Insurers, in respect of a "Summary of Injuries". (Refer to Section C).

5 Release of information under the NSW *Adoption Information Act 1990*. Charges should be raised in accordance with PD2016_036 or any document subsequently amending its provisions.

ENQUIRIES

- pertaining to the **level of charges and GST implications** refer to the latest Information Bulletin on 'Charges for Health Records and Medical/Clinical Reports and the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" (available on the NSW Health Intranet site) respectively or contact Trevor Smith, Finance and Business Management on (02) 9391 9158.
- pertaining to **access of information** refer to Privacy Manual for Health Information (March 2015), or contact Legal Branch on 9391 9606.
- pertaining to **records management policy** should be referred to the Informatics Senior Project Officer on (02) 9391 9155.

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Health Records and Medical/Clinical Reports rates and Fees for Cremation Certificates Issued by Salaried Medical Practitioners of Public Hospital are advised annually by Information Bulletin. Refer to the Policy Distribution System for the latest Information Bulletins. https://www.health.nsw.gov.au/policies/Pages/default.aspx

CONSENT TO MEDICAL AND HEALTHCARE TREATMENT (IB2020_010)

IB2020_010 rescinds PD2005_406

PURPOSE

The purpose of this Information Bulletin is to advise of the release of the *Consent to Medical and Healthcare Treatment Manual.*

KEY INFORMATION

An electronic version of the Manual can be found on the health website at: https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx

The Consent Manual replaces PD2005_406 *Consent to Medical Treatment – Patient Information. (***Note***:* PD2005_406 is rescinded).

The Consent Manual provides operational guidance and procedures to support compliance with the NSW law on obtaining consent to medical and healthcare treatment from patients or their substitute consent providers. It incorporates the following changes:

- Amendments to the *Mental Health Act 2007* including the removal of concept of' primary carers' and the introduction of 'designated carers' and 'principal care providers'
- Amendments to the *Health Records and Information Privacy Act 2002* regarding the disclosure of genetic information to affected relatives
- Clarification that 'mature minors' can consent to or refuse their own treatment, and the circumstances where these decisions can be overridden
- Guidance for Health Practitioners when patients refuse recommended medical treatment in an obstetric setting
- Guidance for Health Practitioners when patients or their parents/guardians seek discharge against medical advice
- Additional information on electronic capture of consent
- Six new state wide consent forms.

The Consent manual is to be implemented by all NSW Health Agencies

327(30/03/20)

ADULT-TO-ADULT LIVING DONOR LIVER TRANSPLANTATION GUIDELINES (GL2008_019)

The purpose of the guideline is to provide guidance to health professionals and additional protection for prospective adult Living Donor Liver Transplantation (LDLT) donors. This guideline is aimed primarily at the jurisdictions that will endorse LDLT, the institutions that will provide LDLT, and the health professionals directly involved in this practice. To the extent that it is adopted by all jurisdictions in line with the particular requirements of their human tissue legislation, and applied in participating liver transplant units, it will promote ethical, lawful and consistent application of quality processes in provision of this complex procedure to donors, recipients and their families.

It should be read in conjunction with **PD2005_406**.

The document can be accessed at: http://www.health.nsw.gov.au/policies/gl/2008/GL2008_019.html

NOTIFICATION OF INFECTIOUS DISEASES UNDER THE *PUBLIC HEALTH ACT 2010* (IB2013_010)

IB2013_010 rescinds IB2012_011.

PURPOSE

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the Ministry of Health website.

NOTIFICATION MECHANISMS

- Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.
- In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.
- Disease notification guidelines for notifiers are available at: **www.health.nsw.gov.au/Infectious/Pages/notification.aspx**

NOTIFICATION FORMS

Doctors and Hospitals

- Doctors and hospital chief executive officers (or general managers) must notify scheduled medical conditions and provide information specified in the **Doctor/Hospital Notification Form**, either by telephone or in writing. The notification can be found at: **http://www.health.nsw.gov.au/Infectious/Documents/doctor-hospital-notification-form.pdf**
- Notifications for AIDS must only include the first 2 letters of the patient's first and last names, and date of birth. Full name and addresses are not to be included.
- The **AIDS Notification Form** can be found at: **http://www.health.nsw.gov.au/Infectious/Documents/aids_notification_form.pdf**

Laboratories

- Laboratories must notify scheduled medical conditions and provide information specified in the **Laboratory Notification Form**, either by telephone or in writing.
- The laboratory notification form can be found at: **http://www.health.nsw.gov.au/Infectious/Documents/ph_labs2010b.pdf**
- Notifications for HIV infection should only include the first 2 letters of the patient's first and last names, and date of birth. Full name and addresses are not to be included.
- Laboratories carrying out confirmatory testing for HIV must notify infections directly to Communicable Diseases Branch. The **HIV notification form** can be found at: **http://www.health.nsw.gov.au/Infectious/Forms/hiv-notification-form.pdf**

NSW PERINATAL DATA COLLECTION (PDC) - REPORTING AND SUBMISSION REQUIREMENTS FROM 1 JANUARY 2016 (PD2015_025)

PD2015_025 rescinds PD2010_072.

PURPOSE

This Policy Directive is effective from 1 January 2016. It covers reporting and submission requirements for the Perinatal Data Collection (PDC), which is used for statewide surveillance to monitor patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

MANDATORY REQUIREMENTS

This policy applies to all midwives and doctors working in public and/or private facilities where a birth occurs. Reporting of all births in NSW to the PDC is a statutory requirement under the NSW *Public Health Act 2010*.

A PDC record must be completed for all births in NSW, including live born babies regardless of gestational age or birth weight, and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

From 1 January 2016 all records must be submitted in accordance with the timeframes described in section 1.3 of the following *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures*.

Section 3 of the following *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures* details the data items to be reported. Section 5 details the mandatory security requirements for data management.

IMPLEMENTATION

Chief Executives of LHDs and General Managers of Private Hospitals are to ensure:

- This policy directive is distributed to all staff involved in collecting and supplying data for the PDC. This includes staff of obstetric and neonatal units, medical record and information services staff.
- Staff have access to electronic systems able to collect the data items in accordance with Section 3 of the following *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures* by 1 January 2016.
- Data collected in accordance with the statutory requirement and this policy directive is submitted in compliance to the schedule provided in the form required for submission.

1. BACKGROUND

1.1 About this document

From 1 January 2016, this Policy Directive rescinds and replaces Policy Directive PD2010_072 concerning the NSW Perinatal Data Collection. This Policy Directive applies to reporting of births to the NSW Perinatal Data Collection (PDC) from 1 January 2016.

The Perinatal Data Collection (PDC) is used for statewide surveillance, monitoring patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

1.2 Key definitions

PDC records must be completed for **all births in NSW**, including live born babies regardless of gestational age or birth weight and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

1.3 Legal and legislative framework

Reporting of all births in NSW is a requirement of the NSW *Public Health Act 2010*. A record for each birth occurring within a Collection Period Quarter must be reported no later than three months after the close of the quarter, based on the date of birth of the baby. The following table lists the due dates for submission of PDC data:

Collection Period	Last Date for Data Submission in Collection Period	Deadline for Correction and Resubmission
Quarter 1 (1 Jan - 31 Mar)	30 June	11 August
Quarter 2 (1 Apr - 30 Jun)	30 September	11 November
Quarter 3 (1 Jul - 30 Sep)	31 December	11 February (following year)
Quarter 4 (1 Oct - 31 Dec)	31 March (the following year)	12 May

Any errors detected in submitted data are to be corrected and resubmitted **within 6 weeks of the date of final data submission**.

It should be noted that the table above shows the last acceptable date for initial data submission. Data may be supplied and accepted on a more frequent basis (eg weekly or monthly) to allow suppliers to obtain more timely feedback on the quality of births data that may better suit the operational processes of the supplier.

It is intended that the Collection Period and final date will be reduced in subsequent collection years and appropriate advice on the applicable Collection Periods will be published.

2. METHOD OF REPORTING

For births on or after 1 January 2016 PDC records must be submitted electronically in the form specified. The method of submission of PDC records is dependent on the type of collection/ submission entity as follows:

- Public Hospitals with maternity units are to submit records directly to EDWARD using a data extract from their maternity information system.
- Private Hospitals are to submit data to PeriPH. PeriPH will apply further processing prior to sending PDC records to EDWARD.
- Independent Midwives will submit data by direct data entry via a secure web-based form (PeriForm). This data, after processing, will be sent to EDWARD. Hospitals without maternity units will be able to utilise PeriForm to submit records for the individual births they manage.

EDWARD will hold the consolidated PDC data for births occurring on or after 1 January 2016.

While the required PDC data is constant, the receipt and processing platform will determine some differences in the extract format.

Paper forms will not be accepted or processed by the Ministry for any births on or after 1 January 2016.

3. DATA ITEMS TO BE REPORTED

3.1 Overview

This section lists the data that must be reported. Details of each of the items, including definitions, reportable values and guide for collection and use are provided in the PDC 2016 Data Dictionary.

As the data are submitted through different mechanisms and from different sources the requirements differ. The tables below specify the data to be reported by collection entity.

Y Required to be reported
n/a Not Applicable for the collection entity

3.2 Perinatal Data Provider

Item	Public Hospital	Private Hospital	Independent Midwife
Perinatal notifier identifier	Y	Y	Y
Perinatal notifier type code	Y	n/a	n/a

3.3 Mother Details

Item	Public Hospital	Private Hospital	Independent Midwife
Mother Client ID (medical record number or other defined identifier)	Y	Y	n/a
Given name	Y	Y	Y
Middle names	Y	Y	Y
Family name	Y	Y	Y
Full address of residence (including street number and name, locality, postcode and state/territory)	Y	Y	Y
Country of residence	Y	Y	Y
Country of birth	Y	Y	Y
Date of birth	Y	Y	Y
Indigenous status	Y	Y	Y

3.4 Newborn Details

Item	Public Hospital	Private Hospital	Independent Midwife
Newborn Client ID (medical record number or other defined identifier)	Y	Y	n/a
Given name	Y	Y	Y
Middle names	Y	Y	Y
Family name	Y	Y	Y
Indigenous status	Y	Y	Y
Baby birth date	Y	Y	Y
Baby birth status (livebirth/stillbirth)	Y	Y	Y
Sex	Y	Y	Y
Plurality	Y	Y	Y
Birth order	Y	Y	Y
Birth weight	Y	Y	Y
Estimated gestational age	Y	Y	Y
Apgar score at 1 and at 5 minutes	Y	Y	Y
Baby resuscitation type	Y	Y	Y

3.5 Pregnancy Details

Item	Public Hospital	Private Hospital	Independent Midwife
Previous pregnancy indicator	Y	Y	Y
Previous pregnancies count	Y	Y	Y
Last birth by caesarean section indicator	Y	Y	Y
Previous caesarean section count	Y	Y	Y
Mother's height (cm)	Y	Y	Y
Mother's weight (kg)	Y	Y	Y
Antenatal estimated date of birth	Y	Y	Y
Antenatal care received indicator	Y	Y	Y
Pregnancy duration at 1st antenatal care	Y	Y	Y
Number of antenatal visits (Antenatal service contact count)	Y	Y	Y
Mother tested for HIV Flag	Y	Y	Y
Mother immunised against pertussis in this pregnancy	Y	Y	Y
Mother immunised against influenza in this pregnancy	Y	Y	Y
Mother diabetes type	Y	Y	Y
Mother chronic hypertension flag	Y	Y	Y
Mother preeclampsia flag	Y	Y	Y
Mother gestational hypertension	Y	Y	Y
Mother eclampsia flag	Y	Y	Y
Hepatitis B surface antigen positive	Y	Y	Y
Smoking in first half of pregnancy	Y	Y	Y
Average number of daily cigarettes smoked in first half of pregnancy	Y	Y	Y
Smoking in second half of pregnancy	Y	Y	Y
Average number of daily cigarettes smoked in second half of pregnancy	Y	Y	Y
Quit smoking in this pregnancy	Y	Y	Y
If quit smoking in this pregnancy, at what gestation week?	Y	Y	Y

3.6 Labour and Delivery

Item	Public Hospital	Private Hospital	Independent Midwife
Labour onset type	Y	Y	Y
Labour induced with oxytocins	Y	Y	Y
Labour induced with prostaglandins	Y	Y	Y
Labour induced by artificial rupture of membranes	Y	Y	Y
Labour induced by other means	Y	Y	Y
Main indication for induction of labour	Y	Y	Y
Labour augmented with oxytocins	Y	Y	Y
Labour augmented by artificial rupture of membranes	Y	Y	Y
Presentation at birth	Y	Y	Y
Analgesia provided in labour – various types	Y	Y	Y
Type of birth	Y	Y	Y
Main indication for caesarean section	Y	Y	Y
Anaesthesia provided during delivery – various types	Y	Y	Y
Perineal status	Y	Y	Y
Episiotomy indicator	Y	Y	Y
Surgical repair of the vagina or perineum	Y	Y	Y
Management type applied in 3rd stage	Y	Y	Y

3.7 Maternity Care

Item	Public Hospital	Private Hospital	Independent Midwife
Model of care during pregnancy	Y	Y	Y
Model of care at birth	Y	Y	Y
Place of birth	Y	Y	Y

3.8 Postnatal Care

Item	Public Hospital	Private Hospital	Independent Midwife
Postpartum haemorrhage within 24 hours of birth	Y	Y	Y
Postpartum haemorrhage within 24 hours of birth requiring blood transfusion	Y	Y	Y
Postpartum haemorrhage within 24 hours of birth – estimated blood loss	Y	Y	Y
Congenital condition present flag	Y	Y	Y
Congenital condition(s) description	Y	Y	Y
Newborn hepatitis B birth dose	Y	Y	Y

3.9 Discharge status of mother and baby

Item	Public Hospital	Private Hospital	Independent Midwife
Discharge status of mother	Y	Y	Y
Mother's date/time of discharge or transfer	Y	Y	Y
Hospital mother transferred to	Y	Y	Y
Discharge status of baby	Y	Y	Y
Baby's date/time of discharge or transfer	Y	Y	Y
Hospital baby was transferred to	Y	Y	Y
Baby feeding on discharge (various)	Y	Y	Y

3.10 System and Service event details

Item	Public Hospital	Private Hospital	Independent Midwife
Mother client identifier – issuing authority	Y	n/a	n/a
Mother client identifier type code	Y	n/a	n/a
Mother service encounter record identifier	Y	n/a	n/a
Mother service event record identifier	Y	n/a	n/a
Mother service event source identifier	Y	n/a	n/a
Mother service event type code	Y	n/a	n/a
Newborn client identifier – issuing authority	Y	n/a	n/a
Newborn client identifier type code	Y	n/a	n/a
Newborn service encounter record identifier	Y	n/a	n/a
Newborn service event record identifier	Y	n/a	n/a
Newborn service event source identifier	Y	n/a	n/a
Newborn service event type code	Y	n/a	n/a
Perinatal birth record identifier	Y	Y	n/a
Perinatal pregnancy record identifier	Y	Y	n/a
Perinatal record source identifier	Y	n/a	n/a
Source create date and time	Y	n/a	n/a
Source modified date and time	Y	n/a	n/a
Perinatal record action type	Y	Y	n/a

4. DATA QUALITY

Data quality checks are made to ensure that all data submitted is compliant with the PDC as specified by the PDC 2016 Data Dictionary. Checks are made as the data is submitted to PeriPH or EDWARD or entered via PeriForm.

Incomplete records or records with errors will be identified and an error report made available to the submitting hospital. These records must be corrected and re-submitted by the reporting entity within the time stipulated (i.e. within 6 weeks of the date of final data submission).

In order to validate the enumeration of births for each calendar year a list of reported births are sent to each hospital and is to be validated against the hospital birth register.

5. SECURITY OF DATA

The Privacy Manual for Health Information (March 2015) and the Privacy Management Plan (Policy Directive PD2015_036) must be observed for all data relating to the PDC.

Public hospitals with maternity units will submit data to EDWARD from behind the electronic security framework of NSW Health. Files must be directed to the location specified in the EDWARD Perinatal Interface Documentation (refer to supporting documents).

Private hospital users require an authorised user account to access and submit data to PeriPH.

Independent midwives (and users from hospitals without maternity units) require an authorised user account to access and submit data via the secure online PeriForm.

To apply for authorised access to PeriPH and PeriForm contact the Data Integrity Officer in Health Systems Information and Performance Reporting Branch, NSW Ministry of Health.

6. PDC INFORMATION – ACCESS AND DISSEMINATION

Information collected by the PDC is used for the following purposes:

- State wide surveillance to monitor patterns of care for mothers and babies, and outcomes of care. Summary information for NSW is published annually on HealthStats NSW at: http://www.healthstats.nsw.gov.au/
- Planning, monitoring and evaluation of maternity services by the Ministry of Health and Local Health Districts.
- De-identified unit record data are provided to the AIHW National Perinatal Statistics Unit for inclusion in the National Perinatal Data Collection.
- De-identified data and summary data are provided to the NSW Ombudsman to support the work of the NSW Child Death Review Team.
- Research purposes with the approval of a human research ethics committee.

PDC data may be accessed in the following ways:

- De-identified unit record data may be obtained via Secure Analytics for Population Health Research and Intelligence (SAPHaRI), which is the NSW Ministry of Health population health data warehouse, analysis and reporting system. SAPHaRI is administered by the Centre for Epidemiology and Evidence, and is accessible by staff of the NSW Ministry of Health and public health services subject to signing of a confidentiality agreement.
- Access to de-identified PDC unit record data for research purposes may also be sought by written request to the Executive Director, Centre for Epidemiology and Research.

7. GLOSSARY

Term/Acronym	Definition
AIHW	Australian Institute of Health and Welfare
EDWARD	NSW Health's Enterprise Data Warehouse for Analysis, Reporting and Decision Support.
PDC	Perinatal Data Collection
PeriForm	A secure online form to allow the entry and submission of individual PDC records
PeriPH	The application and data base to be used by private facilities for the submission and data quality checks for PDC records

8. FURTHER INFORMATION

Detailed information on the PDC data items, codes and guidance on completion of each data item is contained in the *New South Wales Perinatal Data Collection Data Dictionary 2016.*

Further information concerning the collection and submission of PDC data is available on the NSW Health Intranet from the following URL:

http://internal.health.nsw.gov.au/data/collections/pdc/index.html

Including links to the following resources:

- Data Dictionary – EDWARD Data Stream – Perinatal Notification
- Perinatal Data Collection Classification Changes Effective From 1 January 2016 Information Bulletin
- EDWARD Interface Requirements Specification for File Based Extracts – Perinatal Notification Data Stream
- Data Dictionary EDWARD Control and Audit Data Dictionary (excluding data error concepts)
- PeriPH data submission format specification

- Perinatal Data Set Specification 2015-16 (AIHW; Nov., 2014; http://meteor.aihw.gov.au/content/index.phtml/itemId/581388)
- Perinatal NMDS 2014- (AIHW; March, 2014; http://meteor.aihw.gov.au/content/index.phtml/itemId/517456).

For further information about this policy directive or the PDC, contact:

Komala Goutham
Data Integrity Officer
Information Management and Quality Unit
Health System Information and Performance Reporting Branch
NSW Ministry of Health
Phone: 02 9391 9613
E-mail: kgout@doh.health.nsw.gov.au

NSW REGISTER OF CONGENITAL CONDITIONS – REPORTING REQUIREMENTS (PD2018_006)

PD2018_006 rescinds PD2012_055

PURPOSE

This Policy Directive provides guidance to NSW Health staff on the procedure to be followed for the reporting of congenital conditions to the NSW Register of Congenital Conditions.

MANDATORY REQUIREMENTS

All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

This Policy Directive outlines the process for submitting paper and electronic notifications to the Ministry of Health, and presents information on data quality, security, access and dissemination. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

IMPLEMENTATION

This Policy Directive should be distributed to all LHD staff. Staff involved in the identification of scheduled congenital conditions during pregnancy or the post-natal period must follow the procedure set out in this policy directive.

BACKGROUND

About this document

All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

The Register is located in the Centre for Epidemiology and Evidence of the NSW Ministry of Health. Information from the Register is used to monitor the occurrence of congenital conditions for service planning purposes and to identify changes in incidence that may warrant investigation.

Key definitions for scheduled congenital conditions

The Register is a state wide surveillance system that monitors the occurrence of scheduled congenital conditions to plan services for affected families, and identify changes in incidence that may warrant investigation.

Scheduled congenital conditions include:

1. All structural malformations. Examples include spina bifida, microcephaly, transposition of the great vessels, ventricular septal defects, pulmonary agenesis, polycystic lungs, duodenal atresia, exomphalos, hypospadias, cleft lip/palate, microphthalmia, limb reductions, polydactyly, birthmarks greater than 4cm diameter, cystic hygroma and multisystem syndromes including at least one structural malformation.
2. Chromosomal abnormalities. Examples include Down syndrome and unbalanced translocations.
3. Four medical conditions: cystic fibrosis, phenylketonuria, congenital hypothyroidism and thalassaemia major.

Congenital conditions that are not notifiable include:

1. Minor anomalies occurring in isolation.

   Examples of minor anomalies include skin tags, deviated nasal septum, tongue tie, benign heart murmurs, clicky non-dislocating hips, sacral dimples, positional talipes, abnormal palmar creases, and dysmorphic features.

2. Birth injuries.
3. Congenital infections which do not result in a structural malformation.
4. Tumours and cysts.
5. Conditions arising from prematurity or asphyxiation.

Legal and legislative framework

Congenital conditions occurring in a child under one year of age or pregnancies where the fetus has a congenital condition are required to be reported under the NSW Public Health Act 2010.

REPORTING METHOD

Notification types

1. *Notification of a scheduled congenital condition diagnosed in an infant*
   Information in this format should be supplied for congenital conditions detected in stillborn babies or live born babies up to one year of age.
2. *Notification of a scheduled congenital condition diagnosed by prenatal diagnosis*
   Information in this format should be supplied for congenital conditions detected in the fetus during pregnancy, regardless of whether the pregnancy continues.

Guidelines for notification are printed on the outside cover of each notification pad.

In the case of a multiple pregnancy or multiple birth where both babies are affected, a separate form or electronic record must be completed in full for each fetus or baby.

Methods of notification

Information may be supplied in paper or electronic format.

Paper notifications

For submission on paper forms, forms are provided in triplicate with the original sent to the NSW Ministry of Health, one copy for the hospital medical record and one copy for the parent or family. Information for parents and families concerning the Register is printed on the reverse side of the Parent Copy of both notification forms.

Paper notifications should be mailed to:

The NSW Register of Congenital Conditions
Centre for Epidemiology and Evidence
Level 7
NSW Ministry of Health
Locked Mail Bag 961
North Sydney NSW 2059

Electronic notifications

Electronic notifications of scheduled congenital conditions can be facilitated via a hospital's Maternity Information System – the electronic system that captures birth notifications from hospitals. Notifications should be entered immediately following diagnosis. Notifications should be sent to the Ministry of Health on at least a quarterly basis. For facilities interested in submitting notifications electronically, please contact: roccadmin@moh.health.nsw.gov.au.

Information to be notified

Demographic details (mother)
First name
Last name
Date of birth
Hospital medical record number or laboratory number
Residential address
Country of birth
Indigenous status (mother)

Demographic details (live born or stillborn baby)
First name
Last name
Date of birth
Hospital medical record number or laboratory number
Hospital of birth
Sex
Indigenous status (baby)
Plurality
Baby number
Birth weight
Gestation
Outcome
Autopsy/histopathology
Date of death

Pregnancy details (where applicable)
Indication for prenatal diagnosis
Type of prenatal diagnosis
Date of last menstrual period
Relevant medical or family history
Congenital abnormality/syndrome
Diagnosis
Laterality
Date of Diagnosis
Karyotype – balanced, unbalanced

DATA QUALITY

Data submitted to the Register is checked for any discrepancies and further information is requested from the hospital or reporting clinician if information received is inconsistent or incomplete.

DATA SECURITY

Data collected by the Register is protected under the NSW Public Health Act 2010.
The NSW Health Privacy Manual for Health Information (previously known as the NSW Health Privacy Manual) must be observed for all data relating to the Register. This is located at:
http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx.

The Register database is held on the NSW Ministry of Health's local area network, is password protected and is accessible only to the Register staff.
Paper forms submitted to the Register are securely stored and are destroyed no more than five years after the year of birth or completion of the pregnancy.
Personal identifiers (name, residential street number and name, and medical record number) are removed from the database five years after the year of birth or completion of the pregnancy.

DATA ACCESS AND DISSEMINATION

Information obtained from the Register is made available on request. Specific analyses of Register data, or access to unit record data from the Register, may be obtained on written request to the Executive Director, Centre for Epidemiology and Evidence (email: ceemail@moh.health.nsw.gov.au).

CONTACT INFORMATION

For further information about the Register of Congenital Conditions, or this Policy Directive, please contact: roccadmin@moh.health.nsw.gov.au.

NOTIFYING CANCER-RELATED DATA TO THE NSW CANCER REGISTRY (PD2022_008)

PD2022_008 rescinds PD2009_012

POLICY STATEMENT

NSW Health is committed to reducing the burden of cancer in the NSW population and will do this by continuing to capture cancer-related data into the NSW Cancer Registry.

The data captured will be used to report on incidence and mortality from cancer and support programs that utilise the data to reduce incidence and improve outcomes for people diagnosed and treated for cancer.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive outlines the requirements for submitting notifications to the NSW Cancer Registry and presents information on data quality, security, access, and dissemination.

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, public and private sector admitted and non-admitted patient facilities, and pathology laboratories are required to notify the NSW Cancer Registry of all cancer cases.

Under these same provisions, the registrar of births, deaths, and marriages is required to notify the NSW Cancer Registry of deaths due to cancer.

The provisions of the Cancer Institute (NSW) Act 2003 also allow for the NSW Cancer Registry to request and collect clinical data relating to cancer treatment from any facility providing care to cancer patients in NSW.

All data submitted to the NSW Cancer Registry undergo a series of quality checks and validations. If data quality issues are detected that require resolution at the source, an error report is generated and sent to the notifier.

The procedures outlined in the NSW Health privacy manual for health information and the Cancer Institute NSW Data Governance Policy are adhered to by NSW Cancer Registry staff in order to ensure that appropriate data security and governance safeguards are in place.

Data held within the NSW Cancer Registry can be used to support the functions of the Cancer Institute NSW:

- Monitor and record the number of new cases of notifiable cancers and deaths due to notifiable cancers in NSW;
- Produce regular and ad hoc reports on cancer incidence, treatment patterns, mortality, and survival;
- Evaluate the effectiveness of cancer screening programs;
- Assist in planning and monitoring services for cancer control and the care of cancer patients;
- Contribute cancer data to national and international agencies to assist in cancer
- control.

- Review adherence to best practice guidelines and optimal care pathways
- Assist in development and implementation of culturally safe cancer care for Aboriginal people across the optimal care pathways
- Review treatment outcomes of standards of care and also review clinical trial outcomes when transitioned into best practice care for a wider cohort.
- Inform reporting which supports quality improvements in cancer care.

Notifying Cancer-Related Data to the NSW Cancer Registry: Procedures

1 BACKGROUND

1.1 About this document

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, public and private sector admitted and non-admitted patient facilities, and pathology laboratories are required to notify the NSW Cancer Registry of all cancer cases.

Under these same provisions, the registrar of births, deaths, and marriages is required to notify the NSW Cancer Registry of deaths due to cancer.

The provisions of the Cancer Institute (NSW) Act 2003 also allow for the NSW Cancer Registry to request and collect clinical data relating to cancer treatment from any facility providing care to cancer patients in NSW.

1.2 Key definitions

Aboriginal person

An ‘Aboriginal person’ is a person who:

- is of Aboriginal descent
- identifies as an Aboriginal person and
- is accepted as an Aboriginal person by the community in which they live.

Active treatment

A clinical treatment intervention for a specific cancer at a single point in time where the cancer is the principal or an additional diagnosis for the episode of care. Active treatment refers to those under acute or palliative care.

Admitted patient

A person provided a health care service by a hospital, day procedure centre or multipurpose service on an admitted patient basis.

Cancer

Cancer is a Category 3 Scheduled medical condition and is also a notifiable disease under Schedule 2 of the Public Health Act 2010. This document provides guidance regarding the procedures to be followed for the reporting of cancer-related data to the NSW Cancer Registry.

Data custodian

The data custodian is incumbent to the position responsible for day-to-day management and oversight of the data asset, approval of access to data, and the overall quality and security of the data asset.

Non-admitted patient

A person provided a health care service by a hospital, day procedure centre or multipurpose service on a non-admitted patient basis.

Notifiable diseases

A medical condition listed under Schedule 2 of the Public Health Act 2010 (NSW)

Palliative treatment

Treatment aimed at providing pain and symptom relief in order to improve the patient's quality of life

Pathology laboratory

A Pathology Laboratory is a Laboratory where tests are carried out on clinical specimens to obtain information about the health of a patient to aid in diagnosis, treatment, and prevention of disease.

Note: In NSW pathology laboratories include services provided by Pathology NSW, Institute of Forensic Medicine, NSW private sector pathology services providers and interstate pathology laboratories.

Radiology services

Any accredited premises in which radiology services are provided within NSW to diagnose or stage a notifiable cancer or response to cancer treatment, or where interventional radiology treatments for cancer are provided.

Scheduled condition

A medical condition listed under Schedule 1 of the Public Health Act 2010 (NSW).

Tabulated data

Summary data produced from analyses of unit record data using broad categories (e.g. age group) and presented in a way that it is not possible to identify any individual.

Unit record data

Data relating to an individual person, which may be presented in an identified (containing identifying information such as name and address) or re-identifiable (identifying information removed) format

1.3 Legal and legislative framework

The Public Health Act 2010, Public Health Regulation 2012, and Cancer Institute (NSW) Act 2003 give authority to the Policy Directive relating to the collection of cancer-related data and the NSW Cancer Registry.

The Public Health Act 2010 outlines the mandatory requirement to notify cancer cases and cancer-related deaths to the NSW Cancer Registry and describes the penalties for non-compliance. The Cancer Institute (NSW) Act 2003 allows for clinical data relating to cancer treatment to be provided to the NSW Cancer Registry.

The Health Records and Information Privacy Act 2002 outlines the requirements for managing health information, including data collection, storage, use, disclosure, and retention.

The NSW Health Privacy Manual for Health Information provides information to these legislative obligations and outlines procedures to support compliance.

1.4 The NSW Cancer Registry

The NSW Cancer Registry, formerly known as the NSW Central Cancer Registry, is a population-based, central repository of data relating to cases of notifiable cancers, deaths due to notifiable cancers, and clinical treatment data for residents of NSW.
Data is also held in the NSW Cancer Registry for residents of other Australian states and territories who were diagnosed or treated for cancer in NSW. The NSW Cancer Registry also processes all notifications received for the ACT cancer registry.

The Cancer Institute NSW acts as the manager of the NSW Cancer Registry and custodian of the data held within the NSW Cancer Registry on behalf of the Secretary of the NSW Ministry of Health.

1.5 Aboriginal and Torres Strait Islanders

NSW Health Policy Directive *Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients* (PD2012_042) outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander.

Aboriginal and Torres Strait Islander people are under-reported in many health-related data collections in NSW. Self-report in response to the standard Australian Bureau of Statistics question about a person's Aboriginality is the most accurate means of ascertaining whether a client is Aboriginal and/or Torres Strait islander.

The standard question must be asked of all clients of NSW Health services, and the information needs to be recorded accurately according to national standards.

2 MANDATED NOTIFIERS

Sections 82 and 83 of the Public Health Act requires hospital Chief Executive Officers and medical practitioners to notify each case of cancer if they work for certain health entities including:

- Public hospitals within the meaning of the Health Services Act 1997
- Private health facilities, within the meaning of the Private Health Facilities Act 2007
- Any other types of institutions declared by the Public Health Act regulations to be a hospital.

Section 55 of the Public Health Act requires pathology laboratories to notify each case of cancer where the result for a pathology test for cancer, carried out at the request of health practitioner, is positive.

To meet the cancer notification requirements, the notification must be sent to the NSW Cancer Registry either via the NSW Health data warehouse (public hospitals only), or via direct submission in the prescribed format to the NSW Cancer Registry.

3 REPORTING METHODS

3.1 Incidence Cancer cases

Sections 55 and 83 of the Public Health Act 2010 and the Public Health Regulation 2012 requires chief executives of hospitals and laboratories operated by public sector or the private sector within NSW to notify each case of cancer to the NSW Cancer Registry. A separate notification is required for each primary site of cancer.

Lists of notifiable cancers and exclusion criteria can be found in Appendix 1 and 2.

3.1.1 Hospitals

For admitted patients, a cancer notification must be reported at each episode of care where a notifiable cancer is the principal or additional diagnosis and/or where active or palliative treatment has been provided. These notifications are to be provided within 6 weeks of the admission date.

For non-admitted patients, a cancer notification must be reported following a consultation where a diagnosis of a notifiable cancer is first diagnosed and notated in the patient's medical record and following the start of each course of treatment.

Complete and accurate notifications must be reported within 12 weeks of the consultation or course of treatment start date.
An episode of care refers to an admission, or a treatment sequence from commencement to completion (Course).

The data items to be provided may include, but are not limited to:	
Demographics	name, sex, address, date of birth, country of birth, Aboriginality status
Episode of care	facility ID, AMO/AHPRA registration number of treating clinician, admission date, separation date, status at separation
Diagnostic information	date of diagnosis, primary site, morphology, best basis of diagnosis

For an up-to-date list of notification data items please refer to the *current notification specification.*
NSW health public hospitals, multi-purpose services and affiliated health organisations are required to report cancer notifications through the NSW Health data warehouse via the admitted patient data collection extract formats, or the non-admitted patient and supplementary services data collection extract format.

The data extract requirements for reporting through the NSW data warehouse are issued by the Ministry of Health systems information and analytics branch. Requests for information can be sent to: MOH-SIA-HIE@health.nsw.gov.au

Where reporting cancer notifications via the NSW Health data warehouse has not been established cancer notifications must be submitted via data extracts sent directly to the NSW Cancer Registry. The extract requirements for these direct submissions are issued by the Cancer Institute NSW. Submissions must be made via the cancer notification portal.

Private sector hospitals must report cancer notifications directly to the NSW Cancer Registry either via the batch data extract format, or as individual notifications. These submissions must be made via the cancer notification portal..

3.1.2 Pathology laboratories

Public and private sector operated pathology laboratories are required to notify all cases reported as cancer, as well as benign and uncertain-behaviour neoplasms of the central nervous system, to the NSW Cancer Registry.

A pathology report with a confirmed diagnosis of cancer is regarded as the definitive source for determining a cancer case for NSW Cancer Registry. These notifications are to be provided within 6 weeks of the pathology collection date.

Pathology reports for the diagnosis of notifiable cancers may come from histopathology, cytology, cytogenetics, haematology, or molecular diagnostic tests.

The following qualifiers used in pathology reports are regarded as acceptable for a diagnosis of cancer:		
consistent with	compatible with	comparable with
diagnostic of	equivalent to/of	extension into
in keeping with	indicative of	invasion of
supports a diagnosis of	(the features) are those of	typical of

Pathology laboratories must provide a copy of each complete and final pathology report that confirms the diagnosis of a notifiable cancer or contributes to the staging or grading of a cancer and associated prognostic factors to the NSW Cancer Registry.

Supplementary reports detailing the results of additional tests and expert reviews, must also be provided, especially when the diagnosis has been revised to a benign condition.

Pathology laboratories can provide notifications in hard copy (paper format) or soft copy (Electronic Pathology Solution). Hard copy reports must be marked “Private and Confidential” and can be sent to the mailing address provided in Section 5.

3.2 Cancer deaths

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, the NSW Registrar of Births, Deaths, and Marriages is required to notify the NSW Cancer Registry of deaths due to notifiable cancers and the department of forensic medicine where cancer was an incidental finding at post-mortem. These notifications are to be provided within 6 weeks of the date of death or final determination of the cause of death.

The Australian Bureau of Statistics manages the collation of coded cause of death data from state and territory registrars and the National Coronial Information Service and the consolidated data are sought from the Australian Coordinating Registry (ACR) and provided to the NSW Cancer Registry.

Cancer death data and coded cause of death data are provided to the NSW Cancer Registry via encrypted electronic notification files. Aboriginal status must be recorded.

Lists of notifiable cancers and exclusion criteria can be found in Appendix 1 and 2.

3.3 Clinical data

The provisions within the Cancer Institute (NSW) Act 2003 allow the NSW Cancer Registry to request clinical data relating to cancer treatment from any facility providing treatment for cancers in NSW, including private sector health organisations.

The data that must be reported describes the clinical aspects treatments provided to patients with a notifiable cancer. The treatments include radiotherapy, systemic therapies, interventional radiology and other day procedures which aim to remove, control or prepare the cancer for further treatments, or to treat recurrent and metastatic disease.

Clinical data can be provided via extracts from electronic medical record systems used by oncology services or centralised data repositories, via electronic secure data transfer in the form prescribed by the Cancer Institute NSW. Clinical data must be reported within 12 weeks of treatment completion or cancellation, with a minimum frequency of quarterly supply.

Requests for the data extract format requirement specifications for each type of treatment, and details about the data submission process for clinical cancer treatment data, must be sent to CINSW- ClinicalData@health.nsw.gov.au.

4 DATA QUALITY

4.1 Errors

Staff at notifying facilities are to review notifications prior to submission and address any errors detected in source systems where possible.

All data submitted to the NSW Cancer Registry via any of the reporting mechanisms undergo a series of quality checks and validations. If data quality issues are detected that require resolution at the source, an error report is generated and sent to the notifier.

These error reports are to be checked and corrections made by the notifier within 10 working days.

4.2 Requests for further information

Where a notification is received for an equivocal or unconfirmed cancer diagnosis, further information may be requested before the case is registered. In these instances, the NSW Cancer Registry may contact the notifier, or any medical practitioner involved in the treatment of the person concerned to obtain clarification of test results or the results of any additional tests performed, as well as other information concerning the person's medical condition, transmission and risk factors.

It is a requirement that clarification or further information is provided upon request to NSW Cancer Registry staff. Responses to requests for further information are required within 10 working days.

5 DATA STORAGE AND SECURITY

NSW Cancer Registry data are stored on secure servers located on eHealth's infrastructure hosted in the GovDC with access restricted to authorised personnel only.

The procedures outlined in the NSW Health privacy manual for health information and the Cancer Institute NSW Data Governance Policy are adhered to by NSW Cancer Registry staff in order to ensure that appropriate data security and governance safeguards are in place.

6 DATA ACCESS AND DISSEMINATION

Data held within the NSW Cancer Registry can be used to support the functions of the Cancer Institute NSW:

- Monitor and record the number of new cases of notifiable cancers and deaths due to notifiable cancers in NSW;
- Produce regular and ad hoc reports on cancer incidence, treatment patterns, mortality, and survival;
- Evaluate the effectiveness of cancer screening programs;
- Assist in planning and monitoring services for cancer control and the care of cancer patients;

- Contribute cancer data to national and international agencies to assist in cancer control.
- Review adherence to best practice guidelines and optimal care pathways
- Assist in development and implementation of culturally safe cancer care for Aboriginal people across the optimal care pathways
- Review treatment outcomes of standards of care and also review clinical trial outcomes when transitioned into best practice care for a wider cohort.
- Inform reporting which supports quality improvements in cancer care.

Tabulated data from the NSW Cancer Registry can be made available upon request and may require approval from the data custodian.

Unit record data held within the NSW Cancer Registry can be utilised for epidemiological research upon approval from the data custodian, NSW population and health services research ethics committee, and the NSW Ministry of Health. Depending on the research question and data requested, additional ethics approvals may be required.

Further information on data access and the approvals required can be found at Cancer Institute NSW website.

7 CONTACT INFORMATION

Requests for further information about the mandatory reporting requirements of the NSW Cancer Registry must be directed to the cancer notifications manager, NSW Cancer Registry.

Requests for further information about the provision of clinical data related to cancer treatment must be directed to the manager, registries and data collection.

Contact details for the NSW Cancer Registry are provided below:	
Physical address	Cancer Institute NSW Level 4, 1 Reserve Road St Leonards NSW 2065
Secure postal address	Locked Bag 2011 St Leonards NSW 1590 Must be marked: “Private and Confidential”
Phone	(02) 8374 5749
Secure fax	(02) 8374 3644
Email	CINSW-CCR@health.nsw.gov.au
Website	https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/request-unlinked-unit-record-data-for-research/nsw-cancer-registry
Cancer Notification Portal email	CINSW-CNP@health.nsw.gov.au
Cancer Notification Portal website	https://cnp.cancer.nsw.gov.au/Account/Login
Clinical Data notification email	CINSW-ClinicalData@health.nsw.gov.au

APPENDIX LIST

1. List of notifiable cancers
2. Cancers to be excluded from notifications

APPENDIX LIST

Appendix 1: List of notifiable cancers

Description	ICD-10-AM 11th Edition [11]	
	Topography	Morphology
Human immunodeficiency virus (HIV) disease resulting in malignant neoplasms[2]	B21	Ending with /3
All cases of invasive cancer except those specified in Appendix 2 All cases of unequivocally malignant conditions (haematological[3])	C00.0 to C97 D45-47	Ending with /3
Benign, uncertain-behaviour and malignant neoplasms of the central nervous system	C70.0–C72.9 and C75.1–C75.3	
Squamous cell carcinoma of the vermillion surface and border of the lip	C00	M805X/3 to M808X/3
Squamous cell carcinoma of skin of anus	C44.5 ([4])	M805X/3 to M808X/3
Squamous cell carcinoma of skin of vulva	C51.9	M805X/3 to M808X/3
Squamous cell carcinoma of skin of penis	C60.9	M805X/3 to M808X/3
Squamous cell carcinoma of skin of scrotum	C63.2	M805X/3 to M808X/3
Carcinoma in-situ of bronchus and lung	D02.2	Ending with /2
Melanoma in-situ	D03	Ending with /2
Carcinoma in-situ of breast	D05	Ending with /2
Carcinoma in-situ of bladder	D09	Ending with /2

Notes:

1. ICD-10-AM codes taken from the International Statistical Classification of Diseases and Related Health Problems, 11th Revision, Australian Modification (11th Edition, 31/05/2019), published by the National Centre for Classification in Health: https://sydney.edu.au/health-sciences/ncch/
2. When notifying a Topography= B21, the topography of the primary site of the cancer arising from HIV disease must also be notified.
3. Diseases with ICD-10-AM commencing with 'D' and 'L' were reclassified in ICD-O-3 with a malignant morphology code. Despite being classified under 'Neoplasms of uncertain or unknown behaviour' in ICD-10-AM, these diseases are notifiable when paired with the corresponding morphology codes in this table. The NSW Cancer Registry commenced collection of these notifications for cases diagnosed from 2003 onwards. Cases diagnosed prior to 2003 may also be notified, and if the exact date of diagnosis is unknown a default date of 01/01/2001 should be reported.
4. C44.5 with morphology M805X/3 to M808X/3 also covers squamous cell carcinomas of skin sites other than the anus, which are not notifiable.

Appendix 2: Cancers to be excluded from notifications

Description	Topography	Morphology	Exception
In-situ cancers and intraepithelial neoplasia with no mention of invasion	C00.0 to C97	Ending with /2	Carcinoma in-situ of bronchus and lung (D02.2); Melanoma in-situ (D03.0 to D03.9); Carcinoma in-situ of breast (D05.0 to D05.9). Carcinoma in-situ of bladder (D09*)
Benign and uncertain behaviour tumours			Benign, uncertain-behaviour neoplasms of the central nervous system (topography codes C70.0–C72.9 and C75.1–C75.3)
Basal cell carcinomas of the skin	C44*	M8090/3	
Squamous cell carcinomas of the skin	C44*	M805X/3 to M808X/3	Vermilion surface and border of lip (C00.0 to C00.9); Anus (C44.5); Vulva (C51.9); Penis (C60.9); Scrotum (C63.2).
Pre-cancerous conditions.			
Cases where there is an unclear or equivocal diagnosis of cancer and a definitive diagnosis has not been made radiologically, cytologically, or histologically; and the clinician does not regard the patient as having cancer.			

CHILD WELLBEING AND CHILD PROTECTION POLICIES AND PROCEDURES FOR NSW HEALTH (PD2013_007)

PD2013_007 rescinds PD2005_299, PD2006_104, PD2007_023, PD2011_057, PD2011_065, GL2011_008, IB2010_005 & IB2012_002.

PURPOSE

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents/carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

MANDATORY REQUIREMENTS

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

Children and Young Persons (Care and Protection) Act 1998

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children's Court proceedings when required.

Commission for Children and Young People Act 1998*/*Child Protection (Working with Children) Act 2012

- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).

Ombudsman Act 1974

- Maintain systems to prevent '**reportable conduct**' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;
- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the **Mandatory Reporter Guide** and seek assistance from the NSW **Health Child Wellbeing Unit** to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the **NSW Health Child Wellbeing Unit** and the **Family Referral Services** to help respond to vulnerable families, children and young people below the ROSH threshold;
- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the **Child Wellbeing and Child Protection - NSW Interagency Guidelines** and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and/or other child protection training for NSW Health workers.

IMPLEMENTATION

Chief Executives across the NSW public health system are responsible and accountable for:

1. Ensuring that this policy and the associated *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers* are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

Please go to **Child Wellbeing and Child Protection Policies and Procedures for NSW Health** to view the above document.

GENERAL RETENTION AND DISPOSAL AUTHORITY: PATIENT RECORDS (GDA17) AND ADMINISTRATIVE RECORDS (GDA21) (IB2019_015)

IB2019_015 rescinds IB2004/20

PURPOSE

The Board of the State Archives and Records Authority NSW has approved a revised General retention and disposal authority: Public health services - patient records (GDA17), and made a minor change to General retention and disposal authority: Public health services - administrative records (GDA 21) in line with the approval of the Functional retention and disposal authority*: Provision and regulation of childcare services* (FA404).

KEY INFORMATION

1. General retention and disposal authority: Public health services - patient records (GDA17)

GDA17 applies to the records of patient care provided by the NSW Health system. The authority underwent a review and was revised on 30 May 2019.

The disposal action for certain patient records has been changed as a result of the review. NSW State Archives and Records website has available the current version of GDA17 and a schedule of amendments and justifications to show where the retention periods have changed. Where they have changed the old entries in GDA17 can no longer be used as the source of legal authority for the disposal of records under the State Records Act 1998.

2. General retention and disposal authority: Public health services - administrative records (GDA 21)

GDA21 applies to records created and maintained to support the management and delivery of public health care services and programs. It was amended on 30 May 2019 to remove classes covered by FA404, Provision and regulation of childcare services. Those sections of GDA21 relating to childcare can no longer be used as the source of legal authority for the disposal of records under the State Records Act 1998.

FA404 applies to the provision of childcare services by NSW public offices including the local health districts.

Refer to the NSW State Archives and Records website for the latest version of both GDA21 and FA404.

ATTACHMENTS

The authorities mentioned in this information bulletin are available from the NSW State Archives and Records website using the following links.

GDA 17	https://www.records.nsw.gov.au/recordkeeping/rules/gdas/gda17
GDA 21	https://www.records.nsw.gov.au/node/490
FA404	https://www.records.nsw.gov.au/sites/default/files/Recordkeeping/FA0404%20Provision%20and%20regulation%20of%20childcare%20services.pdf

GENERAL RETENTION AND DISPOSAL AUTHORITY – ORGINAL OR SOURCE RECORDS THAT HAVE BEEN COPIED (GA 45) (IB2015_052)

IB2015_052 rescinds IB2009_064.

PURPOSE

To notify the Health system that State Records Authority General Retention and Disposal Authority: *Original or source records that have been copied (GA 45)* has been issued to replace General Retention and Disposal Authority: *Imaged records (GA36)*.

GA 45 provides for the authorised destruction of original or source records that have been copied, provided that certain conditions are met.

KEY INFORMATION

GA 45 provides for the authorised disposal of certain State records which have been successfully copied using microfilming or digital imaging processes. In particular, it describes the circumstances and conditions under which the destruction of certain original or source records is permitted under the provisions of the *State Records Act 1998* after they have been copied.

Whereas GA36 established the conditions under which original records that had been microfilmed or imaged could be destroyed, it primarily applied to paper and excluded records identified as State archives or those required to be retained where created prior to 2000.

The main changes from GA36 to GA45 are:

- Records that are required as State archives or required to be retained in agency may now be destroyed after copying (if the conditions have been met and they do not fall within the exclusions categories) if they were created after 1980, rather than 2000.
- The scope of the authority was widened from original records copied using microfilming or digital imaging processes, to original or source records that have been copied.
- The requirement to assess all requirements for retaining originals was removed, as this condition has become less relevant due to digital copies of paper records being widely accepted.
- Additional exclusions have been included in GA 45 to cover State archives on loan from State Records and records that have high personal value to individuals who were subject to Government control.

GA45 can be accessed on the State Records website:
https://www.records.nsw.gov.au/recordkeeping/original-or-source-records-have-been-copied-ga45

GENERAL RETENTION AND DISPOSAL AUTHORITY - DEPARTMENTS OF FORENSIC MEDICINE (PUBLIC HEALTH SYSTEM) GDA19 (IB2004/44)

The Board of the State Records Authority approved under the provisions of the *State Records Act 1998* on 20 October 2004 the attached "General Retention and Disposal Authority – Departments of Forensic Medicine (Public Health System) as the legal authority for disposing of records retained by Departments of Forensic Medicine in the Public Health System.

Public health services are reminded that the authorisations for destruction of records are given in terms of the *State Records Act* only. A public health service must not destroy any records where they are aware the records may be required as evidence for the purposes of possible legal action or an investigation or enquiry.

GA45 can be accessed on the State Records website:
https://www.records.nsw.gov.au/node/8620851

CHILD DEATH REVIEW TEAM - ACCESS TO RECORDS (IB2014_028)

IB2014_028 rescinds PD2005_286.

PURPOSE

The NSW Child Death Review Team (CDRT) reviews the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths.

The purpose of this information bulletin is to provide advice to the NSW Health system regarding the requirements of current legislation in relation to the CDRT's access to medical/health records.

KEY INFORMATION

Amendments to the *Community Services (Complaints, Reviews and Monitoring) Act 1993 No 2* were made in 2011[81] in response to the Special Commission of Inquiry into Child Protection Services in NSW which was led by the Hon James Wood AO QC in 2008.

These changes had no ostensible impact on the existing requirements for NSW Health agencies in relation to providing full and unrestricted access to records reasonably required for the CDRT to perform its functions. One notable change however, was the transfer of responsibility for support and assistance of the CDRT from the then Commission for Children and Young People to the office of the NSW Ombudsman, and made the Ombudsman the Convenor of the CDRT.

Legislation providing for the Ombudsman to be the Convenor of the CDRT came into effect on 16 November 2011. Under the *Children and Young Persons (Care and Protection) Act 1998* and Section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, there are provisions for the exchange of information about children and young people who have died. The Ombudsman can request full and unrestricted access to NSW Health records when investigating a reviewable death or a death reviewable by the CDRT.

Under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the CDRT's functions include:

- Maintaining the register of child deaths occurring in NSW.
- Classifying those deaths according to cause, demographic criteria and other relevant factors.
- Data analysis to identify relevant patterns and trends.
- Undertake research to prevent or reduce the likelihood of child deaths.
- Make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.
- Identify further research required by the CDRT or other agencies or persons.

The following persons are required under Section 34K to provide the CDRT with full and unrestricted access to records reasonably required for the purpose of the CDRT exercising its functions:

- The Director-General, the Department Head, Chief Executive Officer or senior member of any department of the government, statutory body or local authority.
- The Commissioner of Police.
- The State Coroner.
- A medical practitioner or health care professional who, or the head of a body which, delivers health services to children.
- A person who, or the head of a body which, delivers welfare services to children (including family support services, children's services, foster care or residential out-of-home care, and disability services).
- The principal of a non-government school (within the meaning of the *Education Act 1990*).

[19] Children Legislation Amendment (Child Death Review Team) Act 2011 No 60
http://www.austlii.edu.au/au/legis/nsw/num_act/cladrta2011n60480.pdf

This includes the right to inspect and, on request, to be provided with copies of, any record referred to in that subsection and to inspect any non-documentary evidence associated with any such record. In the legislation, 'record' means *any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means*.

The legislation also details the requirements of the CDRT related persons in relation to maintaining confidentiality of any information acquired for the purposes of the CDRT.

Each Local Health District must ensure requests for information by the CDRT are met as required, and should implement protocols to facilitate this.

It is noted that:

- Any request from the CDRT should be in writing and reference the legislative provisions relied upon by the CDRT for the release of patient information, namely section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ("the Act"). The release must be required for the purpose of the CDRT exercising its functions pursuant to section 34D of the Act.
- Any request from the Ombudsman should be in writing and reference the legislative provisions relied upon for the release of patient information, namely section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ("the Act"). The release must be required for the purpose of the Ombudsman's functions pursuant to section 36 of "the Act."

NSW privacy legislation allows the release of personal and/or health information in circumstances where the organisation (a Local Health District for example) is lawfully authorised to disclose the information; as outlined above.

Where information requested by the Ombudsman or the CDRT contains any reference to reports of Risk of Significant Harm (ROSH), the Health service or health worker handling the request should confirm whether details of the reporter's identity and/or the ROSH report itself are required. If not, de-identified information should be provided. Refer to section 29 of the *Children and Young Persons (Care and Protection) Act 1998* for further information regarding the protection of reporter identity and legal exceptions. Also see PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health Section 9.1.2 for legal and policy advice on the protection of a reporter's identity.

NOTIFIABLE CONDITIONS DATA SECURITY AND CONFIDENTIALITY
(PD2012_047)

PD2012_047 rescinds PD2005_181.

PURPOSE

The purpose of this policy is to provide guidance for NSW Health staff to manage the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated form. This includes:

- Paper notification records;
- Electronic notification records;
- The Notifiable Conditions Information Management System (NCIMS);
- The Secure Analytics for Population Health Research and Intelligence (SAPHaRI); and/or
- Any other form of data that has not been approved for release in the public domain.

MANDATORY REQUIREMENTS

All NSW Health and Local Health District staff must comply with this policy when accessing, managing or analysing notifiable conditions data.

Prior to accessing notifiable conditions data, NSW Health staff must sign each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, to confirm that they have read, understood and agreed to comply with the policies, procedures and conditions set out in it.

Release of notifiable conditions data must be managed according to section 4 – Data and information release.

IMPLEMENTATION

This policy directive should be distributed to all NSW Health staff. Staff with access to notifiable conditions data must follow the procedure set out in this policy directive.

All staff with access to notifiable conditions data in any form must sign the Notifiable Conditions Data - Confidentiality and Security Agreement at Appendix 1.

1. INTRODUCTION

1.1 About this document

Notifications of Scheduled Medical Conditions made under the Public Health Act include highly confidential information. NSW Health staff from Local Health Districts and the NSW Ministry of Health with access to such information should always protect the security and confidentiality of this information.

1.2 Key definitions

This policy refers to the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated data. This includes paper or electronic notifications, the Notifiable Conditions Information Management System (NCIMS), the Secure Analytics for Population Health Research and Intelligence (SAPHaRI), or any other form that has not been approved for release in the public domain.

Notifiable Condition	A medical condition listed under Schedule 1, 2 or 3 in the NSW *Public Health Act* (excluding category 1 conditions and cancer).
Unit record data	For the purpose of this policy directive, 'unit record data' are line listed electronic records of information that relate to the health of an individual which are held by NSW state data collections and owned by NSW Health.
Identifiable data	Information that allows identification of a specific individual.
De-identified data	Information from which identifiers have been permanently removed, or where identifiers have never been included. De-identified information cannot be re-identified.
Aggregate data	Summary data from analysis of unit record data by broad categories (such age group, sex or geographic location) so that it is not possible to identify the individual.
Disclosure	Communication or transfer of information outside NSW Health or Local Health District to Universities, and all other organisations or individuals.
Data custodian	The person with responsibility and administrative control over the ongoing development, data collection, maintenance, review of the data collection and granting access to data.

2. LEGAL AND LEGISLATIVE CONTEXT

The conditions and procedures set out in this document are supplemental and subordinate to any State or Commonwealth statutes, legislation or regulations and any NSW Health policies or guidelines subsequently issued by the Director-General which relate to confidentiality and data security.

Specifically, management of confidential notification data are referred to in the following legislation:
- *NSW Public Health Act 2010*
- *Health Administration Act 1982*

NSW Health Employees with access to notifiable conditions data must also acquaint themselves with the NSW *Health Records and Information Privacy Act 2002* and the Privacy Manual for Health Information (March 2015).

3. ACCESS TO SCHEDULED MEDICAL CONDITIONS DATA

3.1 Personnel

Access to notifiable conditions data for NSW Health Staff should be limited to the minimum level required to fulfil the functions of their position. Individuals requesting access to scheduled medical conditions data (and their managers) must:
- Be aware of their responsibilities with regard to information privacy.
- Undertake training on the operation of any databases or systems which they will operate to record or access personal health information in relation to notifiable conditions data.
- Complete the Confidentiality Agreement (Appendix 1) and identify the appropriate level of access according to their position and role.

3.2 Security

3.2.1 Password Security

NSW Health staff with access to databases containing information on notifiable conditions must observe the following measures in order to maintain security:
- Each individual is assigned a unique username. Access to the data will be controlled by a password. The password must be known only to the individual.

- Passwords are required to be a minimum 6 and maximum 12 characters and contain at least one numeric and at least one text character.
- The individual must not record their password in any file or other electronic document, no matter where or how such a file or document is stored.
- Individuals must change their passwords when requested by system administrators.

3.2.2 Electronic Security

- Access to notifiable conditions data through the NCIMS web based application is to be through individual login passwords only.
- When an individuals' access to the notifiable conditions data is no longer required (i.e. the role of the staff member changes, or their employment by the organisation at which they worked when the Confidentiality Agreement was signed), the staff member and or manager must notify the System Administrators of their changed circumstance, so that role changes can be made or logins disabled.
- System administrators will undertake an audit of NSW Health staff with access at least twice annually.

3.2.3 Physical Security and Storage of Data

- Electronic notifiable conditions data should be password protected and stored on secured networks with appropriately restricted access, not standalone PCs.
- Where access to notifiable conditions data through the NCIMS application is required externally (outside the usual work environment), individuals must ensure that information is not downloaded or saved to a PC.
- Network hardware and any back up or copies of notifiable conditions data must be password protected and stored in a secure location.
- Hard copies of identifiable notifiable conditions data related scheduled medical conditions should be stored in locked cabinets in a secure location.
- Secure document disposal facilities must be available.
- Secure printers and faxes must be available for confidential data management.

3.2.4 Workstation Security

- Care must be taken not to leave documents containing personal health information related to notifiable conditions data on work benches or anywhere they may be visible to unauthorised people.
- Personal health information should be unloaded from computer monitors (or the screen locked) if the monitor is to be left unattended.
- These requirements also apply where notifiable conditions data is handled externally (outside the physical confines of the usual work environment).

3.3 Acceptable use of notifiable conditions data

Notifiable conditions data must only be used for official NSW Health/Local Health District business related to notification or public health action, unless authorised in writing by an appropriate officer (see section 4 - Data and Information Release).

Notifiable conditions data should not be used for personal study. Use of the data for research purposes is subject to the NSW policy directive **PD2015_037**: 'Data Collections - Disclosure of Unit Record Data Held for Research or Management of Health Services' referred to in section 4 - Data and Information Release. Where an individual holds external organisation (e.g. academic) **and** NSW Health/Local Health District appointments, access to notifiable conditions data must not be used for any academic or teaching purposes without prior approval.

4. DATA AND INFORMATION RELEASE

4.1 Legal context for release of data

This section should be read in conjunction with 'Data Collections - Disclosure of Unit Record Data Held for Research or Management of Health Services' (**PD2015_037**).

NSW Health staff with access to notifiable conditions data must not release, pass on or otherwise make available to third parties (where the first party is NSW Health and the second party is the notifiable conditions data user) any data, subset of data or any tables, graphs or other aggregations or manipulations of data obtained or derived from notifiable conditions data where this data or information allows the identification of individual persons, institutions, communities or organisations by any means.

NSW Health staff with access to notifiable conditions data should note that identification of individuals, communities or organisations may occur through the release of specific identifying information such as addresses, or by inference from the combination of multiple non specific or less specific data items (such date of birth plus postcode).

The authority to disclose notifiable conditions data is vested in:

a) the Director General or his/her delegate (for identified unit record data) under the *Health Administration Act 1982* and the *Health Administration Regulation 2012* (subject to the conditions of that Act and Regulation).
b) The Chief Health Officer (for epidemiological data) under the *Public Health Act 2010* and Health Administration Act and *Health Administration Regulation* (subject to the conditions of those Acts and Regulation).

There are no delegations relating to the disclosure of identified unit record notifiable conditions data under the *Public Health Act*.

The delegations under the *Health Administration Act 1982* can be found in section 10 of the Combined Delegations Manual at http://www.health.nsw.gov.au/policies/manuals/Pages/combined-delegations.aspx

Other persons are not authorised to disclose notifiable conditions data.

4.2 Applications for release of data

Applications for release of notifiable conditions data should be made through the relevant data custodian using the appropriate form and will be assessed in accordance with PD2015_037 (Appendix 2).

Applications for the release of identified unit record notifiable conditions data for research or management of health service should be submitted to the NSW Population and Health Services Research Ethics Committee for consideration as per policy directive PD2010_055 *Ethical & Scientific Review of Human Research in NSW Public Health Organisations*. Available at: www.health.nsw.gov.au/policies/pd/2010/PD2010_055.html

Specific guidelines for the release of Aboriginal health information related to notifiable conditions data are required to protect Aboriginal people from the risk of identification as individuals or communities. Disclosure of Aboriginal health information must comply with the NSW Aboriginal Health Information Guidelines.

4.3 Exceptions for release of identifying data

Under the *Public Health Act 2010* (Section 130), it is an offence to disclose information obtained in connection with the Act unless the disclosure is made:

- with the consent of the person whom the information was obtained;
- in connection with the administration or execution of the Act or regulations;
- for the purposes of legal proceedings arising out of the Act or the regulations, of a report of any such legal proceedings;
- with the approval of the Chief Health Officer, or a person authorised by the Chief Health Officer, to a person specified in the approval and the information consists of epidemiological data specified in the approval;
- in any other prescribed circumstances; or
- with other lawful excuse.

4.4 Acknowledgement of use of data in publications

Where notifiable conditions data is approved for release in research or management of health services, all approvals must include a condition that data recipients agree to include a written acknowledgement of the role of NSW Health and the Centre for Health Protection in the fulfilment of any data requests and in the preparation of any report, scientific paper or on-line document (such as a World-Wide Web page). Typically the acknowledgement will appear in the covering letter, foreword or, in the case of electronic documents, as part of the introductory or top-level pages.

The source of notifiable conditions data should be attributed to the underlying data collection. For example, a graph which displays notifiable disease information derived from Notifiable conditions data should have the following attribution: “Source: Notifiable Conditions Information Management System, NSW Health”.

Where data is accessed via a secondary interface, such as SAPHaRI, the underlying data collection should be referenced along with the method of extraction: “Source: Notifiable Conditions Information Management System (Secure Analytics for Population Health Research and Intelligence), NSW Health”.

5. DURATION OF THIS AGREEMENT

The applicant agrees to be bound by the conditions of this Agreement indefinitely or until they sign a new Confidentiality and Data Security Agreement which supersedes this agreement.

The applicant is bound by this Agreement regardless of whether they continue to be an active user of the notifiable conditions data or database system and regardless of whether they remain an employee of or associated with the NSW Health or Local Health District.

6. LIST OF ATTACHMENTS

1. Notifiable conditions Confidentiality and Security Agreement
2. Data request template

Office Use Only
Application granted: Yes/No
Signed: _____
Date: _____

Appendix 1

Notifiable Conditions Data - Confidentiality and Security Agreement

I, (Full name of applicant) _____

(Work phone number)_____ (work e-mail address)_____

(Employed as Position)_____

By (Name of business unit employing the person)_____

Agree to abide by the confidentiality and data security conditions and procedures set out in this document.

By signing this document and each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, I confirm that I have read, understood and have agreed to comply with the policies, procedures and conditions set out in it.

I undertake not to knowingly access any personal health information unless such information is essential for me to properly and efficiently perform my duties. I undertake strictly to preserve the confidentiality of this information and I understand that a breach of this undertaking will result in disciplinary action.

I acknowledge my statutory duty under Section 22 and Section 23 of the NSW Health Administration Act 1982 and Section 130 of the NSW Public Health Act 2010, in relation to the disclosure of information. In order to fulfil this undertaking, I will not divulge any identifying, personal or health information regarding individual persons, except to authorised staff of the NSW Ministry of Health, Local Health District or other staff who require such information to carry out their medical or public health duties.

I further undertake to inform my supervisor immediately if I become aware of any breach of privacy or security relating to the information which I access in the course of my duties.

Signature of applicant _____ Date: _____

Position Title: _____

Witnessed by (Name of witness): _____

Signature of witness: _____ Date: _____

To be completed by Unit manager employing the applicant:

I confirm that, to properly fulfil the functions of their position, the above signed has reasonable need for access to notifiable conditions data. I also confirm that, in order to properly undertake the business of NSW Health or Local Health District, the business unit has a valid requirement for access to this data.

Manager's Name: _____

Signature: _____ Date: _____

Position Title: _____

Business Unit Name: _____ Local Health District_____

For access to notifiable conditions data through the NCIMS application - please tick all that apply

Applicant position:		Intended role:	
Administration	☐	Administration	☐
Immunisation staff	☐	Data entry	☐
Project Officer	☐	Data cleaning/analysis	☐
Public Health Nurse	☐	Epidemiological analysis	☐
Surveillance Officer	☐	Outbreak response	☐
Tuberculosis Nurse	☐	Surge Capacity	☐
Other *(describe)*	☐ _____	Other *(describe)*	☐ _____

End of Agreement

Appendix 2

TRIM REF:

Request for Release of Notifiable Conditions Data

Request for release of notifiable conditions data by requesters external to NSW Health or Local Health District.

To be completed by person making the request

1. **Person and/or agency making request:**

2. **Purpose for which data is sought:**

3. ☐ **Epidemiological/aggregate data** ☐ **Unit record data**
   Where unit record data are sought, please provide a copy of the NSW Population and Health Services Research Ethics Committee approval (according to PD 2012_010)

4. **Description of data requested** *(disease/condition, fields of interest, & time period of interest)*

5. **What (if any) publication of data is intended?**

6. **Date data requested by**: *(allow up to 6 weeks from the date of request)* _____ / _____ / _____

7. **Person taking responsibility for appropriate use of data:**

   Name: _____ Position: _____

   Organisation name: _____

   Phone: _____ Email: _____

   Signature: _____ Date: _____

Fax this form to the Surveillance Manager, Communicable Diseases Branch on 02 9391 9189

NSW Health reserves the right of comment on use of data and interpretation prior to publication.

Request Received: _____ **Request Approved:** _____

Date request completed: ___ ___ / ___ ___ / ___ ___ **Data prepared by:** _____

INTELLECTUAL PROPERTY ARISING FROM HEALTH RESEARCH

(PD2023_007)

PD2023_007 replaces PD2005_370

POLICY STATEMENT

NSW Health recognises that the acquisition and dissemination of knowledge and skills in the area of research and clinical practice is of major public benefit and a primary role of Public Health Organisations.

Public Health Organisations must establish a centralised system of managing their Intellectual Property, utilising an Intellectual Property Committee or other Committees which adhere to the requirements of this Policy Directive. They must also ensure that relevant agreements are in place with Clinical Academics, Visiting Practitioners, Visitors, Students, Independent Research Institutes and other third parties which appropriately deal with Intellectual Property.

SUMMARY OF POLICY REQUIREMENTS

Occasionally, the outcome of Health Research may have a significant commercial value. The objectives of this Policy are to:

- provide a framework for the use, generation, acquisition and management of Intellectual Property in NSW Health
- ensure that Intellectual Property owned by NSW Health is used to generate public value, knowledge transfer and innovation to the fullest extent possible
- encourage health research relating to the public health system and the acquisition and dissemination of knowledge and skills
- foster an environment within which the role of Intellectual Property in enabling clinical application of health research and realising commercial value is understood and recognised
- manage Intellectual Property with a potential commercial value in a manner which benefits the public health system as a whole
- foster an environment within which Intellectual Property issues can be identified and developed, and
- recognise and reward innovation by staff of NSW Health Organisations.

NSW Health provides an environment in which NSW Public Health Organisations are rewarded for the commercial exploitation of Intellectual Property.

The Office for Health and Medical Research will establish a Central Support Service offering assistance in commercialising intellectual property, which Public Health Organisations can delegate matters of that nature to if they are unable to establish or utilise a Committee. Employees of Public Health Organisations will be required to notify the Committee or Central Support Service (whichever is applicable within their Organisation) of Intellectual Property they develop or will imminently develop.

The Committee/ Central Support Service must examine and consider all notifications provided to it by Employees. Further, they will offer legal and commercialisation advice, and make recommendations to the Chief Executive of the relevant Public Health Organisation.

They will also act as a resource for staff on Intellectual Property matters, particularly in relation to the provision of advice on prior disclosure.

The full policy is available at:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_007

STATE HEALTH FORMS (PD2009_072)

PURPOSE

This policy and attached procedures define the processes for the creation and management of State Health Record Forms incorporated in Health Care Records.

The scope of the policy is to have clinical statewide forms filed in the Health Care Record and the standardisation of the physical Health Care/Medical Record Cover as well as other health record documents such as labels and dividers. This policy includes but is not limited to Inpatient facilities, Community Health Centres and outpatient clinics/areas.

MANDATORY REQUIREMENTS

Health services are required to use standardised forms developed by the NSW Health State Forms Management Committee.

All State Health Record Forms for inclusion (or potential for inclusion) in the Health Care Record must be approved by the NSW Health State Forms Management Committee (SFMC) or Health Service forms for use only within the Health Service must be endorsed by the local forms committee. Health Services must establish:

- A functional health service Health Records Forms Committee.
- Processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

All NSW Health **State** Record forms can **only be obtained** from the State Print and Print Management contracted supplier.

IMPLEMENTATION

The Health Service Chief Executive is responsible for:

- Establishing a functional health service Health Records Forms Committee, a member of which must act as representative to the NSW Health State Forms Management Committee (SFMC).
- Establishing processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

The Health Service Records Forms Committee is responsible for:

- Reviewing clinical forms intended for statewide use.
- Approving all clinical forms to be used by its Health Service.
- Ensuring all clinical forms meet the requirements of relevant Australian Standards (e.g. AS2828), NSW Health Policy Directives, a Health Service and State Health Records Forms templates.
- Working with the NSW Health, appointed Print and Print Management Services contracted provider, to facilitate Statewide implementation of the Policy.
- To standardise clinical forms across their health service where possible.
- To provide a formalised communication network between Health Service forms users, Executive, the contracted Print Management Services provider and the SFMC.
- To make recommendations for ongoing introduction/amendment/deletion of forms.

- Ensuring that the terms of reference includes a requirement that direct clinical contribution is obtained as required.

The custodians and authors of Health Records Forms (including the NSW Department of Health) are responsible for:

- Ensuring all steps in the health record forms development processes adhere to policy.
- Submitting relevant forms through their health service representative to the SFMC for review and endorsement.
- If NSW Health Policy Directive or Guideline requires a Health Record form to be used or created in order to comply with that policy or guideline the form must be submitted directly to and processed through the NSW Health SFMC and form a part of that Policy Directive or Guideline before it is distributed for implementation.

Health Support is responsible for:

- Monitoring and Reporting:
  - Supplier (Print and Print Management Services) performance
  - Quality issues (product, artwork and supply)
  - Health Service usage and expenditure
  - Health Records Forms gallery
- Management and support of the SFMC.
- Implementation of a Communication Plan.
- Collaboration with Health Item Master File program.
- Maintenance of the State Health Record Forms and bar-code number allocation register.
- Management of print supplier contract and meeting costs associated with contract, (e.g. destruction of obsolete forms etc).

Persons undertaking the evaluation of forms are responsible for:

- Confirming that the form is compliant with the current Australian Standards on Hospital Medical Records (AS2828).
- Ensuring the form has a consistent format and template.
- Ensuring that the form meets the criteria as per stated throughout the Appendices to this policy.
- There is clear evaluation criteria against which the form is to be evaluated.
- A diverse group is selected to evaluate where applicable and possible and that consultation with any Health Service which is taking part in the evaluation has been consulted with at the highest level.
- Evaluation report is clearly documented and that any changes made to a form are within the boundaries of any policy directive which the form maybe written from.
- That any change which is outside a policy within which the form has been written from is referred back to the content owners for approval.
- That the form is in and remains in State Forms Management Committee State forms template.

BACKGROUND

About this document

In line with the strategic reform initiative, NSW Department of Health has instructed Health Support Services to include forms rationalisation and print management across NSW Health. This project will ultimately cover all forms however initially health records rationalisation is being addressed.

It is estimated that there are approximately 15,000 commercially printed health record forms being used across NSW Health. There is not a common Statewide process to develop or review health (clinical) record forms. Not all forms comply with current Australian standards (e.g. AS2828). NSW Department of Health develops policies and guidelines with health records forms incorporated for implementation across NSW Health without always making provision for:

- A co-coordinated implementation plan across all Health Services and agencies
- Compliance with the current Australian Standards (i.e. for paper-based health care records - AS2828)
- Review of the printing and distribution requirements and impact across all Health Services and agencies.

Key definitions

Health Record Form: A record of the provision of care, assessment, diagnosis, management and/or professional advice given to a person. This term is used inter-changeably with clinical form. A Health Record Form is a Clinical form that is endorsed by Health Service Forms Committee for use within the area/service.

State Health Record Form is considered to be a:

- Clinical Form that is mandated by NSW Department of Health for statewide usage. See appendix 3 for the Statewide forms templates.
- Clinical Form that Health Services have devised for health service or agency use.
- Clinical Form that has undergone a NSW Health State Forms Management Committee (SFMC) approval process.

Health Care Record: A Health Care Record is a documented account of a patient's/client's health evaluation, diagnosis, illness, treatment, care, progress and health outcome that provides a means of communication for all health care personnel during each visit or stay at a health service. It is the primary repository of all information regarding patient/client care.

The record is used to care for the patient/client during an episode of care but may also be used for future episodes of care, communication with external health care providers and regulatory bodies, planning, research, education, financial reimbursement, quality improvement and public health. The health care record may also become an important piece of evidence in protecting the legal interests of a patient/client, clinician or Health Service.

The health care record may be in hard copy, electronic or other form, and unless otherwise indicated, the provisions of this policy directive apply equally to all health care records regardless of the media in which they are kept.

Health Service: a Health Service within the boundaries of the *Health Service Act 1997* (which includes Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Hospitals)

SFMC: NSW Health State Forms Management Committee.

Site: Physical facility or service e.g. Hospital, Community Health Centre, Renal Service, Justice Health site.

Location: Ward, Oral Health, Clinic, Unit e.g. ICU, ED

Rationale

The introduction of statewide health records forms will assist in:

- Promoting quality processes through
  - Consistent business practices when designing and implementing clinical forms across NSW Health.
  - Statewide standardised document control for all Health Record Forms included in NSW Health Policies.
- Health Services and agencies transferring to electronic medical records systems.
- Streamlining the implementation of NSW Health Policy and forms at the Health Service and agency level.
- Supporting scanning of health care records, including a standardised bar-coding system and the maintenance of a State Health Record Forms Register.
- Promoting effective and efficient work practice by:
  - Decreasing the workload at Health Services and Agencies, who are currently responsible for the implementation of forms incorporated in NSW Health policies and guidelines.
  - Standardising information and formatting to assist staff across NSW Health to accurately and consistently collect patient information, regardless of the health care facility or service.

1. NSW Health State Forms Management Committee

1.1 Terms of Reference

The Committee has the following Terms of Reference:

- Co-ordinate the development of State Health Record Forms and documents.
- Standardise State Health Record Forms and documents and across the whole of NSW Health where possible.
- Ensure compliance with relevant Australian Standards where appropriate.
- Ensure liaison and co-ordination with the Electronic Medical Records Project (eMR) and other related electronic information systems.
- Provide a formalised communication network between form users, NSW Department of Health, Health Support and the contracted Print and Print Management Services Supplier.
- Disseminate forms and related information across NSW Health.
- Approve statewide health record forms and allocate a unique form number.
- Oversee the maintenance of the State Health Record Forms Register.
- Ensure actions and issues are assigned to the appropriate personnel either within Health Support, Health Services/Agencies, NSW Department of Health or the contracted Print and Print Management Services Supplier.
- Regularly review the statewide electronic forms web-site, when developed, for accuracy and initiate remedial action as required.
- Make recommendations for ongoing introduction/amendment/deletion of forms.
- To complement existing Health Service Forms Committees to ensure only endorsed approved (local or state) health record forms are produced for filing in the Health Care Record.

1.2 Governance

The Committee will be responsible to the Deputy Director-General, Health System Support.

1.3 Representation

NSW Health Services (NSCCAHS/HNEAHS/SESIAHS/SSWAHS/SWAHS/GSAHS/GWAHS/ NCAHS/CHW and Justice Health)

Health Support
By Invitation as required

- Standards Australia representative
- NSW Department of Health representative
- eMR Project Team representative
- Ambulance Service NSW representative
- MH-OAT representative
- Print and Print Management Services Contractor representative
- Other persons involved with special projects involving clinical forms and health records

3. Development of Statewide Health Record Forms

3.1 Identification of need for new or revised health record forms

Sources for identifying the need for the development or revision of a State Health record form include, but are not limited to:

- State executive sources including legislative requirements, NSW Health Policy Directives, Guidelines, Australian Standards and specific industry requirements, better practice or research evidence
- Service reviews, Incident Information Management System (IIMS), complaints, root cause analysis (RCAs) and peer review
- Internal and External audit reports

3.2 Development Stage

Custodians and authors of proposed State Health Record forms are required to:

- Search for an existing or similar form.
- Source relevant documentation where possible and ensure forms comply with Best Practice, both in forms design and clinical practice.
- Ensure compliance with NSW Health policy directives, guidelines and information bulletins.
- Ensure there is endorsement from Health Services and supply confirmation of this in writing to the SFMC.
- Ensure that the form utilises the SFMC Forms Template.
- Contact relevant Health Service Forms Committee to identify which form is to be replaced and provide reasons for replacement
- Through their SFMC representative, send an electronic version of the form and completed application package for approval to the SFMC – see appendix 7 for application checklist
- Consider usage when stock numbers are being established.
- Specify colour, print and other specifications at the time of form submission.
- Comply with relevant Australian Standards (e.g. AS2828)
- Ensure forms are developed in liaison with appropriate clinical representation at both State and Area level.
- Ensure forms meet medico-legal requirements.
- Ensure relevant stakeholders are alerted to form development.
- Ensure training and/or implementation guidelines and materials are developed and distributed to appropriate Area representatives prior to the introduction of the form.

- The AHS is to establish a single line of communication with the SFMC; and the process for submission to the SFMC should confirm the above has been undertaken and the proposal endorsed at an Area Health Service level, prior to submission.

3.3 Considerations

The impact of creating new Health Record forms is to be considered. This impact may include:

- Increased staff work load due to staff completing the form and Medical Record/Clinical/Health Information Department filing the form.
- Increased size of medical records, which may impact on storage space and have potential OH&S issues due to the weight
- Costs – for example the colour of form or print, NCR paper, A3 size and booklets.

Instructions/protocols/checklists should not, as a general rule, be included on the back of forms. Rather, alternate approaches should be explored to minimize interference with clinical documentation and unnecessary space requirements in the health care record. For example, instructions can be laminated and placed in an obvious area when introducing the form and/or be included in a procedure.

Only Health Record forms endorsed by the SFMC (or Health Service Forms endorsed by the local Forms Committee) will be filed in the Health Care Record. If a Health Record form is released for use without an authorized form number and bar-code identifier when one is required, then it will be deemed ineligible to be filed into the Health Care Record.

Revised forms, once approved, will be printed for use when the current supply is depleted. If a form is deemed to pose a clinical risk it is to be destroyed at the contracted printers and the artwork removed.

Photocopying of blank State Health Record forms for use and filing in the Health Care Record is not permitted.

3.4 Validation Stage

The NSW Health State Forms Management Committee (SFMC) will review the proposed Health Record form based on the following criteria:

- Form must comply with NSW Health State templates and current Health Record Standards (e.g. AS2828).
- A unique form number must be allocated from the State Forms Register.
- A bar code identifier must be allocated based on the determined state form number.
- Working with the NSW Health contracted Print and Print Management supplier, to manage printing of the form using the approved SFMC template.
- Informing author or custodian of approval or non-approval
- Managing the gallery of State Health Record Forms.
- Provide support to authors in design and concepts (e.g. colours of print, paper, scanning requirements).

3.5 Consultation Phase

A consultation phase will occur for a two week period from the time the form is released to the AHS's or relevant Health Bodies for comments to be received back.

3.6 Evaluation Criteria

All Health Record Forms will be evaluated on:

- best practice through
  - Consistent format and standardised template.
  - Compliance with current Australian Standards on Hospital Medical Records (AS2828)
- provision of supporting policy and guidelines
- current clinical policy
- clinical work flow
- financial resources
- implementation requirements and the provision of training materials
- decrease in duplication of data items
- decrease in space requirements of health records i.e. storage requirements.

The evaluation process shall include consultation with the Health Services.

3.7 Transition Period

Implementation

High usage clinical forms will be identified for standardisation into the NSW Health statewide template. It is expected that this is where the greatest impact should be gained for cost saving and standard work practice. Examples of these forms are; Medical record covers, Progress notes, Fluid Balance charts, etc.

Phased Transition

The SFMC will determine based on usage and/or clinical criteria the priority for the standardisation of Statewide forms. If more than one form exists then there will need to be consultation with the key stake holders via the members of the SFMC about the design of the most clinically functional and cost effective solution.

Once the SFMC has developed a new form the Print Management Services vendor will be advised not to replace current stock of previous old forms. When the stock is low or no longer available the "Flag" on the Print Management Services vendor's web site will direct users to the NSW Health Statewide standardised form that must be used.

The replacement Statewide form must be available on the Print Management Services vendor's web site before old stock is depleted to ensure continuity of supply.

If old stock is still available after 6 months the Print Management Services vendor will identify this issue with the SFMC for a decision to either:

- Contact the owner of the form and advise them of "The option to write off old stock"
- Make the stock redundant
- Discuss with the relevant Health Service to determine who will bear this cost.

The Option to Write Off Old Stock

If a Health Service or NSW Department of Health Division needs to write off excess "old" stock (in order to introduce "new" stock rapidly), they must be advised that:

a. The Service Level Agreement Contract allows that the Print Management Services vendor is responsible for the (write off) cost of the first 3 months of stock held,
b. The Health Service would be responsible for the cost of the remaining (unused) "old" stock, and the costs of destruction.
c. Where there is stock held which has not moved in the last 12 months, the Print Management Services contractor would notify the owner of the stock of their intent to write off and destroy (noting the above incurred costs), unless advised otherwise within 2 months time
d. If no response or advice is given after that period, then the stock will be written off and the entire cost of the stock and destruction costs will be invoiced to the initiating source.

State Mandated Forms (those included in a NSW Health Policy Directive)

a. If the form is Print on Demand (POD), it can be transitioned to the NSW State Forms Template immediately as there is no stock on hand.
b. If the form is warehoused existing stock will be run out and the form transitioned into the NSW State Forms Template ready to be printed on the next reprint.
c. New forms required by Policy Directives in the process of formulation will follow the requirements of this policy elsewhere described.

3.8 Health Record forms that require a trial

The following guidelines are to be followed for introduction of a new State Health Record Forms which are not available in the NSW Health Print and Print Management Contractor's State Health Record Forms Library:

a. Complete the request and forward it to the Health Service Forms Committee Representative advising of the need to develop/introduce a State Health Record Form. See Appendix 7 for the Application Checklist.
b. The Health Service or agency Forms Representative is to advise the NSW Health State Forms Management Committee (SFMC) Convenor of the proposed form.
c. The SFMC is to formulate the appropriate Working Party who will be responsible for co-ordinating, providing education and supervising the form trial.
d. The time period required for the trial of a form will be dependent on the usage of form. For forms that have a high usage, a minimum trial period of up to 3 months may be required, whilst forms that have a low usage may require up to a 12 month trial period.
e. During the trial period, stocks of the "old" form (if a revised form) must be withdrawn from circulation, to enable a true and accurate trial of the "new" form to occur.
f. All trial forms to adopt the State Forms Template and to be allocated a 'Trial State Forms Number category and bar code'.
g. At the end of the trial period, the outcome of the trial must be evaluated to determine whether the new form has been accepted by users (results of a compliance audit). If the trial is unsuccessful the current version should be deleted from the State Health Record Forms website as a State form or re-designed. If a local area wishes to continue using the trial form they must give it a local form number.
h. The final form to be registered with State Forms Number, category and barcode.

3.9 Low Usage Forms

Those forms that are identified by the SFMC as extremely low usage can be made available via the relevant website (primarily the NSW Health authorised Print and Print Management suppliers' website). These forms can be viewed and printed direct from the website. These forms must adhere to this policy including usage of the approved NSW Health clinical forms artwork and must be approved by the NSW Health SFMC. As identified by the SFMC by usage at the present time this is expected to be in the realm of 100 per annum per site.

4. REFERENCES

4.1 External

Australian Standard AS2828 - Paper Based Health Care Records

4.2 Internal

Electronic Information Security Policy – NSW Health (PD2013_033)
Health Care Records – Documentation and Management (PD2012_069)
NSW Health Patient Matters Manual
Privacy Manual for Health Information (March 2015)

4.3 Glossary

SFMC = NSW Health Statewide Forms Management Committee
HIMS = Health Information Managers
HS = Health Service
PD = NSW Health Policy Directive
POD = Print On Demand
HSS = Health Support
MHOAT = Mental Health Outcomes Assessment Tool

4.4 Appendices

Appendix 1 - Forms Committee Process and Procedure
- a – State Health Care Record Form Process – New Form Process
- b – State Health Care Record Form Process – Targeted Form standardisation

Appendix 2 - Health Forms Design
Appendix 3 - State Forms Templates
Appendix 4 - State Health Care Record Cover Artwork
Appendix 5 - Terminal Digit Colours for Health Care Record Covers
Appendix 6 - Strip Colours and Patterns
Appendix 7 - NSW Health State Health Record Form Design Checklist

ABORIGINAL AND TORRES STRAIT ISLANDER ORIGIN – RECORDING OF INFORMATION OF PATIENTS AND CLIENTS

(PD2012_042)

PD2012_042 rescinds PD2005_547.

PURPOSE

The policy directive and the associated procedures document outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander. Aboriginal and Torres Strait Islander people are under-reported in many health related data collections in NSW. Self-report in response to the standard Australian Bureau of Statistics question about a person's Aboriginality is the most accurate means of ascertaining whether a client is Aboriginal and/or Torres Strait islander. The standard question must be asked of all clients of NSW Health services, and the information needs to be recorded accurately according to national standards.

MANDATORY REQUIREMENTS

1. All NSW Health services are required to collect consistent and comprehensive data on Aboriginal and Torres Strait Islander health.

2. The *Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients: Procedures* document describes the standards required for the accurate collection and recording of data.

3. The standard question seeking information about a person's Aboriginality should be asked of all clients of NSW Health services to establish whether they are Aboriginal and/or Torres Strait Islander:
   'Are you (is the person) of Aboriginal or Torres Strait Islander origin?"

4. These standard response options should be provided to the clients to answer the questions (either verbally or on a written form):
   - ☐ No
   - ☐ Yes, Aboriginal
   - ☐ Yes, Torres Strait Islander
   - ☐ Yes, both Aboriginal and Torres Strait Islander

5. Asking the question:
   - Staff responsible for registering a client should ask the standard question when the client is first registered with the service.
   - The question should be asked of all clients irrespective of appearance, country of birth, or whether or not the staff know the client or their family background.
   - Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.
   - Specific situations related to asking the question are described in Section 2 and Section 4 of the Procedures document.

6. Recording the Information:
   - Information systems should record whether a client is Aboriginal or Torres Strait Islander using the standard categories, which are outlined in Section 3 in the Procedures document.
   - Responses to the standard questions should be coded as described in Section 3 in the Procedures document.

- A response to the standard question should be a mandatory requirement when registering or entering client details in electronic recording systems.
- Local data management systems must be able to identify those records that are coded as not stated/inadequately described which require follow-up.

7. Training in the correct and consistent recording of whether a client is Aboriginal and/or Torres Strait Islander must be delivered to all staff. See Section 5 in the Procedures document.

8. Data quality assurance and validation activities must be undertaken at the local level (Section 6 Procedures document) and by NSW Ministry of Health (Section 7 Procedures document).

IMPLEMENTATION

1. Roles and Responsibilities of NSW Health agencies:

- Chief Executives, Health Service Executives, and Managers are responsible for the implementation of this policy and procedures at the local level.
- All NSW Health employees are responsible for the accurate recording of Aboriginality when ever this is part of their role.

2. Roles and Responsibilities of NSW Ministry of Health:

- NSW Ministry of Health is responsible for providing the mandatory requirements and procedures, and to support the implementation and evaluation of this policy.

3. Activity Based Funding

With the implementation of activity based funding in July 2012, accurate and consistent recording of Aboriginality is essential for the effective application of associated weighting and will enable LHDs/SHNs to:

- Monitor expenditure on health care against funding for Aboriginal clients.
- Enable clinicians and managers to understand the factors contributing to cost variations including the extent to which these relate to patient complexity or differences in the way services are delivered to Aboriginal clients.
- Make decisions about where to invest additional resources to meet increasing demand in the most cost effective way for Aboriginal clients.
- Contribute information about costs to the national "price setter", the Independent Hospital Pricing Authority.
- Be appropriately funded according to the efficient pricing for treating Aboriginal patients.

1. BACKGROUND

1.1 About this document

This Policy Directive replaces Policy Directive PD2005_547 '*Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients'*. This policy directive revises and updates the previous policy.

1.2 Legal and legislative framework

The '*National best practice guidelines for collecting Indigenous status in health data sets'* (AIHW, 2010) documents the national approach for collecting and recording accurate information on whether a client is Aboriginal and/or Torres Strait Islander.

The Council of Australian Governments (COAG) National Indigenous Reform Agreement requires all jurisdictions, including NSW, to implement the National Best Practice Guidelines.

This policy and procedures document incorporate the activities outlined in the National Best Practice Guidelines. The implementation of these will ensure NSW meets their National Indigenous Reform Agreement obligations in relation to identification of Aboriginal and Torres Strait Islander people.

2. ASKING THE QUESTION

2.1 The Standard Aboriginal and Torres Strait Islander Origin Question

The following question should be asked of all clients to establish whether they are Aboriginal and/or Torres Strait Islander:

'Are you (is the person) of Aboriginal or Torres Strait Islander origin?"

2.2 The standard response options

2.2.1 Three standard response options should be provided to the clients to answer the questions (either verbally or on a written form):

- ☐ No
- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, both Aboriginal and Torres Strait Islander

2.2.2 If the question has not been completed on a returned form, this should be followed up and confirmed with the client.

2.3 How to ask the question

2.3.1 Staff responsible for registering a client should ask the standard question seeking information about a person's Aboriginality when the client is first registered with the service.

2.3.2 The question should be asked of all clients irrespective of appearance, country of birth, or whether the staff know of the client or their family background

2.3.3 The question should be placed within the context of other questions related to cultural background, such as country of birth and main language spoken.

2.3.4 Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.

2.3.5 In some situations (such as in the case of birth and death registrations) the client will be unable to answer the question themselves. In this case it is acceptable for certain others (such as mother, father, close friend, relative, or household member) to be asked the question and to answer the question on the client's behalf if they feel confident to provide accurate information.

2.3.6 In instances where the client is temporarily unable to answer the question, it is also acceptable for certain others who know the client well to respond on their behalf; however this response should be verified with the client wherever possible.

3. RECORDING RESPONSES

3.1 How to record responses

3.1.1. Information systems should record information on whether a client is Aboriginal and/or Torres Strait Islander using the standard national categories, which are:

1. Aboriginal but not Torres Strait Islander origin
2. Torres Strait Islander but not Aboriginal origin
3. Both Aboriginal and Torres Strait Islander origin
4. Neither Aboriginal nor Torres Strait Islander origin
9. Not stated/inadequately described

In addition databases in NSW should use the following additional category:

8. Declines to respond

3.1.2 Responses to the standard questions should be coded to the following national standards.

Response	Coding Category
'Yes, Aboriginal' is ticked, but 'Yes, Torres Strait Islander' is not ticked.	1
'Yes, Torres Strait Islander' is ticked, but 'Yes, Aboriginal' is not ticked.	2
'Yes, Aboriginal' is ticked, and 'Yes, Torres Strait Islander' is ticked.	3
'Yes, both Aboriginal and Torres Strait Islander' is ticked	3
'No' is ticked	4
'No' is ticked and either/both 'Yes, Aboriginal', and 'Yes, Torres Strait Islander' is ticked.	1, 2 or 3
Client is capable of responding but declines to respond following prompting/follow-up	8
Where it is impossible for the question to be asked during the contact period	9
Response to the question has been left blank or is incomplete	9

(Note these categories represent national standards, with the addition of the code 8, used by NSW to identify clients who have declined to respond. In the national categories, the NSW Code 8 would be coded as 9. See Section 3.3 for further information).

3.2 Mandatory completion

A response to the standard question on a person's Aboriginality should be a mandatory requirement when registering or entering client details in electronic recording systems. Staff registering or entering details of a client should not be able to proceed with registration until a response has been completed.

3.3 Identifying records for follow up

3.3.1 Local data management systems should be able to identify those records that require follow up. In NSW the code 8 is used (as described in 3.1.2) to identify clients who have declined to answer, and therefore do not require follow up. Client's coded as 9 (not stated/inadequately described) because of situations where it was impossible for the question to be asked during the contact episode, and other situations where the response was left blank or incomplete, require follow up with the client, to determine the correct code.

3.3.2 Additional categories used by NSW or in local systems for the purposes of workflow management and follow-up must be mapped to the correct national category (Categories 1, 2, 3, 4, and 9) before the data are provided to the national data custodian. In NSW, data coded as category 8 (declined to respond) must be recoded to category 9 before submission to national data custodians.

4. IMPLEMENTING THE PROCEDURES IN SPECIFIC SITUATIONS

4.1 In the event of a birth

4.1.1 For perinatal data collections, the standard questions on whether a client is Aboriginal and/or Torres Strait Islander should be asked directly of the mother, regardless of the information separately recorded in the hospital database.

4.1.2 In NSW, information on whether the mother and the newborn baby are Aboriginal and/or Torres Strait Islander must be recorded in the NSW Perinatal Data Collection (See NSW Policy Directive **PD2015_025**).

4.1.3 The mother should be asked to provide the information on whether her baby is Aboriginal and/or Torres Strait Islander in addition to her own Aboriginality.

4.1.4 It should not be assumed that the baby will share the mother's origin. In particular, if the mother does not report her origin as Aboriginal and/or Torres Strait Islander, it should not be assumed that the newborn is therefore not Aboriginal or Torres Strait Islander.

4.2 If the client is a child under 15

4.2.1 Where the client is a child under 15 years of age, the parent or guardian is asked to declare whether the client is Aboriginal and/or Torres Strait Islander on their behalf.

4.2.2 If the parent or guardian is not available, certain others may be asked to provide this information (see 2.3.4).

4.2.3 If the accompanying adult is unable to provide this information, the child's parent/guardian should be contacted as follow-up to establish whether the child is Aboriginal and/or Torres Strait Islander.

4.3 If the client is too ill to be questioned or is unable to respond

4.3.1 When the client is unable to respond to the standard question because they are too ill, unconscious, or too ill due to psychiatric condition or dementia, in the first instance the staff member should ask the client's carer, relative, or any other person accompanying the client (see 2.3.4).

4.3.2 The response provided by this person should be verified with the client when they have recovered sufficiently to be able to answer the questions themselves.

4.3.3 If the person accompanying the client does not know whether the client is Aboriginal and/or Torres Strait Islander, the client should be asked the question directly when they are capable of responding.

4.3.4 In the event that the person accompanying the client does not know whether the client is Aboriginal and/or Torres Strait Islander and the client does not recover sufficiently to provide this information, the answer to the standard question on Aboriginality should be recorded as a non-response.

4.4 If the client does not speak English, or cannot read or write

4.4.1 If the client does not speak English, but is accompanied by someone who can interpret for them, it is recommended that the person accompanying them is asked to translate the question and their response.

4.4.2 If there is no-one with the client who can speak English, it is recommended that an interpreter, or Aboriginal or Torres Strait Islander liaison officer (who can interpret the relevant Aboriginal or Torres Strait Islander language spoken by the client) be called to assist.

4.4.3 If a form is to be provided and the client cannot read or write, it is recommended that an appropriate staff member (e.g. an interpreter, social worker, Aboriginal or Torres Strait Islander Liaison Officer) go through the questions with the client.

4.4.4 All clients' should be given the opportunity to respond to the standard Aboriginality question for themselves. While a client who speaks an Aboriginal language may be highly likely to be an Aboriginal person, their Aboriginality cannot be assumed; the client may be of both Aboriginal and Torres Strait Islander for example.

4.4.5 Non-English speaking clients from various cultural backgrounds should also be asked the question and given the opportunity to self-report in response to the standard question.

4.5 If the client is deceased

4.5.1 Funeral directors, undertakers, medical practitioners and coroners responsible for registering a death or assessing the cause of death must ask the next-of-kin about whether the deceased is Aboriginal and/or Torres Strait Islander. If no next-of-kin is available, then the question should be asked of the broader family. If this information is not able to be obtained from either of these sources, another person who knew the deceased well may be asked to provide this information.

4.5.2 If information on whether the deceased is Aboriginal and/or Torres Strait Islander is missing on the death registration form, the funeral director should follow up with the next-of-kin before the form is sent to the registry. Similarly, medical practitioners or the coroner responsible should attempt to complete this item before the deceased's information is sent to the registry.

4.6 If staff are reluctant to ask the question

4.6.1 Staff should be encouraged to collect information from all clients in a professional and respectful manner, without anticipating or making assumptions about the client's identity or about how the client is likely to react or respond to any given question. Staff should be encouraged to regard the standard question on a person's Aboriginality as no more or less sensitive or problematic than other items of personal data routinely collected from clients.

4.6.2 All client's, whether Aboriginal, Torres Strait Islander, or non-Aboriginal or Torres Strait Islander, have the right to self-report, rather than have their identity assumed and recorded on their behalf. To refrain from asking any client the standard question on a client's Aboriginality is an act of discrimination which infringes upon the client's right to respond to this question for themselves.

4.6.3 Staff should not modify the standard question in any way. The question should be asked correctly, consistently, and uniformly of all clients, using the wording precisely as stated in this policy and procedure.

4.7 If the client wants to know why they are being asked the question

4.7.1 The following provides several responses that may assist staff in explaining to clients the reasons for asking the standard question on a client's Aboriginality:

a. The question on whether a person is Aboriginal and/or Torres Strait Islander is one of several questions related to a client's identity and demographic characteristics that are asked of all clients who attend a health service, enrol with Medicare, or are involved in the registration of a birth or death.

b. The collection of information on whether a person is Aboriginal and Torres Strait Islander is necessary for government and other services to plan and deliver appropriate services for all Australians, to assess the impact of services on particular groups in the community, and to improve health care and to monitor changes in health and wellbeing over time.

c. The response to this question allows service providers to ensure that Aboriginal and Torres Strait Islander clients have an opportunity to access relevant services such as Aboriginal liaison officers and Aboriginal health workers, health checks, Aboriginal and Torres Strait Islander specific immunisation considerations and PBS listings if they choose.

d. Service providers cannot make assumptions about whether a person is Aboriginal, Torres Strait Islander, or non-Aboriginal and Torres Strait Islander, therefore this information can only be determined by asking the client the standard question.

e. All personal information is protected by privacy law. The Privacy Manual for Health Information (March 2015) provides operational guidance for health service staff to the legislative obligations imposed by the *Health Records and Information Privacy Act 2002*, and outlines procedures to support compliance with the Act in any activity that involves personal health information.

4.7.2 Should a client request a more detailed explanation of where the data go or the ways they are used, staff may wish to refer the client to the Australian Institute of Health and Welfare website **www.aihw.gov.au** or the Australian Bureau of Statistics website **www.abs.gov.au**.

4.8 If the client objects to the question or declines to answer

4.8.1 Where a client objects to the question or declines to answer they should be informed of their right to decline to answer the standard question on whether a client is a Aboriginal and/or Torres Strait Islander person and be advised that their level of care and access to services will not be affected if they choose not to answer the question.

4.8.2 While staff have a duty to collect and record information on whether a client is Aboriginal and/or Torres Strait Islander from all clients as correctly as possible, they are not obliged to convince a disgruntled, upset or unwilling client to respond to the question.

4.8.3 While staff have a duty, if queried, to explain to clients why this question is being asked, they are not obliged to justify the use of the standard question.

4.9 If the client chooses not to answer the question 'correctly'

4.9.1 There may be occasions where a client is known to staff as an Aboriginal or Torres Strait Islander person yet the client chooses not to report as such in response to the standard question. Conversely there may be occasions where a known non-Aboriginal or Torres Strait Islander person chooses to report themselves as Aboriginal or Torres Strait Islander in response to this question.

Clients have a right to self-report whether they are Aboriginal and/or Torres Strait Islander and staff should therefore always record the response that the client provides; they should not question or comment on the client's response.

4.9.2 The client's recorded response should not be altered or annotated in any way to reflect the views of the staff member collecting the information.

4.10 If a client identifies as Aboriginal and/ or Torres Strait Islander

4.10.1 Any client who self-reports as Aboriginal and/or Torres Strait Islander should be offered the services of Aboriginal liaison officers or Aboriginal health workers where available; however, the client's choice to engage or not engage with such services should be respected.

4.10.2 Information about a person's Aboriginality should be included on the client's discharge summary.

4.11 If the client wishes to change personal information on their record

4.11.1 All clients should have the opportunity to confirm or update any previously recorded personal information on a regular basis, including confirmation or alteration of a record that they are Aboriginal and/or Torres Strait Islander.

4.11.2 The NSW Health Client Registration Policy (PD2007_094) describes when to update client registration details. Client/patient details, including information on Aboriginal and Torres Strait Islander origin, should be checked and confirmed or updated, as appropriate each time a client presents for a new phase of treatment.

4.11.3 Any changes to the previously recorded information on whether a client is Aboriginal and/or Torres Strait Islander should be received without comment and clients should not be required to provide a reason for changing their record.

5. STAFF TRAINING

5.1 Training in the correct and consistent collection of information on whether clients are Aboriginal and/or Torres Strait Islander must be delivered to all staff.

5.2 This training may be delivered as part of a training that focuses on overall data collection and data quality.

5.3 While it is recommended that all staff receive training in cultural safety for Aboriginal and/or Torres Strait Islander clients, such training should not be considered a pre-requisite for the collection of information on whether a client is an Aboriginal and/or Torres Strait Islander person using the standard question.

5.4 All staff must complete training requirements as outlined in the *Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health* (PD2011_069).

5.5 All persons responsible for collecting, recording and validating information on whether clients are Aboriginal and/or Torres Strait Islander should be able to demonstrate the following competencies:

a. An ability to ask the standard questions *Are you of Aboriginal or Torres Strait islander origin?'* correctly, and to correctly record responses on paper forms and/or computer systems.

b. An ability to clearly explain to clients the reason for collecting this information.

c. An understanding of why it is important to collect and record information on whether all clients are Aboriginal and/or Torres Strait Islander.

d. An understanding of why it is important to collect this information correctly and consistently, using the standard question.

e. An understanding of the voluntary nature of self-reporting a client's Aboriginality, and of a client's right to decline to answer this question or to change the information recorded.

f. Knowledge of available information and services for Aboriginal and Torres Strait Islander clients, and ability to convey this to clients as required.

g. Knowledge of and ability to conduct follow-up procedures for obtaining missing information, including whether a client is Aboriginal and/or Torres Strait Islander.

6. DATA QUALITY ASSURANCE AND VALIDATION AT LOCAL SERVICE LEVEL

For data quality assurance and validation at the local service level, local service providers must:

6.1 Review all forms and data recording systems to ensure the standard question on whether a client is Aboriginal and/or Torres Strait Islander is included and that coding categories are consistent with this policy and procedure.

6.2 Provide appropriate training, supervision and support to staff in primary data collection and data management roles, to ensure data items such as the item recording a client's Aboriginality are collected correctly and consistently

6.3 Ensure data collection processes and systems are streamlined and user friendly for staff in data collection roles.

6.4 Review client intake procedures to ensure client privacy is maintained, particularly in areas where clients are interviewed to obtain personal information.

6.5 Ensure staff across various levels and disciplines within the service are prompted to check for and follow up on missing client registration details, including information on a client's Aboriginality, in their contact with clients.

6.6 Establish business rules for distinguishing between 'not stated/inadequately described' records that are a result of a client's inability to answer (and are therefore to be followed up) and 'not stated/inadequately described' records in which the client declined to answer (which do not require further follow up).

6.7 Establish policies and procedures for correctly following up and correctly coding records with incomplete information on whether a client is Aboriginal and/or Torres Strait Islander.

6.8 Establish business rules for checking information on a client's Aboriginality against other data items, particularly country of birth, language spoken, and Medicare eligibility.

6.9 Monitor trends in the number and proportion of Aboriginal and/or Torres Strait Islander clients by comparing with the previous year's data, to determine whether there have been any obvious errors in coding.

6.10 Conduct data quality surveys involving direct surveys or interviews with clients, to determine the consistency and accuracy of the collection of information on whether clients are Aboriginal and/or Torres Strait Islander and to develop estimates of under-reporting.

7. DATA QUALITY ASSURANCE AND VALIDATION AT NSW MINISTRY OF HEALTH

For data quality assurance and validation state-wide, NSW Ministry of Health must:

7.1 Ensure data providers are aware of the policy and procedure

7.2 Ensure the correct business rules are applied to cope with different identifications when there are two sources of data (e.g. cause of death forms and death registrations). For example, if one data source identifies the client as Aboriginal or Torres Strait Islander, the record relating to this client should be coded accordingly.

7.3 Regularly monitor information on whether clients are Aboriginal and/or Torres Strait Islander and provide continuing feedback on data quality to local services. In particular, monitor levels of 'not stated' reported from local service providers to determine whether further education or assistance is required.

7.4 Regularly check that codes used for recording a client's Aboriginality in local systems are consistent with the policy and procedures, in particular check that invalid or inappropriate codes are not being used.

7.5 Compare data for Aboriginal and Torres Strait Islander persons with variables such as country of birth, language spoken, and Medicare eligibility, and follow up with local service providers to ensure any issues are investigated.

7.6 Regularly check that local service providers have not set default values for the standard question seeking information on whether a client is Aboriginal and/or Torres Strait Islander. This would be evidenced by no reporting of records with a 'not stated' response to the standard question.

7.7 For each local service, compare the number and proportion of records with information indicating clients are Aboriginal and/or Torres Strait Islander with the previous year's data to determine whether there have been any probable errors in coding.

7.8 Establish a system of review and audit of data collection processes and data quality for local service providers, including review and audit of Aboriginal and Torres Strait Islander data.

7.9 Inform the national data custodian of any events or issues that may have affected the quality of data recording whether clients are Aboriginal and/or Torres Strait Islander for a given period.

7.10 Establish a procedure for the prompt investigation and response to data validation requests from the national data custodian.

8. MONITORING

Monitoring of the implementation and impact of this policy directive will be undertaken by NSW Ministry of Health and Local Health Districts:

8.1 In partnership with the Australian Institute of Health and Welfare, NSW Ministry of Health conducts a biannual survey which estimates the level of correct reporting of Aboriginal and Torres Strait Islander people in NSW public hospital data.

8.2 Local Health Districts will be required to determine appropriate indicators to monitor the adherence to this policy.

9. REFERENCES

- Australian Institute of Health and Welfare (2010). National best practice guidelines for collecting indigenous status in health data sets. Cat. No. IHW 29. Canberra: AIHW.
- Privacy Manual for Health Information (March 2015).
- NSW Health (2007) Client Registration Policy (PD2007_094)
- NSW Health (2011) Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health. Policy Directive PD2011_069.

FRONT SHEET/PRINCIPAL DIAGNOSIS

To be read in conjunction with the Health Care Records Documentation and Management Policy (PD2012_069).

The front sheet of the health record must contain the **principal diagnosis,** other diagnoses and any operation(s) performed. Other conditions of significant concern should also be recorded.

The condition to be selected as Principal Diagnosis is the diagnosis established, after study, to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility). For acute surgical hospitals this will generally be the condition or reason for the surgical procedure(s) performed. The principal diagnosis is the major collection item for hospital morbidity statistics and is an important factor in research, evaluation, planning and allocation of resources.

The front sheet must be signed and designated by the medical officer in charge of the patient's care. This responsibility may be delegated to another medical officer, however, the medical officer in charge of the patient's care remains responsible for ensuring that the delegated duty is performed.

The front sheet of the medical record should be completed within 14 days of the patient being discharged.

HEALTH CARE RECORDS – DOCUMENTATION AND MANAGEMENT
(PD2012_069)

PD2012_069 rescinds PD2005_004, PD2005_015 & PD2005_127.

PURPOSE
The purpose of this policy is to:
- Define the requirements for the documentation and management of health care records across public health organisations (PHOs) in the NSW public health system.
- Ensure that high standards for documentation and management of health care records are maintained consistent with common law, legislative, ethical and current best practice requirements.

MANDATORY REQUIREMENTS

Documentation in health care records must provide an accurate description of each patient/client's episodes of care or contact with health care personnel. The policy requires that a health care record is available for every patient/client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

Health care record management practices must comply with this policy.

IMPLEMENTATION
Chief Executives are responsible for:
- Establishing mechanisms to ensure compliance with the requirements of this policy.
- Ensuring health care personnel are advised that compliance with this policy is part of their patient/client care responsibilities.
- Ensuring line managers are advised that they are accountable for implementation of this policy.
- Ensuring implementation of a framework for auditing of health care records and reporting of results.
- Ensuring health care records are audited and results reported within the PHO.

Facility/service managers are responsible for:
- Ensuring the requirements of this policy are disseminated and implemented in their hospital/ department/service.
- Ensuring health care personnel within their facility/service have timely access to paper based and electronic health care records.
- Monitoring compliance with this policy, including health care record audit programs, and acting on the audit results.

Health care personnel are responsible for:
- Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
- Ensuring they are aware of current information about the patient/client under their care including where appropriate reviewing entries in the health record.

1. OVERVIEW

1.1 Introduction

This standard sets out the requirements for documentation and management for all models of health care records within the NSW public health system. Health care records promote patient safety, continuity of care across time and care settings, and support the transfer of information when the care of a patient/client is transferred eg. at clinical handover, during escalation of care for a deteriorating patient and transfer of a patient/client between settings.

1.2 Key definitions

Attending medical practitioner	Visiting Medical Officer or Staff Specialist responsible for the clinical care of the patient for that episode of care.
Approved clinician	A clinician, other than a medical practitioner, approved to order tests eg Nurse Practitioner.
Health care personnel	A person authorised to provide assessment, diagnosis, treatment/care, observation, health evaluation or professional advice or those personnel who have access to the patient/client health care records on behalf of the NSW public health system to facilitate patient/client care. Health care personnel include clinicians (and students) and clinical support staff. Clinicians include registered health practitioners[83] and other including Assistants in Nursing, social workers, dieticians, occupational therapists and Aboriginal Health Workers. Clinical support staff include Health Information Managers, Clinical Governance and Patient Safety staff, ward clerks, health care interpreters and accredited chaplains.
Health care record	The main purpose of a health care record is to provide a means of communication to facilitate the safe care and treatment of a patient/client. A health care record is the primary repository of information including medical and therapeutic treatment and intervention for the health and wellbeing of the patient/client during an episode of care and informs care in future episodes. The health care record is a documented account of a patient/client's history of illness; health care plan/s; health investigation and evaluation; diagnosis; care; treatment; progress and health outcome for each health service intervention or interaction. The health care record may also be used for communication with external health care providers, and statutory and regulatory bodies, in addition to facilitating patient safety improvements; investigation of complaints; planning, audit activities; research (subject to ethics committee approval, as required); education; financial reimbursement and public health. The record may become an important piece of evidence in protecting the legal interests of the patient/client, health care personnel, other personnel or PHO. The health care record may be paper, electronic form or in both. Where a health care record exists in both paper and electronic form this is referred to as a hybrid record. Where PHOs maintain a hybrid record health care personnel must at all times have access to information that is included in each part. This policy applies to health care records that are the property if, and maintained by, PHOs, including health care records of private patients seen in the PHO. The policy does not apply to records that may be maintained by patients/clients and records that may be maintained by clinicians in respect of private patients seen in private rooms.

[83] Health practitioners registered under the following National Boards - Chiropractic, Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology - are required to comply with the health care records section of their relevant code of conduct/guidelines/competency standards. On 1 July 2012 the following healthcare personnel will be represented by a national registration board - Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners, and occupational therapists http://www.ahpra.gov.au/.

Must	Indicates a mandatory action required by a NSW Health policy directive, law or industrial instrument.
Medical practitioner	A person registered under the Health Practitioner Regulation National Law (NSW) in the medical profession.
Public health organisation (PHO)	a) Local health district. b) Statutory health corporation that provides patient/client services. c) Affiliated health organisation in respect of its recognised establishment or recognised service that provides patient/client services, or d) Ambulance Service of NSW.
Should	Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action.

1.3 Privacy and confidentiality

All information in a patient/client's health care record is confidential and subject to prevailing privacy laws and policies. Health care records contain health information which is protected under legislation.[84] The requirements of the legislation, including the Privacy Principles, are explained in plain English in the NSW Health Privacy Manual.[85] Health care personnel should only access a health care record and use or disclose information contained in the record when it is directly related to their duties and is essential for the fulfilment of those duties, or as provided for under relevant legislation.

1.4 Auditing

Health care records across all settings and clinical areas must be audited for compliance with this policy. PHOs must establish a framework and schedule for auditing of records and approve and designate audit tools and processes.

Clinical audits of documentation in health care records should involve a team based approach with the clinical team consisting of medical practitioners, nurses, midwives, allied health practitioners and other health care personnel, as appropriate.

Health care record audit results should be:
a) Provided to relevant clinical areas and health care personnel.
b) Included in PHO performance reports.
c) Referred to PHO quality committees to facilitate quality improvement.

1.5 Education

PHOs must establish a framework for the development and delivery of suitable education on documentation and management of health care records. All health care personnel who document or manage health care records must be provided with appropriate orientation and ongoing education on the documentation and management of health care records.

The content and delivery of education programs should be informed by health care record audits. The results of such audits should be used to target problem areas relating to particular health care personnel groups or facets of documentation and management.

Specific education must be conducted for the introduction of any new complex health care record forms and for changes in documentation models.

[84] Health Records and Information Privacy Act 2002 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+71+2002+cd+0+N
[85] Privacy Manual for Health Information (March 2015)

2. DOCUMENTATION

2.1 Identification on every page/screen[86]

The following items must appear **on every page of the health care record**, or on each screen of an electronic record (with the exception of pop up screens where the identifying details remain visible behind):

a) Unique identifier (eg. Unique Patient Identifier, Medical Record Number).
b) Patient/client's family name and given name/s.
c) Date of birth (or gestational age/age if date of birth is estimated).
d) Sex. The exception is ObstetriX records where sex of the mother is not recorded.

2.2 Standards for documentation[87]

Documentation in health care records must comply with the following:

a) Be clear and accurate.

b) Legible and in English.

c) Use approved abbreviations and symbols.

d) Written in dark ink that is readily reproducible, legible, and difficult to erase and write over for paper based records.

e) Time of entry (using a 24-hour clock - hhmm).

f) Date of entry (using ddmmyy or ddmmyyyy).

g) Signed by the author, and include their printed name and designation. In a computerised system, this will require the use of an appropriate identification system eg. electronic signature.

h) Entries by students involved in the care and treatment of a patient/client must be co-signed by the student's supervising clinician.[88]

i) Entries by different professional groups are integrated ie. there are not separate sections for each professional group.

j) Be accurate statements of clinical interactions between the patient/client and their significant others, and the health service relating to assessment; diagnosis; care planning; management/ care/treatment/services provided and response/outcomes; professional advice sought and provided; observation/s taken and results.

k) Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient/client or to provide ongoing service at any time.

l) Written in an objective way and not include demeaning or derogatory remarks.

m) Distinguish between what was observed or performed, what was reported by others as happening and/or professional opinion.

n) Made at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.

[86] PD2009_072 State Health Forms http://www.health.nsw.gov.au/policies/pd/2009/PD2009_072.html
[87] Each registered health practitioner is required to comply with the health care records section of the code of conduct/guidelines/competency standards under their relevant National Board
[88] PD2005_548 Student Training and Rights of Patients http://www.health.nsw.gov.au/policies/pd/2005/PD2005_548.html and GL2005_034 Reports - Countersigning Enrolled Nurse, Trainee Enrolled Nurse or Assistant in Nursing Patient Care http://www.health.nsw.gov.au/policies/GL/2005/GL2005_034.html

o) Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.

p) Be relevant to that patient/client.

q) Only include personal information about other people when relevant and necessary for the care and treatment of the patient/client.

r) **Addendum** - if an entry omits details any additional details must be documented next to the heading 'Addendum', including the date and time of the omitted event and the date and time of the addendum.

For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and/or attached to existing forms.

s) **Written in error** - all errors are must be appropriately corrected.
No alteration and correction of records is to render information in the records illegible.

An original incorrect entry must remain readable ie. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction is to draw a line through the incorrect entry or 'strikethrough' text in electronic records; document "written in error", followed by the author's printed name, signature, designation and date/time of correction.

For electronic records the history of audited changes must be retained and the replacement note linked to the note flagged as "written in error". This provides the viewer with both the erroneous record and the corrected record.

2.3 Documentation by medical practitioners

Documentation by medical practitioners must include the following:

a) Medical history, evidence of physical examination.

b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures/ interventions and progress for each treatment episode.

A principal diagnosis must be reported for every episode of admitted patient care.

c) Medical management plan.

d) Where an invasive procedure is performed and/or an anaesthetic is administered, a record of the procedure including completion of all required procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.

e) Comprehensive completion of all patient/client care forms.

f) A copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients/clients must be retained in the patient/client's health care record.

2.3.1 Attending Medical Practitioner

The Attending Medical Practitioner (AMP) is responsible for the clinical care of the patient/client for that episode of care and is responsible for ensuring that adequate standards of medical documentation are maintained for each patient/client under their care.

When documentation is delegated to a medical practitioner e.g. Intern, Resident, Registrar, the AMP remains responsible for ensuring documentation is completed to an appropriate standard that would satisfy their professional obligations.

The AMP should review the preceding medical entries and make a written entry in the health care record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan for the patient/client to ensure it remains current and clinically appropriate, consistent with the AMP's duty of care to the patient/client.

2.4 Documentation by nurses and midwives

Documentation by nurses and midwives must include the following:

a) Care/treatment plan, including risk assessments with associated interventions.

b) Comprehensive completion of all patient client care forms.

c) Any significant change in the patient/client's status with the onset of new signs and symptoms recorded.

d) If a change in the patient/client's status has been reported to the responsible medical practitioner documentation of the name of the medical practitioner and the date and time that the change was reported to him her.

e) Documentation of medication orders received verbally, by telephone/electronic communication including the prescriber's name, designation and date/time.

2.5 Frequency of documentation

The frequency of documentation entries should conform to the following as minimum requirements.

2.5.1 Acute Care Patient/clients

a) Registered Nurse/Midwife, Enrolled/Endorsed Nurse should make an entry in the patient/ client's health care record a minimum of once a shift. An entry by an Assistant in Nursing should **not** be the only entry for a shift.

   Entries should reflect in a timely way the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient/client's condition and/or treatment should be documented as these occur.

b) Medical practitioners should make an entry in the health care record at the time of events, or as soon as possible afterwards, including when reviewing the patient/client.[89]

c) Other health care personnel should make entries to reflect their level of assessment and intervention consistent with the medical management plan.

2.5.2 Long Stay or Residential Patients/Clients

Depending on the health care setting and the length of stay (or expected length of stay) of the patient/ client, health care personnel should make an entry at least weekly in the health care record particularly when warranted by the patient's medical condition or frailty.

Additional entries should be made to reflect changes in the patient/client status, condition and/or treatment or care plan as these occur.

2.5.3 Non-Admitted Patient/Clients

An entry must be made in the health care record for each patient/client attendance (including video conference sessions) and for failures to attend.

[89] Medical Board of Australia. Good Medical Practice: A Code of Conduct http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Entries should reflect the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient/client's condition and/or treatment should be documented.

Attendance of individual patient/clients at sessions of a formal multiple session group program should be noted. Such attendances may be documented in an attendance register or scheduling system rather than the patient/client's health care record. Where a patient/client receives specific individual care or treatment in addition to the group session interaction, this care or treatment should be documented in their health care record.

2.6 Alerts and allergies

Clinicians must flag issues that require particular attention or pose a threat to the patient/client, staff or others including:

a) Allergies/sensitivities or adverse reactions, and the known consequence.

b) Infection prevention and control risks.

c) Behaviour issues that may pose a risk to themselves or others.

d) Child protection/well being matters including

   i. alerts and flags for High Risk Birth Alerts or prenatal reports
   ii. children at risk of significant harm
   iii. where NSW Police or the Department of Family and Community Services have issued a general alert to a PHO.

e) Where patients/clients have similar names and other demographic details.

PHOs must implement systems for the identification of such alerts and allergies. If a label is used on the outside folder of a paper based health care record this does not negate the need for documentation in the health care record of the alert/allergy, and known consequence.

Any such issue should be 'flagged' or recorded conspicuously on appropriate forms, screens or locations within the health care record. Where alerts relate to behaviour issues or child protection matters the alert should be discreet to ensure the privacy and safety of the patient/client, staff or others.

These flags, especially where codes or abbreviations are used, must be apparent to and easily understood by health care personnel; must not be ambiguous; and should be standardised within the PHO.

A flag should be reviewed at each admission. When alerts and allergies are no longer current this must be reflected in the health care record and inactivated where possible.

2.7 Labels

Non-permanent adhesive labels should be avoided. Where considered essential the label must be relevant to the patient/client and placed so that all parts of the health care record are able to be read and patient/client privacy maintained. State approved labels must be used.

2.8 Tests - requests and results

The health care record must document pathology, radiology and other tests ordered, the indication and the result.

When tests are ordered the name of the ordering medical practitioner/approved clinician and their contact number must be clearly printed (if written) or entered (if computerised) on the request form.

Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner/approved clinician, with endorsement involving the name, signature, designation of the medical practitioner/ approved clinician, and date/time.

PHOs must develop local procedures, including steps to be taken, when:
a) Relevant details on the request form are incomplete or illegible.
b) The ordering medical practitioner/approved clinician is not on duty or contactable.

Critical/unexpected/abnormal results should be documented in the patient/client's health care record by the responsible medical practitioner/approved clinician as soon as practicable and any resultant change in care/treatment plans documented.

2.9 Patient/client clinical incidents

All actual clinical incidents must be documented in the patient/client's health care record.[90]

Staff must document in the health care record.
a) Incident Information Management System (IIMS) identification number.
b) Clinically relevant information about the incident.
c) Interactions related to open disclosure processes.[91]

2.10 Complaints

Complaint records are not to be kept with the patient's health care record.[92]

2.11 Emergency Department records

Emergency Department records must include the following:

a) Date and time triaged including triage score.

b) Presenting problem and triage assessment.

c) Date and time seen by a medical practitioner, other clinicians such as a Clinical Initiatives Nurse, Nurse Practitioner, nursing, midwifery and allied health staff.

d) Medical, nursing, midwifery and allied health assessment.

e) Pathology, radiology and other tests ordered. Pathology, radiology and other test results must be followed up and reviewed with notation as to action required.

f) Description of critical/unexpected/abnormal pathology, radiology and other test results. If the patient/client has left the Emergency Department and not been admitted, document the steps taken to contact the patient/client or their carer if the test results indicate that urgent treatment/ care is required.

[90] PD2014_004 Incident Management Policy http://www.health.nsw.gov.au/policies/pd/2014/PD2014_004.html
[91] PD2014_028 Open Disclosure Polocy http://www.health.nsw.gov.au/policies/pd/2014/PD2014_028.html
[92] Complaint Management Policy (section 7.9) http://www.health.nsw.gov.au/policies/pd/2006/PD2006_073.html

g) Details of treatment.

h) Follow up treatment where applicable.

i) Transfer of care date and time, destination (eg. home, other level of health care) method and whether accompanied.

2.12 Anaesthetic reports

Anaesthetic reports must include the following:

a) Pre-operative assessment, including patient anaesthetic history.

b) Risk-rating eg. American Society of Anaesthesiologists (ASA) score.

c) Date and time anaesthetic commenced and completed.

d) Anaesthesia information and management ie. medications, gases, type of anaesthetic.

e) NSW safety checklists including patient assessment and equipment checklists consistent with Australian and New Zealand College of Anaesthetists requirements.

f) Operative note/monitor results.

g) Post-operative notes/orders.

2.13 Operation/procedure reports

Operation/procedure reports must include the following:

a) Date of operation/procedure.

b) Pre-operative and post-operative diagnosis.

c) Indication for operation/procedure.

d) Procedure safety checklist.

e) Surgical operation/procedure performed.

f) Personnel involved in performing the operation/procedure.

g) Outline of the method of surgery/procedure.

h) Product/device inserted and batch number.

i) Changes to, or deviations from, the planned operation/procedure, including any adverse events that occurred.

k) Tissue removed.

l) Pathology ordered on specimens.

m) Post-operative orders.

2.14 Telephone/electronic consultation with patient/clients

When clinical information is provided to a patient/client, or their carer/guardian/advocate, the consultation must be documented in the health care record. The identification of the caller must be documented.

Where the caller is not the patient/client, or their carer/guardian/advocate obtain consent from the patient/client, or their carer/guardian/advocate prior to the consultation. Document the:

a) Caller's name,
b) Relationship to the patient/client, and
c) That the patient/client, or their carer/guardian/advocate has consented to the caller seeking clinical information about the patient/client

in the patient/client's health care record.

2.15 Telephone/electronic consultation between clinicians

Where a clinician involved in the care and treatment of a patient/client formally consults another clinician, via telephone/electronic means, about the patient/client and the consulted clinician provides advice, direction or action, that advice, direction or action must be documented in the health care record by the clinician seeking the advice. The name and designation of the consulted clinician, and the date/time of the consultation must also be documented as soon as practical following consultation with the other clinician and in a manner as to ensure continuity of care for patients.

2.16 Leave taken by patients/clients

Any leave taken by the patient/client should be documented in their health care record with the date/ time the patient/client left and returned. The patient/client should be assessed before proceeding on leave and the outcome of that assessment documented in the health care record, together with the documented approval of the AMP noting the assessment.

2.17 Leaving against medical advice

A patient/client who decides to leave the health service/program against medical advice must be asked to sign a form to that effect with the form filed in the patient/client's health care record. If the patient/client refuses to sign the form this must be documented in the health care record, including any advice provided.

Examples of advice that could be provided to the patient/client include:

a) The medical consequences of the patient's decision, including the potential consequences of no treatment.

b) The provision or offering of an outpatient management plan and follow-up that is acceptable and relevant to the patient.

c) Under what circumstances the patient should return, including an assurance that they can elect to receive treatment again without any prejudice.

3 MANAGEMENT

3.1 Responsibility and accountability

The Chief Executive of the PHO must comply with the State Records Act and its regulation in respect of health care records.[93]

Responsibility for the maintenance of appropriate health care records must be included in the terms and conditions of appointment (including position descriptions) for all health care personnel as defined in this policy.

Documentation must be included as a standing item in annual performance reviews of clinicians. Failure to maintain adequate health care records will be managed in accordance with current NSW Health policies and guidelines for managing potential misconduct.

3.2 Individual health care record

An individual health care record with a unique identifier (eg unique patient identifier, medical record number) must be created for each patient/client who receives health care. Every live or still born baby must be allocated a unique identifier that is different to the mother.

Where multiple patient identifiers exist for the same patient/client within a PHO there must be processes established for their reconciliation and linkage, with the ability to audit those processes.

A reference notation should be placed on the health care record to identify any relevant other documents that relate to the patient's health care. Index or patient administration systems must reference the existence of satellite/decentralised health care records that address a specific issue and that are kept separate from the principal health care record. Due to the nature of the information contained in sexual assault records these must be maintained separately from the principal health care record and be kept secure at all times; as should child protection/wellbeing and genetics records.

Staff screening and vaccination records are considered as personnel rather than health care records and must be maintained separately.

3.3 Access

Health care records should be available at the point of care or service delivery. Health care records must not be removed from the campus unless prior arrangements have been made with the PHO eg. required for a home visit, required under subpoena.

Health care records are only accessible to:[94]

b) Health care personnel currently providing care/treatment to the patient/client.
c) Staff involved in patient safety, the investigation of complaints, audit activities or research (subject to ethics committee approval, as required).
c) Staff involved in urgent public health investigations for protecting public/population health, consistent with relevant legislation.[95]

[93] State Records Act 1998 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+17+1998+cd+0+N
[94] Privacy Manual for Health Information (March 2015)
Health Records and Information Privacy Act 2002 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+71+2002+cd+0+N,
Government Information (Public Access) Act 2009 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+52+2009+cd+0+N
[95] Public Health Act http://www.legislation.nsw.gov.au/

d) Patient/client to whom the record relates, or their authorised agent, based on a case by case basis in accordance with health service release of information policies and privacy laws.
e) Other personnel/organisations/individuals in accordance with a court subpoena, statutory authority, valid search warrant, coronial summons, or other lawful order authorised by legislation, common law or NSW Health policy.

All requests for information, that is contained in a patient/client's health care record, from a third/ external party should be handled by appropriately qualified and experienced health care personnel, such as Health Information Managers, due to the sensitive nature of health care records; the special terminology used within them; and regulatory requirements around access to, and disclosure of, information.

3.4 Ownership

The health care record is the property of the PHO providing care, and not individual health care personnel or the patient/client.

Where shared care models or arrangements exist for clinicians to treat private patient/clients within PHO facilities/settings, responsibility for the management of those health care records must be included in the terms of the arrangement between the PHO and the clinician.

3.5 Retention and durability

Health care records must be maintained in a retrievable and readable state for their minimum required retention period.[96]

Entries should not fade, be erased or deleted over time. The use of thermal papers, which fade over time, should be restricted to those clinical documents where no other suitable paper or electronic medium is available e.g. electrocardiographs, cardiotocographs.

Electronic records must be accessible over time, regardless of software or hardware changes, capable of being reproduced on paper where appropriate, and have regular adequate backups.

3.6 Storage and security

The *Health Records and Information Privacy Act 2002* establishes statutory requirements for the storage and security of health care records, which are also included in the NSW Health Privacy Manual. A summary of these requirements is provided below. However, the Privacy Manual should be consulted for further detail in this area.

Personal health information, including healthcare records, must have appropriate security safeguards in place to prevent unauthorised use, disclosure, loss or other misuse. For example, all records containing personal health information should be kept in lockable storage or secure access areas when not in use.

Control over the movement of paper based health care records is important. A tracking system is required to facilitate prompt retrieval to support patient/client care and treatment and to preserve privacy.

[96] Patient Matters Manual (**http://www.health.nsw.gov.au/policies/manuals/Pages/patient-matters-manual.aspx**) and patient/client records requirements at State Records (**http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/general-retention-and-disposal-authorities-1/?searchterm=GDA**)

A secure physical and electronic environment should be maintained for all data held on computer systems by the use of authorised passwords, screen savers and audit trails. If left unattended, no personal health information should be left on the screen. Screen savers and passwords should be used where possible to reduce the chance of casual observation. Consideration may be given to providing staff with different levels of access to electronic records where appropriate (i.e. full, partial or no access).

Details of the roles and responsibilities of staff, including system administrators and IT technical and support staff, concerning the protection of health care records held on electronic information systems are given in the NSW Health Electronic Information Security Policy
http://www.health.nsw.gov.au/policies/pd/2013/PD2013_033.html

3.7 Disposal[97]

Health care records, both paper based and electronic, must be disposed of in a manner that will preserve the privacy and confidentiality of any information they contain.

Disposal of data records should be done in such as way as to render them unreadable and leave them in a form from which they cannot be reconstructed in whole or in part.

Paper records containing personal health information should be disposed of by shredding, pulping or burning. Where large volumes of paper are involved, specialised services for the safe disposal of confidential material should be employed.

The disposal of health care records must be documented in the PHO's Patient Administration System and undertaken in accordance with the relevant State General Disposal Authority.

[97] Patient Matters Manual (**http://www.health.nsw.gov.au/policies/manuals/Pages/patient-matters-manual.aspx**) and patient/client records requirements at State Records (**http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/general-retention-and-disposal-authorities-1/?searchterm=GDA**)

4 IMPLEMENTATION SELF ASSESSMENT CHECKLIST

An Implementation Self Assessment Checklist is provided to support implementation of this policy.

Requirement: Self Assessment:

	Nil	In development	Partial implementation	Mature
A. STRATEGIC FUNDAMENTALS				
PHO has documented processes to manage health care records				
PHO uses an approved abbreviation list				
There are resources and support to implement the Health Care Records policy and regular monitoring of progress by a responsible officer				
Key performance indicators are developed to monitor and measure implementation of the Health Care Records policy in the PHO Examples of performance measures: 1 Patient identification is on every page of the health care record or on each screen of the electronic record. 2 Handwritten entries are legible to a reader other than the author.				
B. INTEGRATION INTO NORMAL BUSINESS SYSTEMS				
Responsibility and accountability for documentation and management of health care records is clearly stated in position descriptions and incorporated into performance review for all relevant health care personnel.				
The design, approval and implementation of health care records forms (including electronic systems) is consistent with state policies and procedures.				

9. HEALTH RECORDS AND INFORMATION 9.161

Requirement: Self Assessment:

	Nil	In development	Partial implementation	Mature
C. ORGANISATIONAL IMPLEMENTATION				
A schedule is in place for auditing of health care records across clinical settings. This should include both record completeness and clinical audits.				
All clinical areas are audited for compliance with the Health Care Record policy according to the schedule noted above.				
Results and analysis of health care record audits are provided to clinicians and managers, and are used to inform remedial quality improvement activities.				
Results and analysis of health care record audits are used to inform education on clinical documentation.				
There is a process for recognition of excellence in the documentation and management of health care records.				
Health care records key performance indicators are monitored at ward/unit, hospital/service and PHO level and benchmarked with appropriate peers.				

NOTIFICATION OF ACUTE RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE – THE NSW PUBLIC HEALTH ACT 2010 (IB2015_057)

PURPOSE

This Information Bulletin provides guidance on the addition of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) to the list of medical conditions in Schedule 1 of the *NSW Public Health Act*, and to the list of notifiable diseases in Schedule 2 of the Act.

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the NSW Ministry of Health website.

KEY INFORMATION

On 2 October 2015 the *NSW Public Health Act 2010* was amended to add ARF and RHD in a person under the age of 35 to:

a) The list of medical conditions in Schedule 1 to that Act:
   i. That must be notified by medical practitioners to the Secretary of the NSW Ministry of Health,

and

b) The list of notifiable diseases in Schedule 2 to that Act:
   i. That must be notified by health practitioners providing care in hospitals to the chief executive officer of the hospital concerned,

and
   ii. That must be notified by the chief executive officer of a hospital to the Secretary of the NSW Ministry of Health.

NOTIFICATION MECHANISMS

Information on the notification of infectious diseases under the *Public Health Act 2010* is detailed in the Information Bulletin IB2013_010.

Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.

In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.

Disease notification guidelines and notification forms for notifiers are available at:
www.health.nsw.gov.au/Infectious/Pages/notification.aspx

NON-ADMITTED PATIENT DATA COLLECTION: CLASSIFICATION AND CODE STANDARDS FOR REPORTING SERVICES PROVIDED FROM 1 JULY 2016 IN A WEBNAP EXTRACT FORMAT (IB2016_039)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and source system administrators of changes to the classification and code set standard for reporting non-admitted patient service provided from 1 July 2016.

KEY INFORMATION

Due Dates for Reporting

Non-admitted patient activity data must be submitted and of acceptable quality by the 10th calendar day of the month after the month the service was delivered.

Patient or summary level non-admitted patient activity reporting

Patient level non-admitted patient activity is to be reported for in scope activity.

Where the requirement to report patient level activity data cannot be met summary level data must be reported.

The following services are only required to report non-admitted patient activity at the summary level.

1. Group immunisation services (Service Type 023 Immunisation – On Mass (no patient level data)
2. Group diagnostic screening services
3. Needle exchange services and supervised injecting room services (including service units classified to Service Unit Establishment Type 11.04 Needle Exchange Allied Health / CNS Unit).
4. Crisis line counselling telephone services.

This data is to be reported by WebNAP, or by mLoad when that capability is provided.

Summary level must not be reported for any service unit reporting activity at the patient level.

There is no longer a requirement to advise the Executive Director, Health System Information and Performance Reporting Branch of the Local Health Districts (LHDs) and Specialist Health Networks (SHNs) intention to decommission summary level reporting for those service units reporting at the patient level.

Reporting of Services with Multiple Providers

When reporting non-admitted patient services in a WebNAP extract via mLoad each individual service provider should be reported, even if two or more providers have the same provider type code.

Occasion of Service Record Identifier

Each occasion of service must be reported with a unique record identifier in the 'Service Event Record ID' field. When resubmitting an occasion of service record the same record identifier must be reported so that the original record is identified and updated.

Where a record identifier is not unique within a single submission to EDWARD, mLoad will prevent the entire file from loading.

Data element classifications subject to change

The requirements for reporting non-admitted patient activity to the Non-Admitted Patient Data

Collection will change for the following data elements:

1. Provider Type
2. Setting Type
3. Financial group.

The changes are of the following type:

1. Some new categories will become effective from 1 July 2016
2. Some existing categories will expire on 30 June 2016
3. Some continuing categories have descriptive label changes.

Implementation

The classification changes must be implemented for the reporting of non-admitted patient services provided on or after 1 July 2016 where they are reported via a WebNAP extract format.

These changes will require LHDs / SHNs to:

- Modify local source system classifications
- Map the local source system categories to the appropriate WebNAP alias code values
- Modify WebNAP Service Options for the service units reporting summary level data and impacted by the changed classifications

This involves:

  - End dating existing service options containing expired reference codes effective 30 June 2016
  - Establishment of new service options containing the new reference codes effective from 1 July 2016.

LHD / SHNs must advise and instruct their source system vendors of the changed requirements and any subsequent need to modify systems. Where a source system is shared between multiple LHDs / SHNs; are compliant with a State Based Build; and / or are subject to application support services provided by eHealth NSW, it is the responsibility of each LHD / SHN to ensure the technical implementation of the modified reporting requirements are raised through the appropriate application support mechanisms. This includes:

- The LHD / SHN Application Advisory Group (AAG) representative ensuring that the change requirements are on the AAG meeting agenda, discussed at the AAG meetings and are approved within a time frame that will enable the implementation due date to be met.
- Directing and authorising eHealth NSW to make the application build change by raising the request for change on the State-wide Service Desk and tracking the change through to its delivery.

Clarification Advice

The NSW Ministry of Health will provide clarification advice regarding the changed reporting requirements outlined in the attachments. Requests for advice should be directed to the Health System Information and Performance Reporting Branch, NSW Ministry of Health.

Primary Contact:

Position: Data Integrity Officer, Non-admitted Activity
Contact: Jill Marcus
Email: jmarc@moh.health.nsw.gov.au
Telephone: (02) 9391 9897

Escalation Contact:

Position: Manager, Data Integrity and Governance
Contact: David Baty
Email: dbaty@moh.health.nsw.gov.au
Telephone: (02) 9391 9828

LINK TO ATTACHMENTS:

http://www0.health.nsw.gov.au/policies/ib/2016/pdf/IB2016_039.pdf

ATTACHMENT 1

Non-admitted Patient Activity Reporting – Changes to Classification and Code Standards for Reporting Services Provided from 1 July 2016 via a WebNAP Extract Format.
This attachment outlines changes to Non-admitted Patient Data Collection (NAPDC) data elements domains, in scope of the existing WebNAP extract, for services provided on or after 1 July 2016.

The final classifications for each data element reported in a code format, incorporating the changes applicable from 1 July 2016, are provided Attachment 2.

The NAPDC WebNAP Data Dictionary in HIRD provides detailed information pertaining to the concepts and classification, including the new and changed category definitions. Links to this data dictionary are provided on the following NSW Ministry of Health Intranet page:

http://internal.health.nsw.gov.au/data/collections/webnap/webnap-data-dictionary-patient-v6.html

ATTACHMENT 2

Non-admitted Patient Activity Reporting – Classification and Code Standards for Reporting Services Provided from 1 July 2016 via a WebNAP Extract Format.

This document provides the NSW Health State classification and code standards applicable to services provided from 1 July 2016 for data elements in scope of the Non-admitted Patient Data Collection Core Minimum Data Set and reported via the legacy WebNAP patient level extract.

The NSW Health State classification and code standards applicable to services reported in the EDWARD extract format are provided at the following NSW Ministry of Health intranet page:

http://internal.health.nsw.gov.au/data/edward/edward-metadata-data-stream-service-event-nap-flat-file-format.html

NON-ADMITTED PATIENT DATA COLLECTION TRANSITION FROM WEBNAP TO EDWARD REPORTING (GL2015_012)

PURPOSE

The purpose of this Guideline is to advise NSW Health non-admitted patient service providers and non-admitted patient activity source system support staff of the changes in requirements involved in the transition from reporting via WebNAP to reporting via the EDWARD.

An understanding of these differences, and the three phases of implementation, is required to reconfigure source system builds and patient level activity extracts, and redesign non-admitted patient activity reporting business processes.

KEY PRINCIPLES

In line with NSW Health's strategic direction and the significantly increased volumes of non-admitted patient services being reported at the patient level by NSW Health services the Non-Admitted Patient Data Collection will transition to be reported via EDWARD rather than the interim system WebNAP.

The migration of the data collection to EDWARD will have significant benefits for Local Health Districts (LHDs) / Specialist Health Networks (SHNs) and other NSW Health agencies. LHDs / SHNs should expect higher data availability, more efficient data loading and resubmission processes, significantly improved data error reporting functionality and appropriately secured access to activity data.

When reported via EDWARD the non-admitted patient, admitted patient and emergency department activity data will be automatically allocated the appropriate National Weighed Activity Unit (NWAU) and integrated into a single data mart that supports full patient journey analysis utilising the Enterprise Patient Registry unique identifier.

USE OF THE GUIDELINE

In order to minimise the transition burden, requirements have been prioritised across three phases:

- **Phase 1**: Report current scope via EDWARD and decommission WebNAP
- **Phase 2**: Convert source system extracts and classifications to the EDWARD format
- **Phase 3**: Integrate additional reporting requirements for specific clinical streams

The EDWARD Business Implementation (EBI) Program collaborating with the NSW Ministry of Health's Health Systems Information and Performance Reporting (HSIPR) Branch will establish a small project team to support transition, testing and address queries as they arise during the migration period.

Phase 1

Implementation of phase 1 requires LHDs/SHNs to load WebNAP patient level and summary level extracts into EDWARD and to cease reporting to WebNAP.

To support the transition to EDWARD reporting during Phases 1 and 2, a file upload, conversion and transfer tool, the EDWARD mLoad Tool, will be available for LHDs/SHNs to upload patient level and summary level data extracts from source systems in either the WebNAP extract format, or the EDWARD extract format.

The tool will apply the necessary file format conversions to WebNAP extracts compliant with the 2015/16 WebNAP reporting requirements and file format. It will also produce a container header file (based on user inputs) for both WebNAP and EDWARD flat file formats, and transfer files to the EDWARD drop zone where they will be automatically loaded into EDWARD.

During this phase LHDs / SHNs:

1. Must build EDWARD extracts for non-admitted patient source systems that are not yet reporting at the patient level
2. Must commence the reconfiguration of WebNAP extracts such that the source system can report activity directly in the EDWARD extract format
3. May cease reporting summary level data for services reporting at the patient level once reporting through the EDWARD mLoad Tool
4. May commence (or fully implement any) transition steps outlined in later phases.

Phase 1 must be completed by **30 June 2016**, to enable the decommissioning of WebNAP.

Phase 2

Implementation of Phase 2 requires LHDs / SHNs to complete the reconfiguration of WebNAP source system extracts into the EDWARD extract format and source systems to be fully aligned with the EDWARD classification standards.

During this phase any changes effective from 1 July 2016 will also need to be incorporated into the EDWARD extracts.

During this phase LHDs/SHNs may implement Phase 3 implementation steps.

Phase 2 must be completed **by 30 June 2017**, to enable the decommissioning of the WebNAP patient level file conversion functionality, compliance with 2016/17 reporting requirements and to establish the foundations required for implementation of Phase 3.

Phase 3

Phase 3 involves reporting the additional data elements set aside in the EDWARD extract file format for the integration of other non-admitted patient data collections for specific clinical streams. It will involve decommissioning the legacy extracts and legacy data repositories (such as HIE and other disparate databases).

This phase may only impact selected source systems. For example, radiotherapy sources system would add data elements required for the integration of radiotherapy waiting times and non-admitted patient cancer notifications, while source systems used by Hepatitis, HIV/AIDS and sexually transmissible diseases services would add data elements pertaining to communicable diseases.

Phase 3 is expected to be completed **by 30 June 2018**, to enable the decommissioning of the HIE and other legacy data repositories and to establish a single comprehensive non-admitted patient data collection.

FURTHER INFORMATION

The NSW Ministry of Health will provide advice and clarifications regarding the requirements for reporting non-admitted patient activity via EDWARD. Requests for advice should be directed to the Health System Information & Performance Reporting Branch, NSW Ministry of Health.

Primary Contact:

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ATTACHMENT

1. “Non-Admitted Patient Data Collection Migration Strategy and Transition Details” -Guideline.

LINK TO COMPLETE GUIDELINE AND ATTACHMENT :

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2015_012

RIGHT TO ACCESS MEDICAL RECORDS BY LEGAL REPRESENTATIVES – MENTAL HEALTH REVIEW TRIBUNAL HEARINGS (IB2018_019)

PURPOSE

The purpose of this information bulletin is to inform Local Health Districts/Specialty Networks of the right of a patient's legal representative to inspect and access the patient's medical records when the patient has a matter before the Mental Health Review Tribunal and the need to facilitate a legal representative's access to such records.

KEY INFORMATION

Under the Mental Health Act 2007, where the Mental Health Review Tribunal (Tribunal) holds a hearing or review in respect of a mental health patient, the patient has a right to be represented by a legal representative. In certain hearings, such as a mental health inquiry, the patient must be represented by a legal representative (or other person approved by the Tribunal). In most cases, a patient's legal representative will be a legal practitioner from LegalAid or a LegalAid panel firm.

In order to ensure that a patient's legal representative can appropriately represent the patient, the Mental Health Act gives a patient's legal representative the right to inspect or have access to any medical records in the possession of the mental health facility at the Local Health District/Specialty Network relating to a patient who has a hearing before the Tribunal.

A legal representative's right to access a patient's records is important in order to ensure that that the legal representative can understand the basis on which the patient has been detained and can properly and fully make submissions to the Tribunal in relation to the patient's detention.

A Local Health District/Specialty Network must facilitate a patient's legal representative's right to inspect or access information about a patient's detention, including admission documents, progress notes and relevant reports.

In advance of a hearing before the Tribunal, the relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must provide the patient's legal representative with access to the medical records of patients who have a hearing before the Tribunal and who are represented by the legal representative. This should generally be done as follows:

- A list of all patients who will be seen by the Tribunal should be prepared by the relevant unit in the Local Health District/Specialty Network in advance of the Tribunal hearing.
- Two copies of the each patient's "relevant medical records" should be printed in advance of the Tribunal hearing - one copy for the Tribunal and one for the patients' legal representative.
- Where a legal practitioner from LegalAid, or a LegalAid panel firm, attends to represent patients, they should be asked to confirm they have been appointed by LegalAid to act as the patients' legal representative. Once they have confirmed they are acting for the patient/s that will be seen by the Tribunal and the practitioner's identification documents have been sighted, a copy of the relevant records should be provided to the legal representative. A form of Confirmation as Legal Representative is at Appendix 1.
- The relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must keep a copy of the Confirmation as Legal Representative form. This could be kept in a separate file or register in the relevant unit and where reasonable a note should be included in each patient's file noting that the patient's legal representative has been given access to the records.

- In a small number of cases, a legal representative other than from LegalAid, or a LegalAid panel firm, will represent a patient. In such cases, written confirmation they act for the patient, and identification documents sighted, must be provided for inclusion in the patient's medical record before a copy of the relevant records is provided to the legal representative. A copy of the written confirmation should be placed in the patient's medical record.
- If a medical practitioner considers that there is information in the medical records that will be harmful for the patient's legal representative to share with the patient, the medical practitioner should warn the legal representative that it would be harmful to share the information with the patient. A legal representative is obliged to have due regard to the warning and not obliged to disclose the information to the patient. If the medical practitioner remains concerned, the practitioner can seek an order prohibiting the disclosure of information to the patient from the Tribunal.

This procedure can be adapted locally when giving access to electronic records.

Relevant medical records will include, at a minimum:

- For a mental health inquiry, all admission and detention documents relating to the current detention of the patient. This will include Assessment Form/s completed at the time of admission. If a person is transferred from another facility there may be more than one such form.
- For a mental health inquiry, a copy of the Statement of Rights, signed and dated by the patient where possible or, if refused, annotated copies recording the same and notations documenting later service.
- Nomination of Designated Carer form/s (including any exclusions) and, if nomination is refused, documentation of any determination by an authorised medical officer or Director of Community Treatment in relation to their appointment of a Principal Care Provider; evidence of further attempts to have the person nominate a Designated Carer.
- Documentation of any recent reviews carried out by a Consultant and/or Registrar or other member of the treating team.
- Documentation by the Consultant/Registrar of their final review prior to the Tribunal hearing, including any plan that specifies the order to be sought at the hearing.
- Recent progress notes.
- Any recent medical practitioner's report.
- Any recent social work or allied health report.
- Any other documents specifically requested by the Tribunal in relation to the matter.

If the patient's medical record contains details about a risk of significant harm under the Children and Young Persons (Care and Protection) Act, details about the mandatory reporter or the report must not be disclosed to the patient's legal representative.

In some circumstances, a patient's legal representative may request access to additional information about the patient. Where the request relates to the patient's mental health or detention, the information should be provided to the patient's legal representative.

Once the legal practitioner is given a copy of the records, the copy of the records is the responsibility of the legal practitioner and can be removed from the hospital. A patient's legal representative will have their own professional and privacy obligations to maintain the confidentiality of the patient's medical records.

Appendix 1: Confirmation as Legal Representative – LegalAid (including LegalAid Panel Firms) - for matters before the Mental Health Review Tribunal

Confirmation as Legal Representative

I,_____, of_____, confirm that I have been appointed by LegalAid to legally represent the patients below who have a hearing before the Mental Health Review Tribunal and who are detained at _____.
[Name of patients and their MRN to be included by the mental health facility]

Name of Patient	MRN

[Legal representative to delete any patient's name who they are not representing]

If a patient does not confirm the instructions, I undertake to inform the mental health facility and return all records provided to me by the facility.

_____

Signed this day of 20

Note: under the Mental Health Act 2007, if a medical practitioner warns the legal representative of that it may be harmful to communicate to the patient, or any other person, specified information contained in the medical records, the legal representative is to have full and proper regard to that warning and the legal representative is not obliged to disclose to the patient any information in the records.

THE GUARDIANSHIP APPLICATION PROCESS FOR ADULT INPATIENTS OF NSW HEALTH FACILITIES (GL2017_013)

GL2017_013 rescinds GL2016_026

PURPOSE

This Guideline will assist relevant professionals, including medical, allied health, nursing and midwifery staff in NSW Health facilities to understand their roles and responsibilities when making an application to the Guardianship Division of NCAT.

KEY PRINCIPLES

The Guideline aims to standardise practice across NSW Health facilities to improve the process for adult inpatients waiting for a guardianship hearing by ensuring that NSW

Health facilities are aware of:
1. When an application to the Guardianship Division of NCAT is necessary and appropriate.
2. Who is responsible for coordinating the application.
3. Who to consult for advice when considering making a guardianship/financial management application.
4. Making applications and providing reports to the Guardianship Division of NCAT within seven days.
5. What assessments and evidence is required when submitting an application to the Guardianship Division of NCAT.
6. How to record data for patients waiting for guardianship on the patient flow portal.

USE OF THE GUIDELINE

This document provides guidance to NSW Health inpatient facilities and their relevant staff when considering whether an application to the Guardianship division of NCAT is necessary. This document should be used as a practice guideline rather than a mandatory directive.

A full copy of the guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_013

318(26/06/17)

GUARDIANSHIP APPLICATION PROCESS FOR ADULT INPATIENTS OF NSW HEALTH FACILITIES (IB2017_001)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health staff:
1. How to obtain assistance in making submissions to NCAT arguing that Local Health Districts (LHDs) and Specialty Networks have legal standing to lodge applications for guardianship orders on behalf of inpatients, and
2. Of changes to NCAT's practice and procedures.

KEY INFORMATION

GL2016_026: The Guardianship Application Process for Adult inpatients of NSW Health Facilities, has been developed in collaboration with clinicians from across Local Health Districts and Pillar organisations.

1. Applications should now be made in the name of the LHD or Specialty Network and legal assistance is available to support this change
The Guideline recommends that applications to NCAT for guardianship orders be made in the name of the LHD or Specialty Network, rather than in the name of an individual health professional. This represents a change to the previous practice of health professionals, typically social workers, lodging

applicants in their own name. The primary purpose of this change is to protect individual health professionals from any adverse consequences of being named as a party to Tribunal proceedings.

Where applications are made in the name of the LHD, NCAT may hold a directions hearing, and request submissions on whether the organisation has standing to be an applicant.

Should this occur in respect of an application, please contact Legal and Regulatory Services at the NSW Ministry of Health (legalmail@doh.health.nsw.gov.au / telephone 9391 9606) so that assistance with preparing and lodging submissions can be provided.

2. Changes to practices and procedures in the Guardianship Division of NCAT

NCAT has advised that from 1 January 2017:
- The guardianship and financial management application forms will be separated into two forms
- The applicant will be directed to give (serve) a copy of the application and any attachments to the parties and the subject person
- The parties will be directed to give (serve) each other any material instead of the registry distributing it
- All parties will receive a notice of hearing, and
- Prior to the hearing the registry will send a list of the materials provided to the Tribunal to the parties and send the material to the subject person.

Service of a copy of the application and any attachments to the parties and the subject person may be done by providing it to the party, or by posting it to them. Service should be documented by the LHD (for example by making a file note stating that the document was handed to the party or keeping a copy of the covering letter, if service is by post).

318(09/01/17)

ADMISSION POLICY FOR NSW HEALTH (PD2017_015)

PURPOSE

The purpose of this policy is to provide guidance to health service staff in regard to the decision to admit, the admission of patients to hospital and associated business processes. This policy aims to ensure consistency in the way that admissions occur and applies to all NSW public hospitals and publically contracted care in other facilities in NSW.

MANDATORY REQUIREMENTS

This Policy Directive applies to all NSW public hospitals (and publically contracted care facilities), which are required to have local policies, protocols and procedures in place consistent with the attached Admission Policy for NSW Health procedures document.

This policy does not describe the data or reporting requirements for the Admitted (and Non-Admitted) Patient Data Collections, which are outlined in separate policies.

IMPLEMENTATION

Chief Executives are responsible for ensuring that this Policy Directive is brought to the attention of Clinical, Finance and Administrative staff who are involved in the admissions process.
Health System Information and Performance Reporting (HSIPR) branch will provide information to existing data governance groups and key established reference groups to assist with local implementation. HSIPR will arrange individual Local Health District/Speciality Health Network information sessions in 2017 to facilitate the introduction of the Admission Policy.

318(15/06/17)

ADMISSION POLICY FOR NSW HEALTH - Procedures

1 INTRODUCTION

The purpose of this document is to provide guidance to health service staff in regard to the decision to admit, the admission of patients to hospital and associated business processes. This policy provides principles and criteria to assist in the decision making process.

The condition, acuity and clinical needs of the patient, as well as the availability of appropriate clinical resources are to be the principal factors guiding treatment decisions and in determining the most appropriate setting for their care.

The decision to admit should not influence specific care and treatment decisions for individual patients. While the decision to admit is based on providing the most appropriate setting in which to treat the patient, it chiefly determines subsequent administrative processes including billing and data collection and reporting. The specification and requirements for those processes are provided separately rather than in this policy, e.g. resources for the Admitted Patient and other data collections are provided at the Data Collections page of the NSW Health Intranet.

1.1 Scope

This policy applies to all NSW public hospitals as well as publically contracted care in other facilities within NSW.
Decisions to admit and discharge patients are clinical decisions and should only be influenced by non-clinical factors as specifically outlined in the Criteria for Admission below.
Patients within residential aged care or community residential settings are out of the scope of this policy.

1.2 Admission Policy Principles

This policy is built on the following nine principles which must be read in conjunction with the *Criteria for Admission* (see 2.2):

1. The decision to admit a patient is primarily a clinical decision to be made by a clinician with admitting rights to the facility who must determine that the patient requires admission.
2. The decision to admit a patient is to be based on the patient's condition and clinical needs, the facility's ability to meet those needs, including the availability of appropriate clinical resources, and with reference to the *Criteria for Admission* listed below (2.2)
3. The decision to admit should be made when other care and treatment options have been considered and determined not to be optimal for that patient at that time.
4. The decision to admit a patient should not be influenced by the following factors;
    - the facility's key performance indicators;
    - the treatment location; or
    - the patient's financial status.
5. Once a patient has been discharged from admitted patient care, if a clinician with admitting rights determines that the patient again requires admitted patient care, this is to be a new admission; not a continuation of the previous admission.
6. An admission may be planned or unplanned. In the case of a planned admission, the decision to admit may be made prior to the patient's presentation at the facility.
7. The clinician with admitting rights to the facility is responsible for ensuring that the clinical decision to admit and the reason for admission are documented in the patient's health record.
8. Application of the Admission Policy should not restrict local innovation in clinical practice or development of alternative models of care.
9. Local governance will provide the strategic and operational direction through which this Admission Policy is implemented.

2 DEFINITION AND CRITERIA FOR ADMISSION

2.1 Admitted Patient

An admitted patient is a person: (i) for whom a clinician with admitting rights to the facility has determined meets the criteria for admission and requires a level of care provided in an inpatient setting, and (ii) who has undergone the admission process but has not yet been separated by the facility.
For each admission there must be documentation in the patient's health record by the admitting clinician, or another authorised clinician, that supports the need for admission.
An admission can occur in a hospital or, in the case of 'Hospital in the Home' programs, another setting such as the patient's residence.

2.2 Criteria for Admission

2.2.1 Emergency Department Patient

A patient treated solely within the emergency department is not to be an admitted patient.
A patient presenting to an emergency department can only be admitted if a clinician with admitting rights to the facility determines the patient requires admission and the patient is transferred to another appropriate treatment location within that facility.

This is to ensure compliance with national regulatory requirements and is the only non-clinical criterion that should direct the decision to admit or not. This provision should not impact or restrict the care and treatment provided to any emergency department patient.
For further information see 3.1 Patients in Emergency Departments

2.2.2 Intended Medical Care or Clinical Management

- The patient requires observation in order to be assessed or diagnosed, this may constitute:
  - Active, skilled observation for assessment, diagnosis or treatment.
  - Initiation or stabilisation of therapy or palliation.
  - Structured therapeutic contact in a rehabilitation or mental health program.
- The patient requires, at a minimum, daily management of their treatment and/or medication, this may constitute:
  - Observation of vital, physiological, behavioural or neurological signs.
  - Parenteral medications and/or fluid replacement.
  - Structured therapeutic contact with appropriately trained and qualified health professionals in one-to-one counselling sessions or group therapy sessions that have clearly defined clinical outcomes.
- The patient's condition requires clinical management and/or facilities not available at their usual residential environment or other non-admitted setting.

2.2.3 Intended Procedure

The patient requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available. Intended procedures are defined as the following:

- **Type A** procedure as specified in the *Private Health Insurance (Benefit Requirements) Rules 2011.*

  Note: This should be read in conjunction with the *Private Health Insurance Act 2007 (Cth)* and the *National Health Act 1953 (Cth)*; or

- **Type B** procedure is a procedure specified as a Band 1, 2, 3, or 4 as described in the Private Health Insurance (Benefit Requirements) Rules 2011; or
- **Type C** procedure is a procedure specified in reference to Medical Benefits Schedule (MBS) items as detailed in the Private Health Insurance (Benefit Requirements) Rules 2011 general medical services tables. These procedures normally do not require hospital treatment.

Special circumstances that may warrant an admission for a Type C Professional Attention Procedure are:

- The patient's residence is in a remote location
- There is insufficient support available in the patient's usual residence
- The patient requires general anaesthesia so that a Type C procedure can be performed (e.g. child requiring a CT scan).

Note: A patient may remain an admitted patient even if the procedure for which they are admitted is cancelled.

2.2.4 Newborns

A patient aged 9 days or less must be admitted under the following additional scenarios:

- When born in the hospital;
- When a patient was intended to be born in the hospital and the birth occurs within 24 hours of the mother's arrival at the hospital; and
- When a newborn baby born at home or another facility presents to hospital and requires specialist care.

A still born baby (of 20 weeks gestation or more, or if the gestation cannot be determined, with a body mass of 400 grams or more) is not admitted but must be registered in the patient administration system.

2.2.5 Other

Where there is a legal requirement for admission (e.g. under child protection legislation) or involuntary admission of patients under certain legislation, such as the *Mental Health Act 2007 (NSW)*, the *Drug and Alcohol Treatment Act 2007 (NSW)*, and the *Mental Health (Forensic Provisions) Act 1990 (NSW).*

Community Residential services are out of scope for this admission policy as the patients receiving this care are not admitted.

3 ADMISSION GUIDELINES

3.1 Patients in Emergency Departments

A patient treated in and discharged from an emergency department only is not an admitted patient and must not be recorded as such. These patients must be recorded and counted as emergency department non-admitted attendees.
A patient who presents to an emergency department and whose clinical condition meets the criteria for admission, may be formally admitted to the hospital but must be transferred to another appropriate treatment location within the same facility. Such locations may include inpatient wards, operating theatres, short stay units and other treatment locations appropriate to the care required.
When the decision is made to admit a patient from the emergency department, but the patient is discharged, transferred or dies before they proceed to an admitted patient location in that facility, the admission is to be retracted.

The admission date and time are the date and time that the clinical decision to admit the patient is made. The length of time a patient spends in ED is not a criterion for admission; admission is determined by clinical need.

Patients being transferred to another hospital or facility do not require admission before being transferred. Admissions to short stay units must comply with the '*Emergency Department Short Stay Units*' Policy Directive (PD2014_040; 13 Nov., 2014).

3.2 Boarders

A boarder is a person receiving food and/or overnight accommodation from the hospital but does not require clinical treatment or care. For example, a mother accompanies an admitted child or a child staying with an admitted mother.

Patients who turn 10 days of age and do not require clinical care are to be separated and, if they remain in the hospital, are designated as a boarder.

A boarder is not an admitted patient. The hospital may register a boarder in its patient administration system.
A boarder in the Justice Health and Forensic Mental Health Network is defined as a patient who has been medically discharged and is no longer receiving medical treatment. They are however receiving food and/ or accommodation whilst awaiting placement elsewhere.

3.3 Organ Donation

Posthumous organ procurement is the harvesting of human tissue for the purpose of transplantation from a donor who has been declared dead.
Posthumous organ procurement episodes are not reported as admitted patient episodes but must be recorded by the hospital on their patient administration system.
A live organ donor may be admitted to hospital if they meet the criteria for admission.

3.4 Collaborative Care

Collaborative Care is care provided to a patient under an agreement between a purchaser or requestor of admitted patient services and a provider of admitted patient services. Collaborative Care includes:

- contracted care, between a private sector admitted patient facility and a public sector admitted patient facility or two public facilities where a financial or other agreement is in place; AND

- arrangements between two public hospitals where both sites provide part of the continuous care, and where at least one provides only a same-day service, regardless of financial arrangements.

Where a patient is admitted to the purchasing hospital for intended overnight admission and is transferred to and returns from the provider hospital on the same day, the patient must be placed on leave from the first (purchasing) hospital while they are under the care of the second (provider) hospital.
If the patient remains overnight at the second (provider) hospital, they must be discharged from first (purchasing) hospital and admitted to second hospital.

Further information is available in the Admitted Patient Data Dictionary

3.5 Leave from Hospital

An admitted patient may be granted leave with the approval of their Admitting Medical Officer, or other authorised clinician, for a designated period of up to and including seven consecutive days.

The episode of care is continuous while the patient is on leave.

A patient on approved leave may be discharged while on leave.

A voluntary patient on approved leave who does not return by their nominated leave return date, is to be discharged and their discharge date recorded as the earlier of the nominated leave return date or the date which the patient notified the hospital that they were not returning from leave.

A patient that does not return from leave at the conclusion of seven days must be discharged.

For patients who are absent without leave (AWOL), if they do not return within seven days, record the discharge date and time as the date and time at which the patient was first noted to be absent. Involuntary Mental Health patients may be granted a longer period of leave (see section 3.5.2).

Where a patient is on a treatment program that requires admitted patient care each day, but not overnight care, they are to be admitted and discharged each day rather than remaining as a single admission with periods of overnight leave.

Same day patients are not generally granted leave.

3.5.1 Patients on Leave Presenting to an Emergency Department

A patient on leave that presents to the emergency department of the hospital to which they are currently admitted is not to be discharged and then readmitted. The patient should have an ED Type of Visit of 'Current Admitted Patient Presentation' and, if required, a care type change.

A patient on leave from one hospital who presents to the emergency department of another hospital and is admitted to that hospital must be discharged from the first hospital. The second hospital must inform the first that they have admitted the patient.

3.5.2 Involuntary Mental Health Patients

An authorised medical officer may only grant an involuntary patient leave in accordance with the provisions of the *Mental Health Act 2007*.

The period of leave for an involuntary mental health patient may exceed seven days.

An involuntary patient should only be discharged whilst on leave if an authorised medical officer from the admitting facility authorises it, having satisfied themselves that the patient either no longer requires involuntary care under the *Mental Health Act 2007*, or their involuntary care has been transferred to another treating facility or clinician. Under such circumstances, the date of discharge is the date the medical officer authorises the discharge or transfer of the patient. This also applies to involuntary mental health patients who are absent without leave (AWOL).

An involuntary mental health patient on leave from one hospital who presents to another hospital should not be discharged from the first hospital unless an authorised medical officer from that hospital authorises the discharge or transfer of the patient to the second hospital. In the absence of such a discharge or transfer, the patient must remain admitted to both facilities simultaneously.

For further information see Patient Leave Procedures Manual and *Mental Health Act 2007*.

3.6 Care Delivered in an Outpatient Setting

An admission occurs when a clinician with admitting rights to the facility determines that a patient meets the clinical criteria for admission and requires admitted patient care. This does not preclude admitted patients being treated in an outpatient setting.

For procedures and interventions that may be delivered as either admitted or non-admitted care, the decision to admit must be based on the condition, acuity and specific clinical and support needs of that patient.

3.7 Inter-Facility Transfers

A patient that is to be transferred to another facility does not need to be admitted before transfer. Admission to the initial facility may occur if a clinician with admitting rights at that facility determines that the patient meets the clinical criteria for admission and requires admission to the facility prior to transfer.

All inter-facility transfers must comply with '*Inter-facility Transfer Process for Adults Requiring Specialist Care Policy Directive*' (PD2011_031).or *Children and Adolescents – Inter Facility Transfers (PD2010_031).*

3.8 Hospital in the Home

Hospital in the Home (HITH) is a supported model of care and admissions under the HITH program must comply with the provisions of this policy. For specific details around the definitions and eligibility for HITH, refer to the HITH Guidelines and the Admitted Patient Data Collection Data Dictionary.

3.9 Admissions When No Clinician With Admitting Rights is Present

In most circumstances a clinician with admitting rights will be physically present to admit a patient, however there are certain circumstances where this is not the case, such as in small, rural or remote facilities.

In the circumstances where a clinician with admitting rights is not physically present but can be contacted, a decision to admit may be made and conveyed to on-site staff who must clearly document this in the patient's health record.

Where a clinician with admitting rights cannot be contacted to make the decision to admit, an admission cannot proceed. The care provided will be either an ED attendance or a non-admitted service.

4 DISCHARGE

A patient is discharged if:

- the treating clinician has decided that they no longer require admitted patient care, the patient has been advised they can leave and has left the treatment location; or
- the patient signs a "discharge against medical advice form" and leaves the treatment location; or
- the patient is declared deceased.

For patients who are being transferred to another facility for ongoing clinical care, discharge occurs when either (i) the patient is under the care of the transporting authority, if the transporting authority is a separate entity to the treating facility (e.g. NSW Ambulance Service), or (ii) the patient is admitted to the receiving facility, if the original treating facility is providing the transportation.
For Hospital in the Home patients, discharge occurs when the treating clinician has decided that they no longer require admitted patient care and the patient has been advised that they are to be discharged.

5 FURTHER INFORMATION

5.1 Residential Care Clients

For the purposes of this admission policy, residential aged care clients and community residential clients are out of scope.

A residential aged care client is a person who receives care in a wholly or partially Commonwealth funded residential aged care bed.

A community residential client is a person who receives care in a designated mental health or drug and alcohol community residential bed.
While these patients must be registered on a local patient administration system, for reporting purposes these patients are not considered to be admitted patients. Rules surrounding residential aged care and community residential client reporting can be found in the Admitted Patient Data Dictionary.

5.2 Admission Documentation

The documentation in the patient's health record must be sufficient to support their need for admission. For all patients admitted from the elective surgery waiting list, 'Recommendation For Admission' documentation must be completed. See the '*Waiting Time and Elective Surgery Policy*' (PD2012_011) section 2.4.

5.3 Client Registration

The requirement to register patients is separate and additional to admission and the documentation required for an admission. Requirements for patient / client registration are detailed in the following:

- '*Client Registration Policy*' (PD2007_094; 19 December, 2007)
- '*Client Registration Guideline*' (GL2007_024; 19 December, 2007)
- '*Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients*' (PD2012_042; 25 July, 2012).
- '*Health Care Records – Documentation and Management*' (PD2012_069; 21 December, 2012)

6 GLOSSARY

Absent Without Leave (AWOL)
A patient who is absent without leave is a current patient of that facility who has left care without permission to do so.

Admitted Patient
An admitted patient is a person: (i) for whom a clinician with admitting rights to the facility has determined meets the criteria for admission and requires a level of care provided in an inpatient setting, and (ii) who has undergone the admission process but has not yet been separated by the facility.

Episode of Care
Each admission is comprised of one or more episodes of care which represent a period of care with a common clinical focus as reflected by the "care type".

For example, a patient who is receiving acute intervention for a stroke will have a care type change to rehabilitation if and when the main focus of care changes from acute management to functional improvement.

For further details see the '*Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care*' (PD2014_010).

Hospital in the Home (HITH)
Hospital in the Home (HITH) services provide daily care to children and adults with acute conditions who reside outside hospital, as a substitution of in-hospital care.
A person may receive their care at home (including Residential Aged Care Facilities), in a hospital clinic, community setting, at school or in the workplace. The place of residence may be permanent or temporary.

Inpatient Ward
An inpatient ward is a physical location where admitted patients are accommodated or treated for their care and treatment

Non-Admitted Patient
A person who receives care or treatment but has not undergone the hospital's admission process. This includes patients treated entirely within the Emergency Department.

Overnight Admission
An overnight admission is where the admission date and separation date occur on different calendar days.

Same Day Admission
A same day admission is where the admission date and separation date occur on the same calendar day, irrespective of the intended length of stay.

7 FURTHER RESOURCES

NSW Health Policies, Guidelines or Information Bulletins

- '*Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients*' (PD2012_042; 25 July, 2012)
- '*Admitted Patient Election Processes for NSW Public Hospitals – Revised*'(PD2005_221; 27 January, 2005)
- '*Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care*' (PD2016_039)
- '*Children and Adolescent – Inter-Facility Transfers*' (PD2010_031; 2 June, 2010)
- '*Client Registration Guideline*' (GL2007_024; 19 December, 2007)
- '*Client Registration Policy*' (PD2007_094; 19 December, 2007)
- '*Clinical Handover – Standard Key Principles*' ([PD2009_060; 28 September, 2009)
- '*Departure of Emergency Department Patients*' (PD2014_025; 17 July, 2014)
- '*Emergency Department – Direct Admission to Inpatients Wards*' (PD2009_055; 7 September, 2009)
- 'Emergency Department Short Stay Units' (PD2014_040; 13 November, 2014)
- '*Fees Procedures Manual for Public Health Organisations*' (http://www.health.nsw.gov.au/policies/manuals/Documents/fees.pdf)
- '*Health Care Records – Documentation and Management*' (PD2012_069; 21 December, 2012)
- 'Inter-facility Transfer Process for Adults Requiring Specialist Care' (PD2011_031; 1 June, 2011)
- '*Non-Admitted Patient Activity Reporting Requirements*' (PD2013_010; 4 June, 2-13)
- '*NSW Hospital in the Home (HITH) Guideline*' (GL2013_006; 20 August, 2013)
- '*Waiting Time and Elective Surgery Policy*' (PD2012_011; 1 February, 2012)
- NSW Health Fees Procedures Manual.

Legislative or Regulatory Instruments

- *Drug and Alcohol Treatment Act 2007 (NSW)*
- *Mental Health Act 2007 (NSW)*
- *Mental Health (Forensic Provisions) Act 1990 (NSW)*
- *National Health Act 1953 (Cth)*
- *Private Health Insurance Act 2007 (Cth)*
- *Private Health insurance (Benefit Requirements) Rules 2011*
- National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services

PRIVACY INTERNAL REVIEW GUIDELINES (GL2019_015)

GL2019_015 rescinds GL2006_007

PRPOSE

NSW privacy law establishes a process of internal review for handling a privacy complaint, in certain circumstances. These Guidelines help staff navigate and comply with all legislative requirements in conducting a privacy internal review. Guidance is provided on undertaking an appropriate investigation into the privacy complaint, including conducting interviews and consultation requirements. The Appendices include template letters and reports to provide practical assistance to staff, and a consistent approach to privacy complaint handling for NSW Health agencies.

KEY PRINCIPLES

60-day time limit

A privacy internal review must be completed as soon as practicable, and a time limit of 60 calendar days applies. The 60-day time limit starts from the receipt of the first written privacy complaint or request for privacy internal review. In exceptional circumstances, the agency may ask the applicant for an extension of time. (*Sections 5.3 and 5.4*)

NSW Privacy Commissioner

The NSW Privacy Commissioner must be notified of all applications for privacy internal review, provided with a draft investigation report for comment, and provided with the final report and covering letter to the applicant. (*Sections 5.7 and 7.3*)

NSW Civil and Administrative Tribunal

An individual who is dissatisfied with the outcome of the agency's privacy internal review, can lodge an application for administrative review with the NSW Civil and Administrative Tribunal (NCAT). This must be lodged within 28 calendar days of receipt of the privacy internal review report from the NSW Health agency. (*Section 7.1*)

USE OF THE GUIDELINE

Chief Executive

The Chief Executive, or their Senior Executive delegate, is ultimately responsible for the privacy internal review process and outcome. The Chief Executive, or their Senior Executive delegate, should approve the final internal review report and letter to the applicant. (*Section 3.4*)

Privacy Contact Officer, NSW Health agency

Privacy internal review is normally undertaken by the Privacy Contact Officer for the NSW Health agency. Privacy internal review must be undertaken without bias, and by an officer who is neutral to the circumstances relating to the complaint. If an officer was substantially involved in the matter relating to the complaint, including attempts to informally resolve the complaint, they are unable to undertake the privacy internal review. In such case, an alternative review officer must be appointed. (*Section 3.4 & 5.1)*

Ministry of Health

The Privacy Contact Officer, Ministry of Health and legal officers within the Legal and Regulatory Services Branch, may assist agency staff with matters of privacy internal review.
NSW Health agencies should:

- notify relevant privacy internal review matters to the Ministry, (*Section 5.5*)
- seek advice and clarification from the Ministry as necessary, (*throughout*)
- provide the draft internal review report to the Ministry for comment, (*Section 6.2*)
- provide final letter and internal review report to the Ministry, (*Section 6.4*)
- report statistical data on privacy internal reviews in the agency's privacy annual report (*Section 7.2*)

A full copy of the guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_015

USE OF EXCHANGE OF INFORMATION PART 13A CRIMES (DOMESTIC AND FAMILY VIOLENCE) ACT 2007 FORM (IB2016_056)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and Health Information Management staff of the publication of the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form. This Information Bulletin also provides guidelines for the use of the form.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form is a paper form **ONLY** and is **NOT** to be scanned into any electronic medical records systems.

KEY INFORMATION

Reducing domestic violence is a NSW Premier's Priority. Safer Pathway is a whole-of government response designed to provide accessible and effective domestic violence support services to victims, with a focus on victims at serious threat. Under Safer Pathway, police, justice, health, education, child protection and victim service agencies work in an integrated manner to reduce threat to adult and children victims of domestic violence. This is to ensure that a seamless response can meet the individual needs of victims and children, and service providers jointly manage threats of further violence.

NSW Health has a key role as an interagency partner in fortnightly Safety Action Meetings, which are a component of Safer Pathway. Participation in Safety Action Meetings includes file searches for relevant health information, participation in fortnightly meetings and follow up actions resulting from Safety Action Plans. NSW Health is represented by up to three clinicians / healthcare professionals at a Safety Action Meeting, including Mental Health and Drug and Alcohol services wherever possible.

Please note that the information contained in this document is to be read in conjunction with the NSW Government guidelines listed below, and attached to this Information Bulletin. Information and records relating to Safety Action Meetings must be managed and stored in accordance with these documents:
- Safer Pathway Domestic Violence Information Sharing Protocol
- Safety Action Meeting Manual
- Domestic Violence and Child Protection Guidelines

Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form

The NSW Health Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form is a state form that assists NSW Health workers to comply with requirements under the NSW *Crimes (Domestic and Family Violence) Act 2007*.
This legislation governs information sharing related to Safety Action Meetings, and other victims of domestic and family violence at Serious Threat.

The form is available for download as an interactive PDF or to print on demand via Stream Solutions.

A number of key principles underlie information exchange at Safety Action Meetings.
These include:

- The threshold of *serious threat* under which information exchange at Safety Action Meetings takes place, means that there is a reasonable belief that there is serious threat to a victim's life, health or safety, or other person's life, health or safety, due to domestic violence, and action is necessary to prevent or lessen this threat. A threat does not have to be imminent to be serious.

- Information sharing at Safety Action Meetings is limited to that which is necessary to prevent or lessen a serious threat to the life, health or safety of victims, their children or other persons. Each member is responsible for decisions about what information it considers reasonably necessary to share.
- Consent to share information is preferable, but in instances of Serious Threat, not necessary. The Local Coordination Point which is staffed by the Women's Domestic Violence Court Advocacy Support Service, or Victim's Services, are usually responsible for seeking consent from a victim for information sharing at a Safety Action Meeting.
- Consent to share information is NEVER requested from a person listed on a Safety Action Meeting agenda as a perpetrator of violence. Information about Safety Action Meetings and Safety Action Plans must likewise NOT be shared with alleged perpetrators of violence. This could be vital to ensuring the safety of a victim.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form is to be used with the following guidelines:

- Use in preparation for Safety Action Meetings, and other information exchange that takes place under Part 13A of the NSW *Crimes (Domestic and Family Violence) Act 2007*
- A new form is to be used per client and per client file system reviewed:
  - Information from other service areas are **NOT** to be compiled on a single form
  - Information from other clients' files are **NOT** to be compiled on a single form
- Store in the client file reviewed. This must be in paper form **ONLY** and is **NOT** to be scanned into electronic systems.
- Actions from a Safety Action Meeting are to form part of the contemporaneous client notes in the appropriate client file.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form intersects with other healthcare privacy considerations and information exchange processes including:

1. Sexual Assault Communications Privilege

It is vital that staff are aware that information sharing at Safety Action Meetings is limited to that which is necessary. In the case of information which may be subject to the Sexual Assault Communications Privilege, it is recommended that advice from Local Health District legal services, or the Domestic and Family Violence team at the Ministry of Health be sought *prior* to information exchange under 13A.

Sexual assault communications are made in the course of a confidential relationship between a victim of sexual assault and a counsellor. The sexual assault communications privilege provides an absolute prohibition, in NSW courts, against requiring the production of documents recording counselling communications in preliminary criminal proceedings. Once the main criminal proceedings have started, the privilege will also apply unless the court specifically grants leave and requires the documents be provided. Documents that are the subject of this privilege in any criminal proceedings continue to be privileged in subsequent civil proceedings. A sexual assault privilege also applies in ADVO proceedings.

The purpose of this privilege is to give victims a confidential and safe place to talk about, or disclose, information about their traumatic experience, personal or sensitive issues and concerns. It includes counselling communications made by, to or about a victim. In NSW, an objection may be made to produce a protected confidence on the ground that it is privileged; but the victim of the sexual assault can consent to disclosure.

2. Child Protection

In cases of domestic violence where children are victims, or are affected by domestic violence in the home (including when listed on a SAM agenda as a perpetrator of violence), prescribed bodies should exchange information under Chapter 16A in the first instance. Both Part 13A and Chapter 16A prioritises the safety, welfare, and wellbeing of a child or young person over an individual's right to privacy.

Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (CYPCP Act)* overrides other laws that prohibit or restrict the disclosure of personal information such as the *Privacy and Personal Information Protection Act 1998* (*PIPP Act)* and the *Health Records and Information Privacy Act 2002 (HRIP Act)*. The focus of the exchange of information is on the safety, welfare and wellbeing of children, and facilitating the provision of services to these children and their families.

Service providers who are prescribed bodies under the *CYPCP Act* may exchange information that relates to a child or young person's safety, welfare or wellbeing, whether or not the child or young person is known to the Department of Family and Community Services (FACS).

Where Chapter 16A does not apply, information may be shared under Part 13A and the Safer Pathway Domestic Violence Information Sharing Protocol.

NSW Health staff should also be aware that information sharing under 13A *does not replace* mandatory reporting obligations for children and young people at risk of significant harm. Where information exchange processes identify risk of harm to a child or young person, NSW Health staff are required to apply usual clinical practice, including application of the Mandatory Reporter's Guide, and reports to FACs where indicated. This occurs within the normal timeframe for any risk of harm identification and is *not* dependent on Safety Action Meeting dates or processes.

3. Health Information Access

The *Health Records and Information Privacy Act 2002*; the *Government Information (Public Access) Act 2009* and the *Privacy and Personal Information Protection Act 1998* govern access to information held in health records. As a general rule, a victim's personal and health information must never be disclosed to an alleged perpetrator or any other person acting on behalf of the alleged perpetrator, such as the alleged perpetrator's legal representative. Part 13A and the Protocol seek to ensure that the victim's safety is not compromised by individuals' right to access their information under NSW privacy laws. For this reason, Part 13A and the Protocol override the *PPIP Act* and the *HRIP Act* in when the applicant is the alleged perpetrator.

In domestic violence situations it can be important for the victim's safety that the alleged perpetrator remains unaware of impending interventions. If the alleged perpetrator is aware, this may result in an escalation of violence. Service providers must also consider the potential for placing the victim at increased risk of violence where the attempt to reduce or prevent the serious threat was not successful and the alleged perpetrator becomes aware that the victim has reached out for support.

Requests for any file containing the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form and other related file notes, where the applicant is the alleged perpetrator, **could reasonably be expected to expose a person to a risk of harm**. For information relating to this see the NSW Health *Privacy Manual for Health Information*, section 12. Where any doubt exists about the release of information relating to Safety Action Meetings, consult Local Health District legal advice.

4. Subpoenas

A service provider that has used or disclosed information may be subpoenaed to produce the information held, including the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form. If a Local Health District or Specialty Health Network receives a subpoena to produce information about a victim or an alleged perpetrator, that service provider must seek legal advice before producing any information. A subpoena may be challenged on a number of different grounds, including abuse of process, oppression and/or on the basis of a privilege at law over the information.

All subpoenaed files containing the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form, where privilege at law does not exist, should be subject to a Sensitive Information Claim. See NSW Health Subpoenas Policy (PD2010_065) for how to make these claims.

ELECTRONIC MEDICAL RECORDS OF INFORMATION EXCHANGE TO REDUCE DOMESTIC AND FAMILY VIOLENCE THREAT

(IB2020_022)

PURPOSE

This Information Bulletin clarifies the requirements around notations made within electronic medical records of information exchange under Part 13A Crimes (Domestic and Personal Violence) Act 2007.

It contains information for health services which supplements the NSW Health Information Bulletin *Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* (IB2016_056).

KEY INFORMATION

The *NSW Health Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* is a state form that assists NSW Health workers to comply with requirements under the *NSW Crimes (Domestic and Personal Violence) Act 2007*.

This legislation governs information sharing related to Safety Action Meetings, and other victims of domestic and family violence at Serious Threat.

Health workers are to continue to follow the NSW Health Information Bulletin *Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* (IB2016_056), including the guidance around use of the State Form.

Health services may include minimal information in the progress notes of the electronic medical record indicating that information exchange has occurred to reduce a serious domestic violence threat to a person. Standard statements are included below for use in the progress notes. The statements include a prompt on how to respond where clinicians have ongoing concerns regarding a domestic violence threat.

Information *shared* under Part 13A about a client who is the alleged perpetrator

Staff may include a brief statement in the progress notes of the electronic medical record when information is shared under Part 13A about a client who is the alleged perpetrator and a Safety Action Meeting is held that identifies actions for Health pertaining to the perpetrator.

- Any such statement should be labelled *'VAN Progress Note: Strictly Confidential* ***- not*** *to be shared with client'* and indicate that:

  "This client's file has been reviewed and relevant information shared for the express purpose of reducing a serious domestic violence threat to another person/s including children.

  The client must not be informed that this has occurred.

  Any inappropriate disclosure of the information to [insert client's name] has potential harmful consequences for the safety of a victim/s.

  To discuss concerns about an ongoing or escalating domestic violence threat, contact [LHD service/contact]. Where a clinician has reasonable grounds to suspect that there is a serious and imminent risk to the victim/s or others' safety, Police should be contacted."

Information shared under Part 13A about a client who is a victim

Staff may include a brief statement in the progress notes of the electronic medical record when information is shared under Part 13A about a client who is a victim, and a Safety Action Meeting is held which identifies actions for Health.

- Any such statement should be labelled '*VAN Progress Note: Strictly Confidential – not to be shared before contacting the nominated clinician/service below*' and indicate that:

  "*This client's file has been reviewed and relevant information about the client shared for the express purpose of reducing a serious domestic violence threat to the client or another person, including a child.*

  Any inappropriate disclosure of the information has potential harmful consequences for the victims' safety.

  To discuss the above information and/or concerns about an ongoing or escalating domestic violence threat, contact [LHD service/contact]. Where a clinician has reasonable grounds to suspect that there is a serious and imminent risk to the victim/s or others' safety, Police should be contacted."

The suggested statements for progress notes above can also be applied where information is shared at Safety Action Meetings using Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.

For further relevant information on information sharing and documentation please refer to the *NSW Government Domestic Violence Information Sharing Protocol* and, where sharing information under Chapter 16A, the *NSW Health Policy Directive* Child Wellbeing and Child Protection Policies and Procedures for NSW Health *(PD2013_007).*

The complete Information Bulletin is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2020_022

LOOKBACK (PD2023_003)

POLICY STATEMENT

NSW Health Services are to implement lookback processes consistent with the requirements of this Policy Directive to ensure the timely notification and coordinated tracking of affected or potentially affected groups of patients.

SUMMARY OF POLICY REQUIREMENTS

Health Services are to initiate a lookback process when a clinical incident or concern has affected or may affect a group of patients.

Health Services are to undertake the four-step lookback process to identify, track, communicate and provide ongoing advice to these patients. The scope and scale of a lookback process can vary, so Health Services are to use an initial risk assessment to determine whether each element within a step is required.

The lookback process is to align to incident management, open disclosure, critical response and privacy processes.

Health Services are to notify appropriate internal and external bodies and regulators.

In keeping with a risk management approach, Health Services are to escalate as required to the NSW Ministry of Health and/ or the Clinical Excellence Commission.

The lookback process may involve a system wide communication strategy and/ or notifying the wider community. In such circumstances, the Clinical Excellence Commission and/ or NSW Ministry of Health will provide guidance.

The complete Policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_003

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 10 - IMAGING

TABLE OF CONTENTS

	PD/IB/GL NUMBER
Work Health and Safety – Limiting Staff Exposure to Ionising Radiation	PD2019_044

WORK HEALTH AND SAFETY – LIMITING STAFF EXPOSURE TO IONISING RADIATION (PD2019_044)

PD2019_044 rescinds PD2014_026

PURPOSE

The purpose of this Policy Directive is to assist managers, in conjunction with Policy Directive *Work Health and Safety: Better Practice Procedures*, to meet their duty to ensure that occupationally exposed staff are identified, and prevented from being exposed to ionising radiation that exceeds the dose limits set out in Schedule 5 of the *Radiation Control Regulation 2013 (*the Regulation*)*.

The Regulation defines an *occupationally exposed person* as one who is exposed to ionising or non-ionising radiation directly arising out of, or in the course of, the person's employment.

MANDATORY REQUIREMENTS

NSW Health organisations must ensure that:

- Work procedures, which potentially expose staff to ionising radiation, are identified and assessed using a risk management approach as required under the *Work Health and Safety Act 2011* (WHS Act).
- Safe work practices and procedures are documented and implemented so that staff are not exposed to ionising radiation that exceeds the dose limits as set out in Schedule 5 of the Regulation.
- A Radiation Management Plan is developed in accordance with the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) *Radiation Protection in the Medical Applications of Ionizing Radiation* Code of Practice (RPS14).
- Staff who are occupationally exposed to ionising radiation are provided with information and training, as necessary, and are made aware of:
    - The hazards that can arise in connection with the use of regulated material, which is defined under the *Radiation Control Act 1990* as meaning radioactive substances, ionising radiation apparatus, non-ionising radiation apparatus of a kind prescribed by the regulations and sealed source devices
    - The safety arrangements that exist to protect persons from such hazards and the steps the person must take in order to minimise the likelihood that such a hazard will arise
    - The name of the person undertaking the radiation safety officer role or other persons from whom they should obtain advice in connection with any matters relating to the use of radioactive substances and radiation apparatus.
- The requirements as set out in the NSW Environment Protection Authority (EPA) *Radiation Management Licence* are complied with, including the Guidelines and Codes to which the licence refers.
- Part 4 Division 2 of the Radiation Control Regulation is complied with in relation to occupationally exposed staff, including the provision of an approved personal radiation monitoring device.
- All monitoring devices are checked, maintained and calibrated in accordance with the document entitled Radiation Guideline 1: Monitoring devices (clause 32 of the Regulation*)*.
- Radiation accidents are reported, investigated and records of accidents maintained, as required under clause 37 of the Regulation.

- Faults or defects when identified are investigated and rectified and any person(s) who may have been exposed to radiation in quantities in excess of those that would normally be received are informed, as required by Clause 40 of the Regulation.

Ultrasound

- Prior to ultrasound examination, sonographers are advised by the referring clinician if a radiopharmaceutical dose has been administered to the patient (prior administration of a radiopharmaceutical is not in itself a contraindication to performing an ultrasound examination).
- Staff exposure is minimised by scheduling procedures requiring close patient contact. In general, where practicable, routine ultrasound examinations should not be performed soon after a patient has been injected with a radiopharmaceutical except in those circumstances where the wellbeing of the patient necessitates otherwise. (The clinical requirement for an ultrasound in this instance needs to be discussed with the referring medical specialist.)

Modified Barium Swallows (MBS)

- Speech pathologists and other staff participating in MBS and associated procedures using fluoroscopy must use personal protective equipment (PPE) as set out in the *NSW Environment Protection Authority* (EPA) *Policy on X-ray Protective Clothing (2014)* and good radiation practice, as set out in the EPA document *Radiation Guideline 6 Part 2: Registration Requirements & Industry Best Practice for ionising radiation apparatus used in diagnostic imaging.*
- For fluoroscopy procedures including MBS studies where speech pathologists, radiologists or other staff such as nurses are present inside the screening room and not behind a protective shield, a properly fitted lead apron and thyroid collar must be worn. This work practice is considered adequate for pregnant staff, provided the lead apron is properly fitted to cover the abdomen, and the radiation monitor (where applicable) is worn under the apron.
- Staff undertaking studies requiring fluoroscopic examination of the patient should receive proper training in all aspects of these studies. This should include training in radiation safety and the proper use of PPE to ensure that doses to themselves and the patient are minimised.
- X-ray equipment used for fluoroscopy procedures including MBS shall be maintained in a condition that meets the requirements for registration in NSW, and only operated by persons licensed to carry out the proposed procedure.

IMPLEMENTATION

Roles and responsibilities:

Chief Executives, Local Health Districts are required to ensure***:***

- The mandatory standards contained in this Policy Directive are communicated to all managers and occupationally exposed staff, and implemented.

Managers and supervisors are required to ensure:

- They identify staff who are occupationally exposed to ionising radiation and assess and minimise or eliminate exposure to ionising radiation
- Radiation monitoring devices and the appropriate personal protective equipment is made available to and utilised by relevant staff
- Staff involved in work procedures that involve possible exposure to ionising radiation receive training in radiation safety and the proper use of PPE to ensure that doses to themselves and the patient are minimised.

Staff are required to ensure:

- They comply with the safe work practices established in their workplace
- They wear the personal radiation monitor issued and any personal protective equipment required while involved in the use of ionising radiation
- They report to the person undertaking the radiation safety officer role any matter which they are aware of which may compromise radiation protection.

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 11 – INFECTIOUS DISEASES, IMMUNISATION AND RELATED MATTERS

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Tuberculosis – Sputum Induction Guidelines	GL2009_006
Tuberculosis in Children and Adolescents	GL2005_060
Tuberculin Skin Testing	PD2009_005
Bacille Calmette-Guerin (BCG) Vaccination	GL2023_003
Tuberculosis Contact Investigations	GL2019_003
NSW Aboriginal Blood Borne Viruses and Sexually Transmissible Infections Framework 2016-2021	IB2016_020
Neonatal and Infant Hepatitis B Prevention and Vaccination Program	PD2023_032
Authorised Nurse Immunisers and Authorised Midwife Immunisers	PD2023_027
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NSW Framework and Standard Operating Theatre Procedure for HIV Point of Care Testing	GL2019_010
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Management of people exposed to a contact order condition	PD2019_037
Surveillance & Response for Carbapenemase-Producing Enterobacterales (CPE) in NSW Health Facilities	GL2019_012
Triggers for Escalation Following Detection of Infection Outbreaks or Clusters	GL2019_013
Early Response to High Consequence Infectious Diseases	PD2023_008
NSW Infection Prevention and Control Response and Escalation Framework	IB2023_019

Last updated October 2023

PRINCIPLES FOR THE MANAGEMENT OF TUBERCULOSIS IN NSW
(PD2022_007)

PD2022_007 rescinds PD2014_050

POLICY STATEMENT

All services related to diagnosis and treatment of presumptive or confirmed tuberculosis (TB) (active or latent) and complications arising from the TB disease process must be provided at no charge to patients within the NSW public health system. This includes the provision of services for TB related investigations, care and treatment, and management of any disease- or treatment-related complications.

SUMMARY OF POLICY REQUIREMENTS

TB is a notifiable condition under the NSW *Public Health Act 2010*, with doctors required to notify all persons they reasonably suspect to have TB to their local public health unit, and laboratories required to notify all positive results of TB tests.

District and network chief executives are responsible for ensuring appropriately skilled medical and nursing staff are available to manage patients with active or latent TB and provide TB prevention activities to minimise the public health impact of TB. Districts and networks must appoint a TB coordinator to oversee for the provision of TB services within the district or network.

All cases of possible and confirmed TB are to be managed in conjunction with a TB service. All isolates of *M. tuberculosis* complex identified must be referred to the Mycobacterium Reference Laboratory for confirmation and drug susceptibility testing. Treating authorised prescribers must always treat TB disease with multiple antituberculosis agents following the most recent evidence-based practice.

All patients diagnosed with TB in NSW are to be tested for human immunodeficiency virus (HIV). All rifampicin resistant and multidrug resistant TB cases in NSW are to be reviewed by an expert panel.

Patient management must be individualised and seek active input from patients to allow for the least restrictive management that enables them to achieve treatment success. Wherever possible, clinical care is to be delivered in a manner that allows patients to maintain normal employment and/or education activities once non-infectious.

Districts and networks must provide mechanisms to monitor adherence with treatment in a manner that is minimally restrictive to patients, while ensuring treatment success. A mechanism must be available to supervise all prescribed doses for patients identified as being at significant increased risk of treatment non-adherence if required.

All healthcare workers are required to comply with the NSW Health infection control guidance to minimise the risk of TB transmission in healthcare settings.

District and network TB services must quickly identify patients that are putting other people at risk, or are at-risk of such behaviours, and encourage, facilitate, and if required enforce compliance to TB treatment.

TB services are required to undertake contact investigation and screening of contacts.

Districts and networks are required to provide testing for latent TB infection to individuals at risk of acquiring TB infection or those vulnerable to disease progression, including review and follow-up health care workers and students that test positive for latent TB infection.

TB services are to triage, investigate, and provide follow-up care to people referred from the Department of Home Affairs that live within the district or network boundaries, and to provide the required feedback. Districts and networks are required to provide a BCG vaccination service to residents living within the district or network boundaries.

The full Principles for Management of Tuberculosis in NSW Policy is available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_007

TUBERCULOSIS – MINIMISING THE RISK OF TUBERCULOSIS IN PATIENTS STARTING ANTI TNF INHIBITORS (GL2008_007)

This Guideline is to be read in conjunction with the following Policy Directive:
PD2009_005 *Tuberculin Skin Testing*

Introduction
Tumor necrosis factor (TNF) is a proinflammatory cytokine which has a pivotal role in the pathogenesis of several autoimmune diseases, including rheumatoid arthritis and other inflammatory joint disease, psoriasis, and inflammatory bowel disease.

Three anti-TNF α agents are now available in Australia (infliximab, etanercept, and adalimumab) to treat selected autoimmune diseases. However, TNF α is a significant component of the human immune response to infection1, and treatment with anti-TNF α agents is associated with an increased risk of infection. The development of active Tuberculosis (TB) disease has occurred in some patients who have received anti-TNF α therapy in countries with high TB prevalence2.

The following guidelines have been developed to reduce the risk of active TB developing in patients receiving anti-TNF α therapy.

Before starting ANTI-TNF α inhibitors all patients should have:

1. A careful review of their history of exposure to TB, and an assessment to exclude active TB.
2. A baseline Tuberculin Skin Test for evidence of TB infection.[a]
3. A Chest X ray to exclude active TB and assess evidence of past or current TB.

Latent Tuberculosis
Patients with evidence of latent tuberculosis infection (LTBI) who have not previously received effective treatment for TB and in whom active TB is excluded should be treated with isoniazid (5mg/kg to maximum of 300 mg/day) and pyridoxine (25mg/day) for a period of 9 months3. The first month of isoniazid treatment should be completed prior to starting an anti-TNF α inhibitor. Evidence of LTBI may include:

1. TST ≥ 5 mm
2. Radiological evidence of past TB

Patients with chest x-ray abnormalities, cough or other clinical features suggestive of active TB should have sputum examined for AFBs before commencing treatment with isoniazid.

Physicians should include the risk of potential adverse effects of isoniazid therapy in their assessment of the overall risk of commencing treatment with an anti-TNF α inhibitor.

Monitoring of isoniazid therapy, patients on isoniazid preventive therapy should have monthly assessment of:
- their hepatic function
- their compliance with the prescribed medication, and
- the development of TB.

1. Atkinson YH et al (1988) Recombinant human tumour necrosis factor-alpha. Regulation of N-formylmethionyl-leucylphenylalanine receptor affinity and function in human neutrophils. *J Clin Invest,* 81; 759 – 765

2. Gomez-Reino JJ et al (2003)Treatment of rheumatoid arthritis with tumour necrosis factors inhibitors may predispose to significant increase in tuberculosis risk. *Arthritis & Rheumatism*, 48; 2122 – 2127

a Footnote: While a positive IGRA is good evidence for Latent TB infection a negative IGRA may not exclude TB. Careful consideration must always be used when interpreting TB screening results.

3. Carmona L et al (2005) Effectiveness of recommendations to prevent reactivation of latent tuberculosis infection in patients treated with tumour necrosis factors antagonists. *Arthritis & Rheumatism*, 52; 1766 - 1772

Treatment of TB

Where active TB is diagnosed in a person receiving anti-TNF α therapy:

- cease anti-TNF α inhibitor
- reduce other immunosuppressants to lowest possible effective dose.

Patients with active TB should be referred to a NSW Chest Clinic for management and treatment of TB. Treatment should be in accordance with NSW Health TB treatment guidelines.

REFERENCES

1. Atkinson YH et al (1988) Recombinant human tumour necrosis factor-alpha. Regulation of N-formylmethionyl-leucylphenylalanine receptor affinity and function in human neutrophils. *J Clin Invest,* 81; 759 – 765

2. Gomez-Reino JJ et al (2003)Treatment of rheumatoid arthritis with tumour necrosis factors inhibitors may predispose to significant increase in tuberculosis risk. *Arthritis & Rheumatism*, 48; 2122 – 2127

3. Carmona L et al (2005) Effectiveness of recommendations to prevent reactivation of latent tuberculosis infection in patients treated with tumour necrosis factors antagonists. *Arthritis & Rheumatism*, 52; 1766 - 1772

TUBERCULOSIS – SPUTUM INDUCTION GUIDELINES (GL2009_006)

Guideline to reduce the risk of occupational exposure to TB during sputum induction procedures. Sputum induction is a procedure used for patients who have trouble producing sputum spontaneously. The patient inhales nebulised hypertonic saline solution, which liquefies airway secretions, promotes coughing and allows expectoration of respiratory secretions. Sputum induction is simple and non-invasive, and if successful, often precludes the need for bronchoscopy.

The procedure produced coughing so it is likely that infectious droplets, if present, will be expelled into the room air. Strict airborne respiratory precautions should be observed whenever sputum induction is performed.

The full guidelines can be downloaded at
http://www.health.nsw.gov.au/policies/gl/2009/GL2009_006.html

TUBERCULOSIS IN CHILDREN AND ADOLESCENTS (GL2005_060)

GL2005_060 rescinds PD2005_069.

Introduction

Tuberculosis (TB) in children and adolescents differs markedly from that in adults.

Many children acquire tuberculosis infection, which is characterised by delayed hypersensitivity and few organisms, but relatively few develop the disease. However, the risk of doing so remains life long. While the initial infection in most children occurs in the lungs, TB in children and adolescents should be considered, at least potentially, to be a systemic disease. The primary complex, comprising the site of infection and the involved regional lymph nodes, may heal or complications may develop from enlargement of these lymph nodes or their rupture and the spread of bacilli into the bloodstream, giving rise to disseminated disease. The risk of dissemination is greatest within the first 12-24 months after infection and in the first 3 years of life.

The following are important aspects of the disease in children and adolescents:

Risk of disease following primary infection

Data derived from studies in the United Kingdom in the 1950's and 60's, for children followed for up to two years after being infected, indicated that the risk of development of radiological changes in the chest consistent with TB infection were greatest in the first year of life and decreased progressively thereafter.1

These studies demonstrated the span of risk for children progressing to active disease over a two year period as follows: children aged less than 1 year - 23 to 43%, children aged 1 to 5 years - 11 to 24%, children aged 6 to 10 years - 8 to 25% and for children aged 11 to 15 years – 16% with females having a higher rate of disease than males.

For children with a normal chest x-ray at the time of their first positive tuberculin skin test the lifetime risk of developing TB is between 2 and 10%. These risks are related to general health, nutrition and other disease states. Although one might expect, with better nutrition and living standards, that currently, the lifetime risk may be lower, there is some Australian data from adult research that indicate that this may not be the case.2

Infectivity

TB in children is primary TB, a disease which is predominantly one of delayed hypersensitivity with few organisms and variable immune response. Childhood TB is rarely contagious because:

- children usually have a small bacterial load;
- children very rarely have cavitating disease; and
- children usually swallow their sputum, and have a far less effective cough than adults.

Rarely children, and occasionally adolescents, may be infectious and have adult type disease.

Diagnosis

Diagnosis of TB infection is based on tuberculin skin testing (TST).

Table 1: Recommended stratification of TST induration size to identify those requiring assessment for preventive therapy. *

The selection of an appropriate cut off for referral is influenced by the probability that the TST represents recent infection and the risk of progression to active disease if there is infection with TB.

1 Miller FJW, Seale RME, Taylor MD. TB in Children. Boston; Little Brown & Co. 1963, page 231 - 232.

2 Marks G, Bai J, Simpson SE, et al. Incidence of Tuberculosis among a cohort of tuberculin positive refugees in Australia. Reappraising the estimates of risk. American Journal of Respiratory Care Medicine 2000; 162: 1851 - 1854.

≥ 5 mm	≥ 10 mm#	≥ 15 mm#
Recent high risk contacts of persons with infectious TB	Born or resident in countries with high prevalence of TB (>50 cases/100,000pp)	Children ≥ 4 years of age without any risk factors
HIV infection or other immune suppressed (including steroids)	Locally identified high risk populations	
TST conversion in the last 2 years	Children < 4 years of age	
Chest X-Ray evidence of past untreated TB	Travel or stay in high prevalence countries	
	Persons with certain medical conditions (eg diabetes; prolonged corticosteroid or immunosuppressive therapy; haematological malignancies (eg Hodgkins, lymphoma); chronic renal failure; low body weight & malnutrition	

* All children < four years of age who have had close contact with a case of infectious TB should receive preventive therapy irrespective of TST response, until the second TST (3 months later) proves negative.

BCG vaccination is unlikely to affect TST interpretation in children vaccinated ≥ 5 years previous. However, where BCG is recent (within 5 years) or where there have been 2 or more BCG vaccinations, the above stratification may need to be modified and the TST results should be interpreted individually by physicians experienced in TB medicine.

Diagnosis of TB disease is based on clinical symptoms and signs, chest x-ray or other investigations and smear and culture of infected body material (if available).

Preventive therapy

Preventive therapy in children with TB infection and no evidence of the disease is used to:

- reduce the lifelong risk of developing TB disease;
- reduce the risk of developing TB disease in the years immediately after acquiring the infection, particularly disseminated disease in children under the age of four years.

Six months isoniazid preventive therapy should be considered for otherwise healthy children and adolescents who have evidence of TB infection and no evidence of TB disease.

The incidence of liver toxicity from isoniazid in children is extremely low and routine monitoring of liver function is not recommended. Prophylactic pyridoxine is not normally recommended with isoniazid in children. Pyridoxine is recommended for children and adolescents on meat and milk deficient diets, those with nutritional deficiencies including all symptomatic HIV infected children, exclusively breast feed infants older than 6 months of age and pregnant adolescents.1

Child contacts of patients with drug resistant TB and especially multi-drug resistant TB should be individually assessed by an expert in TB care and treatment.

Children who have evidence of TB infection and show changes consistent with TB disease on a chest x-ray (including mediastinal lymphadenopathy) should be regarded as having the disease and given full treatment.

1 American Academy of Pediatrics. Tuberculosis. In: Pickering LK, ed.2000 Red Book: Report of the Committee on Infectious Diseases.25th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2000: page 604

Treatment

Children with TB disease should be treated according to the guidelines published in the Journal of Paediatrics and Child Health.1

Directly observed therapy (DOT) should be regarded as the method of choice for TB treatment in NSW. DOT may be undertaken by well-motivated parents. When this occurs, regular contact (at least weekly) with the treating team is essential. Decisions relating to the supervision of TB medication need to be made by the treating team on a case-by-case basis.

References:

i Miller FJW, Seale RME, Taylor MD. TB in Children. Boston; Little Brown & Co. 1963, page 231 - 232.
ii Marks G, Bai J, Simpson SE, et al. Incidence of Tuberculosis among a cohort of tuberculin positive refugees in Australia. Reappraising the estimates of risk. American Journal of Respiratory Care Medicine 2000; 162: 1851 - 1854.
iii American Academy of Pediatrics. Tuberculosis. In: Pickering LK, ed.2000 Red Book: Report of the Committee on Infectious Diseases.25th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2000: page 604
iv VOSS LM, et al. Position Paper Management of tuberculosis in children. Journal of Pediatrics and Child Health (2000) 36, 530 – 536.

TUBERCULIN SKIN TESTING (PD2009_005)

This Policy Directive is to be read in conjunction with NSW Health Department Policy Directives:

PD2013_032 BCG (Bacille Calmette Guerin) Vaccination
PD2005_406 Patient Information and Consent to Medical Treatment
PD2007_036 Infection Control Policy
PD2013_043 Medication Handling in NSW Public Health Facilities
PD2008_017 Tuberculosis Contact Tracing
PD2015_011 Immunisation Services - Authority for Registered Nurses and Midwives
GL2005_060 Tuberculosis in Children and Adolescents

1. Introduction

The procedures incorporated in this document are required to be complied with.

1.1 Definitions

The tuberculin skin test (TST) is used primarily to identify people infected with *Mycobacterium tuberculosis (MTB)*. It is used to identify such people because they have a 5-10% lifetime risk of developing TB disease[1]. TST should therefore be targeted to those individuals at risk either of acquiring TB infection or of progressing to TB disease, once infected.

Preventive treatment of people infected with MTB reduces their risk of developing TB disease by up to 90%[2].

1.2 Composition and Safety

The form of tuberculin used in Australia is purified protein derivative (PPD). PPD consists of bacteria-derived protein without viable organisms and is safe for use in immune compromised persons and in pregnancy.

1.3 Methods of TST Administration

In Australia, tuberculin skin testing is administered by the Mantoux method which involves the intradermal injection of 5 Tuberculin Units (TU) of PPD. Multiple puncture tests are also available to test the cell-mediated response to a variety of antigens including PPD. However, these are not recommended as an alternative to the TST as the dose is less precise and operator variability may be greater.

1 VOSS LM, et al. Position Paper Management of tuberculosis in children. Journal of Pediatrics and Child Health (2000) 36, 530 – 536.

2. Indications/Contra-indications regarding TST

2.1 General Indications for TST

TST is routinely recommended for the following persons:

- people identified as close contacts of persons with infectious TB (as defined in Policy Directive PD2008_017 Tuberculosis Contact Tracing);
- health care and other workers in whom surveillance is proposed because of ongoing increased risk of acquiring infection;
- people with medical risk factors that increase the likelihood of latent infection progressing to disease;
- prior to BCG vaccination in those over 6 months old; and
- in certain clinical situations, to assist in diagnosing or excluding TB disease.

2.2 Contra-indications to TST

TST is best avoided in:

- persons who report any severe adverse reaction following previous TST;
- persons previously treated for active TB disease;
- persons with documented/known prior positive TST reactions;
- persons with a high fever or recent significant infection, eg measles and chicken pox;
- following recent immunisation with MMR, varicella and yellow fever within the last month as the risk of a false negative TST result is increased. Oral typhoid and oral polio (OPV) vaccines do not necessitate a delay in testing (OPV is no longer used in Australia but have been received overseas);
- the 9th edition of the Australian Immunisation Handbook does not mention oral rotavirus vaccination in the context of TST tests, but as with other live oral vaccines, there should be no need to modify timing of TST based on administration of this vaccine.[3]

An undocumented history of a prior positive TST is not an absolute contra-indication to TST because patient recall is often inaccurate.

3. Methods

3.1 Who may administer TST?

- Medical Practitioners;
- Registered Nurses employed in an Area Health Service who have the requisite Authority as defined in the NSW Health Department PD2015_011 Immunisation Services – Authority for Registered Nurses and Midwives. These nurses may undertake TST following NSW Health Department Policies without the written order of a medical practitioner; and
- Registered Nurses who work under the written order of a medical practitioner, as PPD is a schedule 4 drug.

All health professionals performing TST should be appropriately trained to administer and interpret the test results.

3.2 Procedure for the administration of a TST

3.2.1 Confirm the identity of the patient to be tested

3.2.2 Obtain consent

- Informed consent is required. Verbal consent is sufficient, signed consent forms are not required for minor procedures such as TST administration;
- the procedure must be explained to the patient and documented in the patient's medical record - see PD2005_406 Patient Information and Consent to Medical Treatment.

3.2.3 For consent to be valid

- The person must have the capacity to give consent, that is the person must be able to understand the implications of having the treatment or procedure;
- the consent must be freely given;
- the consent must be specifically for the procedure that is being undertaken; and
- the patient must be informed in broad terms of the procedure that is intended.

A person is incapable of giving consent if he/she cannot understand the general nature and effects of the proposed treatment, including implications and possible side effects or:

- is a child is under the age of 14 years, (consent of the parent or legal guardian is necessary); and
- is a school student, without written parental/guardian consent prior to an on-site school screening activity, regardless of age.

Note: while children between the ages of 14 and 16 may give consent, it is prudent to obtain consent of the parent or guardian.

3.2.4 What to do when a person is incapable of giving consent:

The provisions of the *Guardianship Act* apply to a person who is 16 years or older who is incapable of giving consent to the carrying out of medical or dental treatment.

TST is considered "medical treatment" within the meaning of the *Guardianship Act* (section 33(1)). TST falls within the meaning of "minor treatment" under the *Guardianship Act*.

Section 36 of the *Guardianship Act* provides that for minor medical treatment consent may be given by the "person responsible" for the patient or by the Guardianship Tribunal. The person responsible for the patient is defined under section 33A of the Act.

Consent to undertake TST should be obtained in writing from the person responsible.

Minor treatment may be carried out without any consent if there is no person responsible for the patient, or there is such a person, but that person cannot be contacted or is unable or unwilling to make a decision concerning a request for that person's consent for the treatment providing the medical practitioner supervising the carrying out of the TST certifies in writing in the clinical record that:

- the treatment is necessary and undertaking the TST will promote the patient's health and well being; and
- the patient does not object to the carrying out of the TST.

Section 33(3) of the Act provides guidance on the definition of what constitutes a patient objecting to treatment.

Where it is necessary to obtain consent of the Tribunal legislation requires that applications for consent are made in respect of each patient concerned. Prior to granting consent the Tribunal considers the views of the patient, the person proposing the treatment, any person responsible for the patient, and any guardian appointed with respect to the patient's treatment.

4. Pre TST Assessment

Obtain a history or documentation of the following:

- prior TB;
- any potential TB exposure;
- any previous TST and the result;
- BCG vaccination;
- medical conditions or treatment that may effect the TST result as outlined in section 10; and
- review the contraindications for TST as outlined in section 2.2.

5. Administration of the TST

5.1 Position

Seat the patient with the left arm resting on a table. Young children should be seated on their attendant's lap with other arm held securely under the attendant's arm. The child's body is held firmly and at the same time the attendant holds the arm on which the test is to be carried out, slightly flexed.

5.2 Site

The anterior aspect of the left forearm at the junction of the upper and middle thirds, using an area away from blood vessels or skin lesions.

5.3 Dose of PPD for adults and children

Five (5) Tuberculin Units (TU) per 0.1ml is the standard dose for the TST.

5.4 Technique

Use either a single-use insulin syringe with a 29-gauge needle or a 1 mL single-use syringe with 26 or 27 gauge needle. Administer the PPD intradermally with the bevel of the needle uppermost. Inject slowly to produce a pale discrete "bleb" (lump) 5 to 10 mm in diameter. If leakage occurs, repeat the injection at another site at least 5 cm away or in the other forearm.

Repeated TSTs at exactly the same site may result in increased reaction. For this reason the requirement to vary the test site is particularly important in serial or repeated TSTs especially with the 2-step protocol[4].

5.5 Advice to the patient

The patient should be given clear instructions and an information sheet advising of the following:

- not to cover the site with dressings;

- not to apply any lotions to the area;
- to avoid scratching the site if it becomes itchy;
- possibility of skin blistering and/or ulceration following the TST;
- when to return for reading of the TST; and
- to contact the clinic if concerned in the interim.

5.6 Infection control

All procedures should follow the current NSW Health Department PD2007_036 Infection Control Policy.

6. Storage of PPD

- PPD should be stored away from light at 2-8 degrees Centigrade. Discard product if exposed to freezing.
- PPD should be administered as soon as possible after drawing up into the syringe and following administration, as the solution can be adversely affected by exposure to light. PPD remaining in a vial may be kept in the refrigerator and used for up to 30 days before discarding, providing care is taken to avoid contamination of the vial[5]. It is essential that the date the vial is opened be recorded to ensure disposal occurs within the recommended timeframe.

7. Adverse reactions

Adverse reactions to TSTs are rare. They include:

- vaso-vagal reactions;
- immediate flare with a local rash;
- blistering and/or ulceration at the site of the injection;
- lymphangitis; and
- serious or life-threatening hypersensitivity reactions. These are extremely rare (0.08 reactions per million doses of PPD)[6]

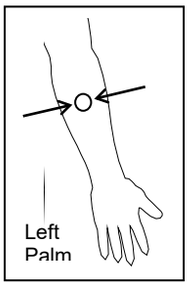
Although the risk of anaphylaxis is very low, adrenaline (and information re its dosage and administration) must be available when TST is being undertaken[7].

8. Pregnancy

There is no evidence that TST poses any risk in pregnancy and/or when breastfeeding an infant[8] or that tuberculin reactions are influenced by pregnancy[9].

9. Reading

The tuberculin skin test should be read 48 to 72 hours after the injection, by measuring the diameter of **induration** across the transverse axis of the forearm.



Only the induration should be measured, not the erythema (redness).

Record the TST results in millimetres (mm) of induration, not as **positive** or **negative**. A tuberculin skin test with no induration should be recorded as **0 mm**.

The tuberculin skin test is to be read by the "pen technique".

Slowly draw a line with a ballpoint from a point 2 to 3 cms away from the margin of the skin test reaction, towards its centre. Maintain skin tension by exerting slight traction in the opposite direction to the pen movement.

When the ballpoint reaches the margin of the indurated area you will feel definite resistance, lift the pen. Repeat the procedure from the opposite side of the reaction. Measure the distance between opposing lines with a ruler.

9.1 Documentation

Document in the patient's medical record:
- the date the TST was administered;
- the dose of PPD administered;
- the batch number and expiry date of the PPD;
- BCG vaccination history, including age or ages at vaccination;
- the presence or absence of BCG scars;
- date the TST was measured;
- size in mm of the transverse diameter of induration;
- presence of vesiculation; and
- signature of the person administering the TST and reading the result.

10. Interpretation of TST results

The TST result should be interpreted in light of factors that increase the probability that the patient has been infected with TB. These include:
- recent high risk (close) contact with persons with infectious TB;
- residence in countries with high prevalence of TB (>50 cases/100,000 persons);
- persons with chest x-ray evidence of past, untreated TB;
- prior or current residence in high-risk congregate settings (eg. prisons, homeless shelters, alcohol rehabilitation and drug treatment centres);
- prior vaccination with BCG;
- intravenous drug use;
- health care workers; and
- exposure to mycobacteria other than TB (MOTT).

The TST result may be decreased by:
- immuno suppressive therapy, malignancy and HIV/AIDS[10];
- acute viral or bacterial infections, including 5-17% of persons with active TB[11];
- infancy, advanced age[12], renal failure[13] or significant malnutrition[14], and
- recent (within 4 weeks) live virus vaccinations[15].

Note that technical factors also influence the TST induration size. Such factors include:
- variation in the storage, handling and dosage of PPD used; and
- errors in administration or reading.

10.1 Prior vaccination with BCG

Most people vaccinated with BCG will develop, within 2 months, a TST reaction which will then wane variably over time. TST following BCG vaccination is not recommended to assess the effectiveness of BCG.

BCG vaccination given in infancy is unlikely to affect TST interpretation in adults[16]. Where BCG has been given in the last 5 years or more than one BCG has been administered the interpretation of TST results needs to be undertaken by a physician with experience in TB medicine[17].

TST reactions > 20mm are rarely due to BCG alone[18].

10.2 Evidence of TST conversion

Where serial tests are done a TST conversion is defined as an increase in the diameter of TST induration of ≥ 10mm, between consecutive readings[19]. This increase usually occurs in 4 – 8 weeks following exposure to TB.[20]

TST conversion indicates recent TB infection. Occasionally false positive conversions may occur due to the TST booster phenomenon. The 2-step TST may assist in distinguishing true conversions from the booster phenomenon (see section 11 – Two-step TST and the Booster Phenomenon).

10.3 The size of the TST induration

The interpretation of TST reactions to identify those requiring assessment for preventive therapy is based on: (a) the probability that the TST represents recent infection and (b) the risk of progression to active disease if there is infection with MTB.

Note that all children < 4 years of age who have had close contact with a case of infectious TB should receive preventive therapy irrespective of TST response, until the second TST (3 months later) proves negative (See GL2005_060 - TB in Children and Adolescents).

Table 1. TST induration diameter which should be considered indicative of infection with MTB in various clinical settings

≥5mm	≥10mm#	≥15mm#
Recent high risk (close) contacts of persons with infectious TB	Persons born or resident (for greater than 3 months) in countries with high prevalence of TB (>100 cases/100,000)	People > 4 years of age without any identified risk factors
Persons with HIV infection	Children < 4 years of age without any identified risk factors	Health Care Workers with BCG vaccination in the past 10 years
Persons with organ transplants or immune suppressive therapy equivalent to prednisone >15mg/day for >1 month	Persons who live or spend time in high risk congregate settings (eg prisons, homeless shelters, alcohol rehabilitation and drug treatment centres	
Persons with CXR evidence of past untreated TB	Health care workers without prior BCG vaccination in the past 10 years	
	Intravenous drug users	
	Persons on prednisone equivalent to ≥15mg/day or for ≥1 month or those with certain medical conditions eg diabetes; silicosis; some malignancies (head, neck, lung and haematological); chronic renal failure; gastrectomy or jejunal bypass; malnutrition or low body weight (>10% below ideal body weight)[21]	

BCG vaccination is unlikely to affect TST interpretation in adults, if given in infancy. However, where BCG is recent (within 5 years) or where there have been 2 or more BCG vaccinations, the above stratification may need to be modified and TST results should be interpreted individually by physicians experienced in TB medicine.

10.4 TST positive persons

The recommended management for persons identified as TST positive is either preventive therapy or chest x-ray follow up.

If preventive therapy is not given, the person is to be counselled about the future risk of TB and to seek medical care if symptoms develop. Chest x-ray follow up is required in three to four months and then annually for two years. The risk of developing tuberculosis is highest within the first two years.

11. Two-step TST and the Booster Phenomenon

In some people previously exposed to *Mycobacteria* the ability to mount an immunological response to mycobacterial antigens wanes over time. These individuals may not initially react to a TST, but the TST may boost immunological memory for the mycobacterial antigens. If this does occur, a repeat TST shortly after the initial one will produce a much larger TST response (a boosted response). The initial TST result is therefore falsely negative and the second result should be considered the true result. However, this boosting phenomenon may be misinterpreted as a TST conversion.

The TST boosted response is maximal 1-5 weeks after the first TST, but can persist for 1-2 years[22]. A 2-step TST is designed to avoid false negative baseline TSTs, so a subsequent positive TST is not misinterpreted as a TST conversion. The second TST of the 2-step procedure should be done 1-5 weeks after the initial negative TST. The results of the second TST should be taken as the baseline for future assessment of TST conversion.

The 2-step TST is ideally suited to the situation of health worker screening where it is expected that there will be repeat testing at future regular intervals, and it is desirable to identify booster phenomena so as not to confuse the results with genuine TST conversion in health care workers. The 2-step TST is not routinely recommended in contact tracing.

12. Alternative/in vitro tests

Interferon-y-release-assays such as the QuantiFERON tests (Cellestis Limited, Carnegie, Melbourne), are assays that detect cell mediated immune (CMI) responses to TB specific proteins that are secreted by the *M.tuberculosis* organism. These CMI responses are demonstrated to be both specific for *M.tuberculosis* infection and have less cross-reactivity with BCG and most non-tuberculosis mycobacteria.

The QuantiFERON - TB Gold® assay has been evaluated for use with immune competent healthy adults. A result of greater than 0.35IU/ml of interferon to the specific antigens indicates TB infection.

The assay has not been evaluated for use within children aged < 12 years, infants, pregnant women, immunocompromised individuals (HIV positive individuals), or people with certain clinical conditions predisposing immunosuppression (i.e. diabetes, silicosis, cancers, organ transplants), or those taking immunosuppressive medication. Studies are currently underway to assess the performance of QuantiFERON - TB Gold® within these groups.

The US Center for Disease Control and Prevention state in the Morbidity and Mortality Weekly Report of 16 December 2005/54/No.RR-15, that the QuantiFERON - TB Gold® assay may be used in certain circumstances to diagnose LTBI. However, the National Tuberculosis Advisory Committee is currently evaluating the results of international studies to determine the recommendations for use of QuantiFERON - TB Gold® in Australia. The TST continues to be the recommended methodology for diagnosing LTBI and QuantiFERON TB Gold® is not recommended for assessment of LTBI[23].

Persons referred to NSW TB Prevention and Control Services for evaluation of LTBI following screening with QuantiFERON - TB Gold® must have their results assessed in conjunction with other clinical and laboratory information to determine the risk of TB infection and/or active TB. It is not considered necessary to undertake a TST in this group of people.

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BACILLE CALMETTE-GUERIN (BCG) VACCINATION (GL2023_003)

GL2023_003 replaced PD2013_032

GUIDELINE SUMMARY

This Guideline sets out the recommendations for use of the bacille Calmette-Guérin (BCG) vaccination in NSW.

BCG vaccination has an important role in prevention of travel-acquired tuberculosis (TB) in young children from diverse backgrounds born in NSW and has a more limited role in overall prevention of TB in a low TB incidence setting such as Australia.

KEY PRINCIPLES

Bacille Calmette-Guérin (BCG) vaccination is to be used in accordance with the National Health and Medical Research Council (NHMRC) Australian Immunisation Handbook and as per the recommendations in these guidelines.

A pre-vaccination risk assessment is required to determine whether BCG vaccination should occur, and whether a pre-vaccination tuberculin skin test (TST) is required.

Comprehensive education must be provided to the vaccine recipient, or their parents/ care givers and consent sought. BCG vaccinators must be appropriately credentialled and experienced in intradermal administration.

Mechanisms must be in place to report vaccinations to the Australian Immunisation Register, and to manage and report adverse events following immunisation including accelerated reactions. Local Health Districts and Specialty Health Networks are responsible for assessing, maintaining, and reassessing their capability level to deliver BCG vaccination to their community, as per the NSW Health Policy Directive *Principles for the Management of Tuberculosis in New South Wales* (PD2022_007).

The Bacille Calmette-Guérin (BCG) Vaccination guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_003

345(13/02/23)

TUBERCULOSIS CONTACT INVESTIGATIONS (GL2019_003)

GL2019_003 rescinds PD2008_017

PURPOSE

Contact investigation is an essential component of tuberculosis (TB) prevention. The rationale for contact investigation is that people who were recently exposed to patients with TB may have become infected and will have an increased risk of developing TB disease, particularly within the first two years after acquisition of the infection.

Decisions about the extent of contact investigation need to be guided by sound clinical and epidemiological indications. The aims of contact investigation are to:

- Identify and treat cases of TB disease among those in contact with the index case including identification of a possible source case;
- Identify persons who have latent TB infection (LTBI) and offer treatment for LTBI or monitoring by chest radiography (CXR);
- Provide timely treatment, education and support for persons identified with evidence of disease or infection, and;
- Provide education and support for all persons identified as having exposure risk.

KEY PRINCIPLES

Individuals have a right to be informed about significant risks to their health and recommended courses of action to manage these risks.

The priorities for TB contact investigation are determined by:

- The likely infectiousness of the index case;
- The risk of exposure of contacts to the index case, and;
- The vulnerability of contacts to disease progression.

Contacts should be prioritised according to their risk of exposure to an infectious TB case and their level of risk for disease progression; screening should be conducted in a stepwise fashion using the concentric circles model until no evidence of transmission is found.

Typically, household contacts are highest priority but consideration must be given to close non-household contacts and vulnerable contacts, regardless of their level of exposure.

Treating clinicians are responsible for individual case management with NSW TB services to support adherence to the prescribed treatment therapy or chest radiograph surveillance.

USE OF THE GUIDELINE

TB contact investigations are an important public health activity that should be carried out by the LHD TB Service as part of routine management of a patient diagnosed with TB.

LHD TB Services should:

- Undertake contact investigations for all TB cases
- Notify the NSW TB Program and their local PHU Director of contact investigations where:
    - Screening involves a healthcare facility or educational institution;
    - Screening that may attract media interest or may cause large scale public concern;
    - Large screenings (where more than 25 contacts at high risk of exposure are identified); and
    - Situations where a high or medium infectiousness index case spent greater than eight hours on an aircraft, and
    - Contact investigations that cross state and/or international jurisdictional borders.
- Communicate with representatives of all relevant jurisdictions (including interstate TB services where relevant) where contact investigations cross jurisdictional boundaries
- Provide sufficient information to ensure appropriate screening of contacts, and ongoing management for those identified as having LTBI or TB disease

- Complete summary contact investigation data on the Notifiable Conditions Information Management System (NCIMS)
- Undertake a routine review process of the quality and completeness of contact investigations.

LHD Public Health Units should:

- Provide assistance including surge capacity, data management, public communication support and assistance with decision making around the investigation where requested by the LHD TB Service
- Facilitate public health inquiries under section 106 of the *Public Health Act.*

The NSW TB Program should:

- Provide advice on large and/or complex contact investigations as requested
- Convene an expert panel where required to support the contact investigation for large and/or complex situations
- Report on contact investigation indicators.

The complete Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_003

316(27/03/19)

NSW ABORIGINAL BLOOD BORNE VIRUSES AND SEXUALLY TRANSMISSIBLE INFECTIONS FRAMEWORK 2016-2021 (IB2016_020)

IB2016_020 replaces GL2007_002

PURPOSE

This Information Bulletin advises that the Information Bulletin IB2016_015 *NSW Aboriginal Blood-Borne Viruses and Sexually Transmissible Infections Framework 2016-2020* has been rescinded, and superseded by the *NSW Aboriginal Blood Borne Viruses and Sexually Transmissible Infections Framework 2016-2021*.

KEY INFORMATION

The Aboriginal BBV and STI Framework 2016-2021 outlines the priorities for BBV and STI prevention, testing, treatment and management for Aboriginal people in priority settings including Aboriginal Community Controlled Health Services (ACCHSs) and other primary health settings, Local Health Districts (LHDs) and Non-Government Organisations (NGOs).

Implementation of this Framework in conjunction with the NSW HIV Strategy 2016-2020, NSW STI Strategy 2016-2020, NSW Hepatitis B Strategy 2014-2020 and NSW Hepatitis C Strategy 2014-2020, will support the achievement of health equity for Aboriginal people in NSW.

The Framework is aligned to support achievement of the goals and targets of the *National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017*.

To view the NSW Aboriginal Blood Borne Viruses and Sexually Transmissible Infections Framework 2016-2021 please go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2016_020#

301(06/05/16)

NEONATAL AND INFANT HEPATITIS B PREVENTION AND VACCINATION PROGRAM (PD2023_032)

PD2023_032 replaced PD2017_036

POLICY STATEMENT

NSW Health is committed to reducing the risk of hepatitis B transmission to neonates born in NSW. This Policy Directive focuses on the screening of all pregnant women for hepatitis B disease, appropriate referral to a specialist hepatology service/ specialist hepatologist as required, and the follow-up and management of all infants born to hepatitis B surface antigen (HBsAg) positive women.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive must be read in conjunction with the current edition of The Australian Immunisation Handbook.

The Policy Directive aims to ensure consistent implementation of the NSW Neonatal and Infant Hepatitis B Prevention and Vaccination Program in all local health districts; and applies to NSW ante- and post-natal services, maternity hospitals, and public health units within the local health district.

All maternity facilities must offer hepatitis B surface antigen (HBsAg) screening and referral where appropriate to all pregnant women. HBsAg positive pregnant women with a high viral load (>200,000 or 5.3 log10 IU/mL) are recommended to be referred to a hepatology service/ specialist hepatologist.for management and follow up. HBsAg positive pregnant women with a low viral load (≤200,000 or 5.3 log10 IU/mL) can be managed by either their general practitioner or hepatology service.

All maternity facilities are required to offer Hepatitis B immunoglobulin (HBIG) to all neonates born to HBsAg positive mothers within 12-hours of birth. In addition, all neonates regardless of mothers HBsAg status must be offered the hepatitis B vaccine within 7-days of birth.

For reporting requirements, all maternity facilities are required to enter hepatitis B data onto eMaternity or Cerner as appropriate and report regularly to their Local Health District

The Neonatal Hepatitis B Hospital Coordinator must forward a copy of the Neonatal and Infant Hepatitis B Follow Up Letter to the LHD Neonatal and Infant Hepatitis B Lead and the mother's nominated doctor, if known to assist with following up babies born to a HBsAg positive mother.

In addition, the Neonatal Hepatitis B Hospital Coordinator must complete the Maternity Unit Record Form for every infant born to a HBsAg positive mother. The completed form must be sent to the LHD Neonatal and Infant Hepatitis B Lead to ensure all reporting and monitoring responsibilities are met.

The LHD Neonatal and Infant Hepatitis B Lead is required to send a copy of the *Neonatal and Infant Hepatitis B Follow Up Letter to General Practitioners* and the *Maternity Unit Record Form* to the local PHU Immunisation Coordinator for monitoring and follow up of vaccination course completion.

All neonates born to HBsAg positive mothers outside of NSW Health facilities should be notified to the local public health unit to assist with monitoring the completion of their primary hepatitis B vaccination course.

Following collection of the data, the local health district is responsible for reporting program performance and follow-up all neonates born to HBsAg positive mothers who are overdue for vaccination.

The full Neonatal and Infant Hepatitis B Prevention and Vaccination Program policy is available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_032

AUTHORISED NURSE IMMUNISERS AND AUTHORISED MIDWIFE IMMUNISERS (PD2023_027)

PD2023_027 replaced PD2022_016

POLICY STATEMENT

NSW Health is committed to improving immunisation coverage rates and achieving national goals and targets. The immunisation status of community members is seen to be greatly improved if registered nurses and midwives, who have specialised training, are able to provide vaccination services that are complementary to those performed by medical practitioners and nurse practitioners.

This Policy Directive applies to Authorised Nurse Immunisers and Authorised Midwife Immunisers only. It is not applicable to registered nurses and midwives who have not completed the specified training but who may administer vaccines under the direction and authorisation of a medical officer or nurse practitioner.

SUMMARY OF POLICY REQUIREMENTS

NSW Health organisations must have processes in place to ensure Authorised Nurse Immunisers and Authorised Midwife Immunisers employed by their organisation are currently registered with the Australian Health Practitioner Regulation Agency (AHPRA) and legally able to practice within the scope of their registration in NSW.

To become an Authorised Nurse Immuniser or Authorised Midwife Immuniser, a registered nurse/ midwife must have successfully completed the recognised training stated in this Policy Directive.

Further training is required for Authorised Nurse Immunisers and Authorised Midwife Immunisers:

- supplying or administering a SARS-COV-2 (COVID-19) vaccine; OR
- working in, or in conjunction with, NSW TB Services, to supply and administer Tuberculin and the Tuberculosis vaccine (BCG).

Authorised Nurse Immunisers and Authorised Midwife Immunisers must administer vaccines as recommended by the National Health and Medical Research Council, and in accordance with the Australian Immunisation Handbook.

All vaccinations and restricted substances are stored in accordance with the National Vaccine Storage Guidelines 'Strive for 5'.

Authorised Nurse Immunisers and Authorised Midwife Immunisers are to have a complete anaphylaxis kit with in-date adrenaline for use in the treatment of anaphylaxis and ensure that procedures for the administration of adrenaline comply with the Australian Immunisation Handbook

The Authorised Nurse Immuniser or Authorised Midwife Immuniser must report each adverse event following immunisation to the local Public Health Unit and ensure that a designated medical officer is contactable for medical advice.

All vaccinations administered must be recorded on the Australian Immunisation Register (AIR) and the Authorised Nurse Immuniser or Authorised Midwife Immuniser must maintain authority to immunise.

The full Authorised Nurse Immunisers and Authorised Midwife Immunisers policy is available at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_027

STATEWIDE STANDING ORDERS FOR THE SUPPLY OR ADMINISTRATION OF MEDICATION FOR PUBLIC HEALTH RESPONSE (PD2016_035)

PD2016_035 rescinds PD2013_035.

PURPOSE

The public health response for people exposed to an infectious or otherwise hazardous agent may include the urgent provision of prophylactic medication. In addition, in some circumstances, the public health response includes urgent provision of a medication to treat a person who already has the infection.

The Policy Directive - *Statewide Standing Orders for the Supply or Administration of Medication for Public Health Response* authorises an appropriately educated registered nurse to administer and / or supply specified medications and sets out procedures for dispensing, supplying and administering medications for the purpose of treatment or prophylaxis against certain notifiable conditions or to those who fit an agreed case definition. This Policy Directive when activated for public health response, applies where provision of medication is required as a result of exposure to certain notifiable conditions. Settings may include health facilities where availability of an authorised prescriber would delay a timely response, residential care facilities, airports, schools, or workplaces.

MANDATORY REQUIREMENTS

This Policy Directive does not require further authorisation by Institutional / Local Health District Drug and Therapeutics Committees and overrides any inconsistent local policy.

This standing order will be submitted to the NSW Therapeutic Advisory Group for review annually by Health Protection NSW.

IMPLEMENTATION

Roles and Responsibilities

NSW Ministry of Health:

- Ensure the mandatory requirement for annual review by the NSW Therapeutic Advisory Group.

Chief Executives, Health Service Executives, Managers:

- Ensure services and personnel are aware of their roles and responsibilities under the policy.

Public Health Unit Director:

- Ensure that local protocols and procedures are in place to support implementation of the policy
- The Standing Order activation section is completed prior to each occasion of use
- In order to fulfil the standing order, dispensing of medications will need to be arranged with a public hospital pharmacy department, on behalf of the public health organisation, and at the request of the Public Health Officer (if a medical officer) or an authorised prescriber designated by the district's public health unit director / Public Health Officer.

Medical Public Health Officer:

- The Medical Public Health Officer must check the medication record (Section 8.2 or 8.3) documenting the drug supply and CONFIRM BY SIGNING this entry WITHIN 24 hours.

1. BACKGROUND

1.1 About this document

The *Statewide Standing Orders for the Supply or Administration of Medication for Public Health Response* authorises a registered nurse to administer and / or supply for administration specified medications and sets out procedures for ordering, dispensing, supplying and administering medications for the purpose of treatment or of prophylaxis against certain notifiable conditions or to those who fit an agreed case definition.

This Policy Directive is intended for use by registered nurses employed in a public health organisation for the supply or administration of medication for Public Health response in 'off site' settings to the public health organisation. In the case of administration of vaccines for a public health response, although it is desirable, it is not mandatory for the registered nurse to be an Authorised Nurse Immuniser. Settings may include health facilities where availability of an authorised prescriber would delay a timely response, residential care facilities, airports, schools, or workplaces.

Competency to administer medications is included in the qualifications of medical practitioners, dentists, nurse practitioners, midwife practitioners, registered nurses, and registered midwives, but only in accordance with any practice conditions imposed by the person's place of employment and the endorsements, notations and conditions on the person's registration.

The following statewide standing orders are for:

- The management of influenza cases and contacts
- The management of meningococcal disease contacts
- The management of measles contacts
- The subsequent use of adrenaline (epinephrine) to treat anaphylaxis.

1.2 Key definitions

Case	Individual diagnosed with a condition meeting standard defining criteria.
Contact	Individuals who meet the definition of a contact for a specified disease as documented in public health guidelines.
Clearance	Use of medication to prevent secondary cases, through elimination of the bacteria from possible carriers in the defined network of close contacts of each case.
Medical Public Health Officer	*Public Health Officer under the Public Health Act* (who is a medical officer), or a medical officer designated by the District's Public Health Unit Director / Public Health Officer.
Medication	Used singularly throughout the Policy to describe a drug, medicine, pharmaceutical preparation (including a compounded preparation), therapeutic substance, and vaccine.
Prophylaxis	Use of medication to prevent illness in contacts of a known case of disease.
Public health organisation	A local health district, or statutory health corporation, or an affiliated health organisation in respect of its recognised establishments and recognised services.
Registered Nurse	Includes nurses and midwives registered with the Nursing and Midwifery Board of Australia.
Supply	To administer or dispense medications to a group or a specific patient and is consistent with the definition of supply in section 3 of *the Poisons and Therapeutic Goods Act 1966*. Includes administration of a single dose or medication pack dispensed for treatment or prophylaxis by a Registered Nurse.
Treatment	Use of medication to treat an individual case of disease

1.3 Legal and legislative framework

Section 121 of the *Public Health Act 2010* allows the Secretary of the NSW Ministry of Health to appoint individuals to the position of Public Health Officer for a part of the State or for the purpose of exercising particular public health functions. These functions include the investigation of matters affecting public health and coordinating activities in relation to the reduction of any risks to public health in that part of the state.

Clauses 170 and 171 of the Poisons and Therapeutic Goods Regulation 2008 allow the Secretary of the NSW Ministry of Health to authorise (for the purposes of the Act) a particular person (by means of an instrument in writing given to the person) or a specified class of persons (by means of an instrument published in a manner approved by the Secretary) to supply restricted substances according to clause 53 of the regulation. The authorisation only applies to registered nurses or midwives employed by a public health organisation for the medications listed in the standing orders included in this policy.

2. IMPLEMENTATION OF STATEWIDE STANDING ORDERS FOR PUBLIC HEALTH RESPONSE

When a statewide standing order is applied, public health organisation executives are to ensure:

A registered nurse operating under this standing order is aware of their responsibility to:

- ☐ Determine whether the patient meets the criteria for the standing order and explain the treatment and its purpose to the patient (or guardian)
- ☐ Check that the patient is not showing signs and symptoms requiring immediate medical review and contact the medical officer or refer to the emergency department for immediate review as required
- ☐ Determine any known allergies, hypersensitivity to the medication or contraindications to treatment and contact the medical officer to discuss how to proceed
- ☐ Obtain patient / guardian consent from the patient receiving treatment. Nurses or midwives who are authorised to initiate medications have the same obligations as medical practitioners when obtaining consent for the procedures which they are authorised to perform
- ☐ Document all assessments and details relating to the supply or administration of medication
- ☐ Remain competent in cardio-pulmonary resuscitation, and the administration of adrenaline (epinephrine) in the management of anaphylaxis
- ☐ Practice under the Policy Directive PD2013_043 - *Medication Handling in NSW Public Health Facilities*
- ☐ Record the name of the person and the date the medication is supplied to the patient on the medication label at the time of supply - where this information is not available at the time of supply from the hospital pharmacy
- ☐ Record the administration / dispensing of each medication (see sections 8.1, 8.2 and 8.3) and
- ☐ Ensure records relating to the administration / dispensing of medication are retained in accordance with the State Records Authority General Retention and Disposal Authority for Public Health Services: Patient / Client Records (GDA 17).

The Medical Public Health Officer is aware of their responsibility to:

☐ Brief the registered nurse on the relevant section of the Standing Order and complete the Standing Order activation section prior to each occasion of use

☐ Arrange dispensing of medications with the public hospital pharmacy department, including the estimated quantity required

☐ Be able to be contacted to provide advice to the registered nurse during the treatment or prophylaxis program, and

☐ Check the medication record (section 8.2 or 8.3) documenting the drug supply and confirm by signing this entry within 24 hours.

The public hospital Pharmacy Department is aware of their responsibility to:

☐ Label all medication that is to be supplied for dosing at a later time with the name(s) and strength(s), active ingredient(s) of the medication and the directions for use, including duration of use and other required information. If known, the patient's name must be included on the label. Additional information that should also be supplied includes the Consumer Medicine Information (Full manufacturers product information accessible via CIAP).

3. MEDICATIONS FOR TREATMENT OF INFLUENZA

Purpose

This standing order sets out procedures for ordering, supplying and administering the anti-influenza medications oseltamivir (Tamiflu®) and zanamivir (Relenza®), for the purpose of treatment of influenza.

This standing order authorises a registered nurse, who practices in accordance with the requirements set out in section 2, to administer and/or supply the specified medications for the treatment of influenza to those who fit the agreed clinical case definition of influenza-like-illness according to NSW Health Public Health Response Guidelines[1] or on laboratory diagnosis of influenza. Anti-influenza medications have been shown to attenuate disease in cases of influenza if given early in the course of the illness (within 48 hours of developing symptoms). There may be benefit in providing anti-influenza medications to hospitalised patients after 48 hours.

Medications - oseltamivir and zanamivir

This standing order does **NOT** apply to the following patient groups. A medical officer must approve the supply of anti-influenza medications to these groups:

- Oseltamivir to children under the age of 1 year
- Zanamivir to children under the age of 5 years
- Pregnant or breast-feeding women.

Oseltamivir is approved for use as treatment in children 1 year and older, and zanamivir is approved for use as treatment in children five years and older. The decision to administer to children under these ages should only be taken when the potential benefit is considered to outweigh the risk of harm. In these circumstances the medications must be prescribed by a medical practitioner following consultation with a paediatrician.

Oseltamivir and zanamivir should be used with caution in pregnant or breast-feeding women and only where the potential benefit is considered to outweigh the risk of harm. Treatment may only be prescribed by a medical officer.

If the registered nurse applying the standing order has any concerns regarding patient safety for provision of the medication (e.g. people with significant chronic illness or immunosuppression), the nurse should arrange for the Medical Public Health Officer or emergency department to review so the supply or administration of medication can occur as soon as possible.

1 Series of National Guidelines, Influenza Control Guideline for Public Health Units, Communicable Disease Network Australia. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-influenza.htm

3.1 Standing order for supply of oseltamivir (Tamiflu®) for TREATMENT

<table>
<tr><td>TITLE</td><td>Standing order for Influenza TREATMENT</td></tr>
<tr><td>Drug(s)</td><td>Oseltamivir (TAMIFLU®)</td></tr>
<tr><td>Presentation [1]</td><td>30 mg, 45 mg and 75 mg capsule
6 mg/mL powder for oral suspension - reconstitute with 55 mL water</td></tr>
<tr><td>Indication</td><td>Oseltamivir is approved for use as treatment of Influenza in adults and children one year and older</td></tr>
<tr><td>Contraindications[1]</td><td>▪ History of hypersensitivity or allergy to oseltamivir , fructose intolerance (this applies to oral suspension only), routine haemodialysis or continuous peritoneal dialysis, subjects with creatinine clearance <10mL/min, history of renal impairment (seek medical advice)
▪ The safety and efficacy of oseltamivir in paediatric patients have not been established in children aged less than 1 year of age.</td></tr>
<tr><td>Precautions[1]</td><td>Use with caution in pregnant or breastfeeding women
Use with caution in adults with chronic renal impairment (reduce dosage)*</td></tr>
<tr><td>Dose[4]</td><td>Recommended dose of oseltamivir for treating patients more than one year of age
<table>
<tr><th>Bodyweight in kg</th><th>Recommended dose</th><th>Equivalent volume for 6 mg/mL oral suspension</th></tr>
<tr><td>15kg or less</td><td>30mg</td><td>5mL</td></tr>
<tr><td>More than 15kg to 23kg</td><td>45mg</td><td>7.5mL</td></tr>
<tr><td>More than 23kg to 40kg</td><td>60mg</td><td>10mL</td></tr>
<tr><td>More than 40 kg</td><td>75mg</td><td>12.5mL</td></tr>
</table>
*Dosage for adults with renal impairment:
Creatinine clearance 30 – 60 mL/min 30 mg TWICE daily for five days
Creatinine clearance 10 –30 mL/min 30 mg ONCE daily for five days
Seek medical advice prior to supply or administration of oseltamivir for patients with creatinine clearance of less than 10 mL/min and for patients on haemodialysis or chronic ambulatory peritoneal dialysis.</td></tr>
<tr><td>Dose frequency[1]</td><td>TWICE daily for five days</td></tr>
<tr><td>Administration[1]</td><td>As a result of reported gastrointestinal upset, oseltamivir should be taken with food. For young children, the dose can be mixed with soft food e.g. yoghurt, honey to disguise the taste of the medicines.</td></tr>
<tr><td>Drug Interactions[1]</td><td>Information derived from pharmacology and pharmacokinetic studies of oseltamivir suggest that clinically significant drug interactions are unlikely.</td></tr>
<tr><td>Adverse effects[1]</td><td>▪ Common: Nausea and vomiting (most common in first 1-2 days); headache;
▪ Rare: GI bleeding; haemorrhagic colitis increased liver enzymes; hepatitis; rash; allergy including anaphylaxis; severe skin reaction; neuropsychiatric event e.g. abnormal behaviour, hallucinations, delirium (mainly in children); laxative effect (suspension). See product information for full list.</td></tr>
<tr><td>Documentation</td><td>Obtain consent, explain side effects, and provide consumer medicine information and patient information sheet</td></tr>
<tr><td>Related Documents</td><td>NSW Health Influenza Factsheet
Consumer Medicine Information for Tamiflu®
Patient Information Sheet for Tamiflu (section 8.4)</td></tr>
</table>

1 The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

3.2 Standing order for supply of zanamivir (RELENZA®) for TREATMENT

TITLE	Standing order for Influenza TREATMENT
Drug(s)	**Zanamivir (RELENZA®)**
Presentation [1]	**5 mg** powder / blister; four blisters in each Rotadisk. Powder is inhaled by mouth using a delivery device called a DISKHALER
Indication	Zanamivir is approved for use as treatment of Influenza in adults and children 5 years and older
Contraindications[1]	History of hypersensitivity to zanamivir or lactose.
Precautions[1]	▪ Use with caution in pregnant or breast-feeding women and subjects with severe asthma or chronic respiratory disease ▪ Children may not be able to inhale zanamivir properly, resulting in inadequate tissue concentrations.
Dose [1]	10 mg (two 5mg blisters) inhaled
Dose frequency[1]	**TWICE** daily for 5 days
Administration[1]	Refer to the "patient instructions for use" for the Diskhaler use. Patients with asthma should use their bronchodilator prior to using zanamivir. If new onset wheeze develops after using zanamivir, discontinue therapy.
Drug Interactions[1]	No clinically significant drug interactions have been reported in clinical studies to date.
Adverse effects[5]	Adverse effects are rare (0.1%) and include bronchospasm (may be fatal); dyspnoea allergy including oropharyngeal oedema, rash and anaphylactic / anaphylactoid reaction. See Product Information for full list.
Documentation	Obtain consent, explain side effects, and provide Consumer Medicine Information for Relenza and patient information sheet for Relenza.
Related Documents	NSW Health Influenza Factsheet Consumer Medicine Information for Relenza Patient Information Sheet for Relenza (section 8.5)

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

1 The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

4. MEDICATIONS FOR THE PROPHYLAXIS OF INFLUENZA

Purpose

This standing order sets out procedures for ordering, supplying or administering the anti-influenza medications oseltamivir (Tamiflu®) and zanamivir (Relenza®), for the purpose of **prophylaxis** of influenza.

This standing order authorises a registered nurse, who practices in accordance with requirements set out in section 2, to administer and / or supply the specified anti-influenza medications for the prophylaxis against influenza to those who fit an agreed case definition.

Prophylaxis should be provided as soon as possible but not if more than seven days has elapsed since the last contact with a probable or confirmed case of influenza. Once it is determined that prophylaxis is required, administration or supply should commence as soon as possible. The clinical condition of all contacts of the confirmed case of influenza should be reviewed prior to administration or supply of prophylaxis to determine whether they have developed symptoms or signs of influenza infection.

Medications - oseltamivir and zanamivir

This standing order does **NOT** apply to the administration or supply of:

- Oseltamivir to children under the age of 1 year
- Zanamivir to children under the age of 5 years
- Pregnant or breast-feeding women.

The decision to administer to children under these ages and pregnant or breast-feeding women should only be taken where the benefit is considered to outweigh the risk, and medication must be prescribed by a medical practitioner including consultation with a paediatrician for children.

If the registered nurse applying the standing order has any clinical concerns regarding patient safety for provision of the medication, the nurse should arrange for the Medical Public Health Officer or emergency department to review so the supply or administration of medication can occur as soon as possible.

4.1 Standing order for supply of oseltamivir (Tamiflu®) for PROPHYLAXIS.

<table>
<tr><td>TITLE</td><td>Standing order for Influenza PROHPYLAXIS</td></tr>
<tr><td>Drug(s)</td><td>oseltamivir (TAMIFLU®)</td></tr>
<tr><td>Presentation [1]</td><td>30 mg, 45 mg and 75 mg capsule
6 mg/mL powder for oral suspension - reconstitute with 55 mL water</td></tr>
<tr><td>Indication</td><td>Oseltamivir is approved for use as prevention of Influenza in adults and children 1 year and older.</td></tr>
<tr><td>Contraindications[1]</td><td>▪ History of hypersensitivity or allergy to oseltamivir, fructose intolerance (this applies to oral suspension only), routine haemodialysis or continuous peritoneal dialysis, subjects with creatinine clearance <10mL/min, history of renal impairment (seek medical advice)
▪ The safety and efficacy of oseltamivir in paediatric patients have not been established in children aged less than 1 year of age.</td></tr>
<tr><td>Precautions[1]</td><td>Use with caution in pregnant or breastfeeding women
Use with caution in adults with chronic renal impairment (reduce dosage)*</td></tr>
<tr><td>Dose[6]</td><td>Recommended dose of Tamiflu for patients more than one year of age
<table>
<tr><td>Bodyweight in kg</td><td>Recommended dose</td><td>Equivalent volume for 6 mg/mL oral suspension</td></tr>
<tr><td>15kg or less</td><td>30mg</td><td>5 mL</td></tr>
<tr><td>More than 15kg to 23kg</td><td>45mg</td><td>7.5 mL</td></tr>
<tr><td>More than 23kg to 40kg</td><td>60mg</td><td>10 mL</td></tr>
<tr><td>More than 40kg</td><td>75mg</td><td>12.5 mL</td></tr>
</table>
*Dosage for adults with renal impairment:
Creatinine clearance of greater than 30 – 60 mL/min 30 mg ONCE daily for 5 days
Creatinine clearance of 10 –30 mL/min 30 mg SECOND daily
Seek medical advice prior to supply or administration of Tamiflu for patients with creatinine clearance of less than 10 mL/min and for patients on haemodialysis or chronic ambulatory peritoneal dialysis.</td></tr>
<tr><td>Dose frequency[1]</td><td>ONCE daily for 10 days</td></tr>
<tr><td>Administration[1]</td><td>As a result of reported gastrointestinal upset, oseltamivir should be taken with food. For young children, the dose can be mixed with soft food e.g. yoghurt, honey to disguise the taste of the medicines.</td></tr>
<tr><td>Drug Interactions[1]</td><td>Information derived from pharmacology and pharmacokinetic studies of oseltamivir phosphate suggest that clinically significant drug interactions are unlikely.</td></tr>
<tr><td>Adverse effects[1]</td><td>▪ Common: Nausea and vomiting (most common in first 1-2 days), headache;
▪ Rare: GI bleeding; haemorrhagic colitis increased liver enzymes; hepatitis; rash; allergy including anaphylaxis; severe skin reaction; neuropsychiatric event e.g. abnormal behaviour, hallucinations, delirium (mainly in children); laxative effect (suspension). See product information for full list.</td></tr>
<tr><td>Documentation</td><td>Obtain consent, explain side effects, and provide consumer medicine information and patient information sheet</td></tr>
<tr><td>Related Documents</td><td>NSW Health Influenza Factsheet
Consumer Medicine Information for Tamiflu®
Patient Information Sheet for Tamiflu (section 8.4)</td></tr>
</table>

1The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

Standing order activation: *(to be completed for each episode of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

4.2 Standing order for supply of zanamivir (Relenza®) for PROPHYLAXIS.

TITLE	Standing order for Influenza PROHPYLAXIS
Drug(s)	**zanamivir (RELENZA®)**
Presentation [1]	**5 mg** powder / blister; four blisters in each Rotadisk. Powder is inhaled by mouth using a delivery device called a DISKHALER
Indication	Relenza is indicated for prophylaxis of infection due to influenza A and B in adults and children (greater than or equal to five years) to reduce transmission among individuals in households with an infected person.
Contraindications[1] and exclusions	History of hypersensitivity to zanamivir or lactose.
Precautions[1]	Use with caution in pregnant or breast-feeding women and subjects with severe asthma or chronic respiratory disease
Dose [1]	10 mg (two 5mg blisters) inhaled
Dose frequency[1]	**ONCE** daily for 10 days
Administration[1]	Refer to the "patient instructions for use" for the Diskhaler use. Patients with asthma should use their bronchodilator prior to usinging zanamivir. If new onset wheeze develops after taking zanamivir, discontinue therapy.
Drug Interactions[1]	No clinically significant drug interactions have been reported in clinical studies to date.
Adverse effects[1]	▪ Adverse effects are rare (0.1%) and include bronchospasm (may be fatal); dyspnoea allergy including oropharyngeal oedema, rash and anaphylactic / anaphylactoid reaction. ▪ Note: there is a warning in the product information regarding an association between zanamivir and neuropsychiatric symptoms (e.g delirium or abnormal behaviour); however, at present, evidence suggests that these rare events are more likely to be due to influenza. ▪ See Product Information for full list.
Documentation	Obtain consent, explain side effects, and provide consumer medicine information and patient information sheet.
Related Documents	NSW Health Influenza Factsheet Consumer Medicine Information for Relenza® Patient Information Sheet for Relenza (section 8.5)

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

1 The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

5 CLEARANCE ANTIBIOTICS FOR MENINGOCOCCAL DISEASE

Purpose

This standing order sets out procedures for ordering, supplying or administering ciprofloxacin, ceftriaxone or rifampicin for close contacts of a case of meningococcal disease. Among close contacts, there is often an asymptomatic individual who is carrying the organism that caused the infection in the index case. The purpose of clearance antibiotics is to eliminate meningococci from any carrier in the defined network of close contacts of each case of meningococcal disease, to reduce the risk of further transmission and prevent further cases of invasive disease.

This standing order authorises a registered nurse, who practices in accordance with requirements set out in section 2, to administer and / or supply the specified antibiotics to contacts of cases of meningococcal disease in the seven days prior to onset of illness according to criteria specified in the national guidelines including[1]:

- Household of a case (including sexual partners)
- Child care facilities or family day care where the case of meningococcal disease was in the same room for more than four hours
- School or university contacts who are “household-like” contacts
- Health care workers who have intubated the case without a face mask or done mouth to mouth resuscitation (after onset of illness)
- Contacts in seats adjacent to the case during long distance travel (more than eight hours)

Medication should be provided as soon as practicable to identified contacts, but should not be provided if more than four weeks have elapsed since the last contact with a probable or confirmed case of meningococcal disease.

Medications

Three antibiotics, ciprofloxacin, ceftriaxone and rifampicin, are considered equally effective as clearance antibiotics for use by defined contacts of a case with meningococcal disease.

The recommended medication for specific patient groups[2]:

- Ciprofloxacin is the preferred medication for all age groups and for women on the contraceptive pill.[3] Ciprofloxacin is currently not available as a suspension except through the Special Access Scheme.
- Ceftriaxone is the preferred medication for use in pregnant women and in women who are breastfeeding.
- Rifampicin can be used for children under 12 who cannot be appropriately dosed with ciprofloxacin tablets.

Where compliance may be an issue, use of ciprofloxacin, which requires only a single oral dose, may be advantageous unless otherwise contraindicated.

1 Invasive Meningococcal Disease CDNA National Guidelines for Public Health Units July 2014, The Department of Health. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-IMD.htm
2 Chemoprophylaxis for meningitis. In: eTG complete [Internet]. Melbourne: Therapeutic Guidelines Limited; 2015 Jul.
3 Potential impact on cartilage development for prebubertal children. However, when given for prophylaxis as a stat dose, the effect is unlikely to be a concern

5.1 Standing order for ciprofloxacin for close contacts of meningococcal disease

TITLE	Standing order for meningococcal contacts - ciprofloxacin
Drug(s)	**ciprofloxacin**
Presentation [1]	Tablets - 250mg, 500mg Ciprofloxacin is currently not available as a suspension except through the Special Access Scheme
Indication [1 2]	▪ Clearance of meningococcal carriage in close contacts of known cases. ▪ Ciprofloxacin is the preferred option for women taking oral contraceptives
Contraindications[1]	▪ Not to be given in pregnancy or during breastfeeding ▪ Allergies to ciprofloxacin or other quinolones / fluoroquinolones
Precautions[1]	▪ Adrenaline (epinephrine) must be available for the registered nurse or midwife to administer if anaphylaxis occurs. ▪ Use with caution in patients with cystic fibrosis, central nervous system disorders, such as severe cerebral arteriosclerosis or epilepsy, renal impairment, and liver damage. ▪ G6PD deficiency - increases risk of haemolytic anaemia. ▪ Potential impact on cartilage development for prepubertal children. However, when given for prophylaxis as a stat dose, the effect is unlikely to be a concern. ▪ Avoid direct sunlight and ensure adequate hydration
Dose[1]	**Adults:** 500mg, **Children younger than five years:** 30mg/kg up to 125mg, **Children five to 12 years:** 250mg
Dose frequency[1]	Single dose
Administration[1]	▪ Oral (with a full glass of water) ▪ If possible, recipients should be observed for 30 minutes post-ingestion.
Drug Interactions[1]	▪ Ciprofloxacin may interact with, omeprazole, thyroxine warfarin, cyclosporin, metoclopramide, NSAIDs, and other medicines. Check with a pharmacist for any clinically relevant interactions in patients taking other medicines. ▪ Patients are advised that ciprofloxacin may enhance the effects of caffeine.
Adverse effects[1]	▪ Common (>1%): rash, itch, nausea, vomiting, diarrhoea, abdominal pain, dyspepsia. ▪ Infrequent (0.1-1%): headache, dizziness, insomnia, depression, restlessness, tremors, arthralgia, arthritis, myalgia, tendonitis, interstitial nephritis, raised liver enzymes. ▪ Rare (<0.1%): blood dyscrasias, peripheral neuropathy, hepatitis, tendon rupture, anaphylaxis, psychotic reactions, severe skin reaction, QT prolongation. See Product Information for full list. ▪ The majority of listed adverse effects are very unlikely as only a single dose is being given.
Documentation	Obtain consent, explain side effects and provide consumer medicine information and patient information sheet
Related Documents	NSW Health Meningococcal disease Factsheet Consumer Medicine Information for ciprofloxacin Patient Information Sheet for ciprofloxacin (section 8.7)

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

1 The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration
2 Chemoprophylaxis for meningitis. In: eTG complete [Internet]. Melbourne: Therapeutic Guidelines Limited; 2015 Ju.l

5.2 Standing order for ceftriaxone for close contacts of meningococcal disease

TITLE	Standing order for meningococcal contacts - ceftriaxone
Drug(s)	**ceftriaxone**
Presentation [1]	Powder for injection 250mg, 500mg, 1G per vial
Indication [1 2]	▪ Clearance of meningococcal carriage in close contacts of known cases. ▪ Ceftriaxone is the preferred option during pregnancy.
Contraindications[1]	▪ Not to be given to premature neonates up to corrected age 41 weeks or infants less than 4 weeks old ▪ Known allergy to the cephalosporin class of antibiotics or a major allergy to penicillin (anaphylaxis, angioneurotic oedema, urticaria). ▪ Lignocaine should not be used as a diluent for intramuscular injection in patients who are hypersensitive to lignocaine
Precautions[1]	▪ Adrenaline (epinephrine) must be available for the registered nurse or midwife to administer if anaphylaxis occurs. ▪ Not to be injected intravenously ▪ History of hypersensitivity to cephalosporins, penicllins or other drugs ▪ History of antibiotic-associated pseudomembranous colitis ▪ History of gastrointestinal disease (particularly colitis), severe renal impairment (e.g. dialysis), lignocaine toxicity, chronic hepatic disease, and malnutrition.
Dose[1]	**Adults:** 250mg IM **Children less than 12 years of age**: 125mg IM **Note: Not in children less than four weeks old**
Dose frequency[1]	Single dose
Administration[1]	▪ Deep intramuscular injection in lignocaine solution 1% to reduce pain at the injection site ▪ Dissolve the contents of 500mg vial in 2mL or 1g in 3.5mL of lignocaine 1% solution, administered by deep intragluteal injection. The lignocaine solution must never be administered intravenously. Product is for single use in one patient only. Discard any residue.
Drug Interactions[1]	No drug interactions of particular concern
Adverse effects[1]	▪ Common or infrequent: diarrhoea, nausea, vomiting, pain and inflammation at injection site, rash, headache, dizziness, allergy. ▪ Rare (<0.1%): neurotoxicity (eg confusion, seizures, encephalopathy) particularly with high doses and / or renal impairment, blood dyscrasias, thrombocytopenia, bleeding, renal impairment. ▪ The majority of listed adverse effects are very unlikely as only a single dose is being given. ▪ See Product Information for full list.
Documentation	Obtain consent, explain side effects, and provide consumer medicine information and patient information sheet
Related Documents	NSW Health Meningococcal disease Factsheet Consumer Medicine Information for ceftriaxone Patient Information Sheet for ceftriaxone (section 8.8)

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

1 The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

2 Chemoprophylaxis for meningitis. In: eTG complete [Internet]. Melbourne: Therapeutic Guidelines Limited; 2015 Jul.

5.3 Standing order for rifampicin for close contacts of meningococcal disease

TITLE	Standing order for meningococcal contacts - rifampicin
Drug(s)	**rifampicin**
Presentation	Capsules - 150mg, 300mg, Tablets - 600mg, Syrup - 100mg/5mL
Indication	Clearance of meningococcal carriage in close contacts of known cases. (Rifampicin is not indicated for the treatment of meningococcal infections.)
Contraindications [1]	Jaundice, history of hypersensitivity to any of the rifamycins, severe liver disease, pregnancy
Precautions[1]	▪ Hepatic disease; malnourishment; concomitant TB and leprosy; concomitant hepatotoxic drugs; sodium metabisulfite allergy for those taking rifampicin syrup; porphyria; diabetes; premature and newborn infants. ▪ Rifampicin stains body fluids such as urine, sweat and tears, an orange, red or brown colour. Soft contact lenses should not be worn until the urine has returned to its normal colour, as they may become stained. ▪ Women taking the oral contraceptive pill should use another form of contraceptive for the cycle during which they are taking rifampicin. ▪ Pregnancy – may cause bleeding problems in newborn. If used in last few weeks of pregnancy, Vitamin K should be given to mother and newborn infant. ▪ Lactation - Rifampicin is excreted in breast milk and infants should not be breastfed by a patient receiving rifampicin.
Dose[2]	**Adults:** 600mg, **Children over 1 month of age:** 10mg/kg, **Children less than 1 month of age:** 5mg/kg **If weights are not able to be obtained, the following dosage is recommended** [3]**:** **Age** / **Recommended dose** / **Equivalent volume of 100mg/5ml oral liquid** 0-2 months / 20mg / 1 mL 3-11 months / 40mg / 2 mL 1-2 years / 100mg / 5 mL 3-4 years / 150mg / 7.5 mL 5-6 years / 200mg / 10 mL **Note: Ciprofloxacin is preferred for children older than 6 years if able to tolerate tablets**
Dose frequency[2]	All dosages are TWICE daily (every 12 hours) for 2 days
Administration[1]	Rifampicin should be taken on an empty stomach at least 30 minutes before or two hours after food.
Drug Interactions[1]	If taking concomitant antacids, rifampicin should be given at least one hour before the ingestion of antacids. Rifampicin interacts with numerous drugs by accelerating their breakdown and reducing their activity. Check pharmacology texts and/or obtain advice from a pharmacist for patients taking other medications. Examples of interacting medicines include but are not limited to oral anticoagulants (e.g. warfarin), anticonvulsants (e.g. phenytoin, phenobarbitone), antiarrhythmics, tamoxifen, antipsychotics (e.g. haloperidol), antifungals (e.g. fluconazole, itraconazole), antiretroviral drugs (e.g. zidovudine, saquinavir, indinavir), beta-blockers, calcium channel blockers (e.g. diltiazem, verapamil), clarithromycin, corticosteroids,

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2 Chemoprophylaxis for meningitis. In: eTG complete [Internet]. Melbourne: Therapeutic Guidelines Limited; 2015 Jul.

3 Guidance for public health management of meningococcal disease in the UK. Health Protection Agency Meningococcus and Haemophilus Forum.
Updated March 2012. Available from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322008/Guidance_for_management_of_meningococcal_disease_pdf.pdf

	cyclosporin, systemic hormonal contraceptives, benzodiazepines (e.g. diazepam), doxycycline, fluoroquinolones, sulfonylureas, levothyroxine, opioids, methadone, tacrolimus, tricyclic antidepressants (e.g. amitriptyline, nortriptyline).
Adverse effects[1]	Common (>1%): Gastrointestinal symptoms (e.g. nausea, vomiting, cramps); rash; body fluid, soft contact lens discolouration (red / orange); Rare (<0.1%): hepatitis, See Product information for full list. Rare adverse effects such as hepatitis are very unlikely as the course for prophylaxis is short.

TITLE	Standing order for meningococcal contacts – rifampicin
Documentation	Obtain consent, explain side effects and provide consumer medicine information and patient information sheet
Related Documents	NSW Health Meningococcal disease Factsheet Consumer Medicine Information for rifampicin. Patient Information Sheet for rifampicin (section 9.6)

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

6 POST-EXPOSURE PROPHYLAXIS OF MEASLES

Purpose

This standing order sets out procedures for ordering, supplying or administering normal human immunoglobulin (NHIg) or measles-mumps-rubella vaccine (MMR) for measles post exposure management of susceptible contacts. A person considered '**susceptible'** to measles is someone who cannot provide acceptable presumptive evidence of immunity to measles as described in 'Measles: Control guidelines for NSW Public Health Units'[1]

This standing order authorises a registered nurse, who practices in accordance with requirements set out in section 2, to administer the specified immunoprophylaxis to defined contacts to protect them from developing measles. Defined contacts may include:

- All household members of the case
- All people sleeping overnight in the same room as the case (e.g. in a hospital, boarding school or military barracks)
- All children and adults at family day care, child care, preschool, school or other educational setting who share a classroom with the case
- People who shared a waiting area at the same time as the infectious case (such as patients in a health care facility's waiting room and any people accompanying these patients) and people who were in a waiting area or consulting room previously occupied by an infectious case for up to 30 minutes after the case has departed
- All work colleagues of the case who share the same work area
- Others who attend or work in the same educational institution as the case, and may have spent time in the vicinity of the case, but do not share a classroom (e.g. a high school, college, lecture theatre block)
- Others who may have been present in the general area where the case was known to be (e.g. cinemas, shopping centres, aeroplane flights and restaurants).

1 Measles: Control guidelines for NSW Public Health Units. Available from: http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/measles.aspx

Immunoprophylaxis

Cases of measles are infectious for around four days prior and four days after the onset of rash. NHIg or MMR should be given as soon as practicable to identified contacts. MMR can be administered within 72 hours (three days) of first contact with an infectious case and NHIg can be administered up to 144 hours (6 days) after first contact. NHIg can be ordered from the Australian Red Cross Blood Service using the order form at

http://www.blood.gov.au/system/files/documents/form-nhig-201115-online.pdf.

Determine the appropriate prophylaxis according to the NSW Health Control Guidelines for Measles[1] based on the time since exposure, age and underlying conditions of the contact:

- Immunocompromised — NHIg
- Pregnancy — NHIg
- Babies under 9 months — NHIg
- Babies at 9 months, children and adults — MMR within 72 hours, NHIG 3-6 days

6.1 Standing order for Measles-Mumps-Rubella Vaccine

TITLE	Standing order for Measles IMMUNOPROPHYLAXIS – MMR
Drug(s)	**Measles-Mumps-Rubella Vaccine**
Presentation [1]	Vials of lyophilised vaccine 0.5 mL (contains live attenuated virus) Store vials at two to eight deg. C. (Refrigerate. Do not freeze.). **Maintain cold chain at all times and protect from all light.**
Indication	Active immunisation to prevent measles in susceptible contacts of confirmed cases of measles.
Contraindications[1]	▪ People with impaired immunity, including AIDS or HIV with impaired immunity, high-dose oral corticosteroids, high-dose systemic immunosuppressive treatment or general radiation, lymphoma, leukaemia. ▪ Untreated tuberculosis ▪ Pregnant women ▪ Allergy to MMR or any component of the vaccine
Precautions[1]	▪ Adrenaline (epinephrine) must be available for the registered nurse or midwife to administer if anaphylaxis occurs. ▪ Patients should be observed for a sufficient period (at least 20 minutes) for the occurrence of early onset reactions seen with measles vaccine ▪ Recent administration of blood product containing antibody (such as NHIG) ▪ Vaccination with another live vaccine in the past 4 weeks ▪ Avoid pregnancy for 28 days after MMR vaccination ▪ Children with a history of seizures- may require treatment to reduce fever 5-12 days after vaccination ▪ Do not use after expiry date on label.
Dose[1]	For both adults and children, the dose of MMR is the same. Reconstitute using diluent supplied.
Dose frequency[1]	Single dose - where a second dose is required, the minimum interval between doses is four weeks.
Administration	Subcutaneous injection - Inject the total volume of the single dose vial (about 0.5mL) into skin of the deltoid muscle or the anterolateral thigh.

1The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

[1]	
Drug Interactions[1]	Immunosuppressants. Immunoglobulin products should not be administered within three weeks after MMR.
Adverse effects[1]	▪ Common (>1%): Headache, Fever may occur 5-12 days after vaccination and last 2-3 days. Fever may be high and should be managed with paracetamol. Lymphadenopathy and rash may occur 1-3 weeks after vaccination and are usually transient. Transient injection site reactions. ▪ Infrequent (0.1-1%): febrile seizures, parotid swelling, arthritis and arthralgia (in children) may occur 1-3 weeks after vaccination and are usually transient. ▪ Rare (<0.1%): thrombocytopenia, chronic joint symptoms. It is uncertain whether encephalopathy occurs, however if it is associated it is less frequent than occurs with measles infection, Anaphylaxis following injection of MMR is rare. There is NO association between MMR vaccination and autism,
Documentation	Obtain consent, explain possible adverse effects and provide consumer medicine information for MMR and patient information sheet
Related Documents	NSW Health Measles Factsheet Consumer Medicine Information sheet for MMR Patient Information Sheet for MMR vaccine (section 8.9)

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

6.2 Standing order for Normal Human Immunoglobulin

TITLE	Standing order for Measles IMMUNOPROHPYLAXIS - Normal Human Immunoglobulin
Drug(s)	**Normal Immunoglobulin - VF**
Presentation [1]	Vials of solution for intramuscular injection, 160 mg/mL: 2 mL, 5 mL 'Normal Immunoglobulin-VF' Store vials at 2 to 8 deg. C. (Refrigerate. Do not freeze). **Maintain cold chain at all times and protect from all light**
Indication	Passive immunisation to prevent measles in susceptible contacts of confirmed cases of measles
Contraindications[1]	▪ Coagulation disorders that would contraindicate intramuscular injections (such as severe thrombocytopenia) ▪ Individuals with isolated immunoglobulin A (IgA) deficiency, unless they have been tested and shown not to have circulating anti-IgA antibodies
Precautions[1]	▪ Seek expert advice prior to administration if live vaccines (e.g. polio, measles, varicella-zoster) have been given within the last 3 weeks. ▪ Must not be injected intravenously ▪ Do not use if the product appears to be turbid by transmitted light or contains any sediment ▪ Do not use after expiry date on label. Must be used immediately after opening the vial and any unused solution discarded ▪ Should be given with caution to patients with a history of prior systemic allergic reactions following the administration of human immunoglobulin preparations. ▪ Consult with obstetrician or GP for pregnant women.
Dose[1] [2]	Immunocompromised 0.5mL/kg - **to max of 15 mL** All others 0.2mL/kg - **to max of 15 mL**
Dose frequency[1]	Single dose
Administration [1]	▪ NHIg should be brought to room temperature before use, and given slowly by deep intramuscular injection in the buttocks, using a large gauge (19 or 20mm) needle. ▪ Where large doses of NHIG are required the dose should be divided in two and injected in each buttock. Hyaluronidase and/or a suitable local anaesthetic may be added to the injection if desired. ▪ NHIg should not be given intravenously. An attempt to draw back on the syringe after IM insertion of the needle should be made in order to ensure that the needle is not in a small vessel.
Drug Interactions[1]	▪ Passively acquired antibody can interfere with the response to live, attenuated virus vaccines. Contact must be informed that they are unable to receive any live vaccines (polio, measles, varicella-zoster) for at least 5 months after IMI NHIg (6 months for immunocompromised patients). ▪ Immunoglobulins should not be administered for at least two weeks after a vaccine is given.
Adverse effects[1]	▪ Common: Local tenderness, erythema and muscle stiffness may occur at the site of injection and may persist for several hours. Mild pyrexia, malaise, drowsiness and urticaria have been reported occasionally after injection. ▪ Rare: Skin lesions, headache, dizziness, nausea, general hypersensitivity reactions and convulsions. Anaphylaxis following injection of NHIG is very rare.
Documentation	Obtain consent, explain side effects and provide consumer medicine information and patient information sheet
Related Documents	NSW Health Measles factsheet Consumer medicine information sheet Patient Information Sheet for NHIg (section 8.10)

1The drug information provided is to act as a guide only, for further information reference should be made to the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

2 Measles: Control guidelines for NSW Public Health Units. Available from: http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/measles.aspx

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

7 ADRENALINE (EPINEPHRINE) FOR ANAPHYLAXIS

Purpose

This standing order sets out procedures for administering adrenaline (epinephrine) for the management of anaphylaxis subsequent to the administration of antibiotics or immunoprophylaxis under public health standing orders.

Symptoms and signs of anaphylaxis

Anaphylaxis causes respiratory and / or cardiovascular signs or symptoms AND involves other organ systems such as skin or gastrointestinal tract, with:

- Skin signs, such as the rapid development of urticarial lesions or erythema, angioedema
- Abdominal cramps, diarrhoea and / or vomiting.
- Signs of upper airway obstruction, such as hoarseness and stridor.
- Indications of lower airway obstruction, such as subjective feelings of retrosternal tightness, dyspnoea or wheeze.
- Limpness and pallor, which are signs of severe anaphylaxis in children.
- Profound hypotension in association with tachycardia, and / or other signs of cardiovascular disturbance, such as sinus tachycardia or severe bradycardia, and weak or absent pulses, when severe.
- Alteration in level of consciousness.

Management of anaphylaxis

- If the patient is unconscious, place them on the left side and position to keep the airway clear. If the patient is conscious, place supine in ‘head down and feet up’ position (unless this results in breathing difficulties).
- Give adrenaline (epinephrine) by intramuscular injection (see standing order for dosage) for any signs of anaphylaxis associated with respiratory and / or cardiovascular symptoms or signs. Although adrenaline (epinephrine) is not required for generalised non-anaphylactic reactions (such as skin rash without other signs or symptoms), administration of intramuscular adrenaline (epinephrine) is safe.
- If there is no improvement in the patient’s condition within five minutes, repeat dose of adrenaline (epinephrine) every five minutes until improvement occurs. Make every effort to call for assistance after first dose
- If oxygen is available, administer by facemask at a high flow rate
- Call for professional assistance and call an ambulance. Never leave the patient alone.
- Begin expired air resuscitation for apnoea, check for central pulse. If central pulse not palpable, commence external cardiac massage (ECM).
- All cases should be admitted to hospital for further observation and treatment.

Experienced practitioners may choose to use an oral airway if the appropriate size is available, but its use is not routinely recommended unless the patient is unconscious.

Antihistamines and / or hydrocortisone are not recommended for the emergency management of anaphylaxis.

7.1 Standing order for adrenaline (epinephrine) for management of anaphylaxis

TITLE	Standing order for adrenaline (epinephrine) for anaphylaxis subsequent to the administration of antibiotics or immunoprophylaxis under public health standing orders
Drug(s)	**adrenaline (epinephrine):1000**
Presentation [1]	Solution for injection (clear, colourless) 1 mg/1mL
Indication [1]	The drug of choice in the emergency treatment of acute severe anaphylactic reactions due to insect bites, drugs and other allergens.
Contraindications[1]	Nil relevant
Precautions[1]	▪ Adrenaline (epinephrine) injection contains no antimicrobial agent. It should be used only once and any residue discarded. Adrenaline (epinephrine) injection should not be used if it is coloured. ▪ NOT to be injected intravenously ▪ Use a 1mL syringe to improve the accuracy of measurement when drawing up small doses ▪ Local ischaemic necrosis can occur from repeated injections in one site ▪ Check expiry date of adrenaline (ephinephrine) injection prior to use and on a regular basis.
Dose[1] [2]	**INTRAMUSCULAR ADRENALINE (EPINEPHRINE) DOSAGE** **Adult / child 10 micrograms/kg (equates to 0.01mL/kg adrenaline (epinephrine) 1: 1,000). Maximum single dose is 500 micrograms (0.5mL). Table below gives dosage recommendations according to age.** **Dose using 1:1,000 ampoules containing 1 mg per 1 mL**

Age	Weight (approx)	Adrenaline (epinephrine) 1:1,000
Less than 1yr	5-10 kg	0.05 - 0.1 mL
1-2 yr	10 kg	0.1 mL
2-3 yr	15 kg	0.15 mL
4-6 yr	20 kg	0.2 mL
7-10 yr	30 kg	0.3 mL
10-12 yr	40 kg	0.4 mL
more than 12 yrs and adult	More than 50 kg	0.5 mL

Dose frequency[12]	Make every effort to call for assistance after first dose **Repeat doses every 5 minutes until improvement occurs**
Administration[12]	Intramuscular injection preferably in the mid-anterolateral (upper outer) thigh (do not inject into buttocks).
Drug Interactions[1]	No drug interactions of particular concern
Adverse effects[1]	Fear; anxiety; restlessness; headache; tremor; weakness; dizziness; pallor; palpitation; respiratory difficulty; hypertension; injection site necrosis. See Product Information for full list.
Documentation	Adrenaline (epinephrine) recipients should be referred to hospital for further observation and treatment
Related Documents	Nil

1 The drug information provided is to act as a guide only, for further information reference should be made to the Australian Medicines Handbook and the full manufacturers product info <accessible via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

2 Australian Technical Advisory Group on Immunisation (ATAGI). The Australian immunisation handbook 10th ed (2015 update). Canberra: Australian Government Department of Health, 2015.
http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home

Standing order activation: *(to be completed for each occasion of use)*

Date:	**Public Health Officer Name:**	**Signature:**
Reason for activation: *(Include Index case record number or outbreak response name as applicable)*		

8 ATTACHMENTS

8.1 Procedure checklist for RNs / midwives to administer or supply medications

☐ Arrange the supply of medications from the designated public hospital pharmacy department. The Medical Public Health Officer should advise the Pharmacy of the medicines required, the estimated quantity and patients' details, if known.

☐ Arrange the supply of an anaphylaxis kit (adrenaline (epinephrine) and 1ml syringes) and be familiar with the adrenaline (epinephrine) treatment protocol, found on the back cover of the current edition of "The Australian Immunisation Handbook" [1].

☐ Assess the eligibility for case or contact in accordance with the NSW Health Public Health Control Guidelines[2].

☐ Explain the rationale and purpose of the medication to the case / contact (or parent / guardian).

☐ Check with the case or contact (or parent / guardian) if they:

1. Are pregnant
2. Have any known allergies
3. Are currently taking any interacting medications or
4. Have pre-existing medical condition(s) where the use of a particular medication may be contraindicated or precautions may be required.

☐ Should the case or contact have a contraindication or precaution to the medication, contact the Medical Public Health Officer.

☐ Explain the adverse effects of the recommended medication.

☐ Provide the Patient Information Sheet, the Consumer Medicine Information Sheet(s), and the NSW Health Fact Sheet and advise them to inform their general practitioner of the treatment at the next visit.

☐ For each person, document the following details: name, address, date of birth, sex, phone number; whether the person has any relevant conditions established above; that information has been given. The form provided in the Appendix 8.2 and 8.3 should be used to document these details.

☐ Record whether valid consent has been given.

☐ Supply recommended medication, labelled by the pharmacist for that patient / contact name. If the name was unknown by the pharmacist at the time he/she packaged and labelled the medication, the Registered Nurse / midwife is to hand write the name, drug frequency, dose, duration and date on the label at the time of supply.

☐ The Medical Public Health Officer must be available to provide advice to the registered nurse if there are any concerns or questions.

☐ For each individual, document as appropriate the administration details and the number of doses supplied.

☐ At the completion of any mass vaccination / treatment program, the Medical Public Health Officer must review, and sign and date the records as soon as possible and ideally within 24 hours, to confirm that the program was conducted in accordance with the standing order.

1 Australian Technical Advisory Group on Immunisation (ATAGI). The Australian immunisation handbook 10th ed (2015 update). Canberra: Australian Government Department of Health, 2015.
http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home
2 NSW Health Public Health Control Guidelines. Available from:
http://www.health.nsw.gov.au/Infectious/controlguideline/Pages/default.aspx

8.2 Record of supply / administration - medication records for Individuals

Date:	**Index Case ID:**	
Surname:	**First name:**	
Address:	**Phone number:**	**MRN** *(where applicable)*
	DOB:	**Male** ☐ **Female** ☐

Pregnant: Yes ☐ No ☐

Breastfeeding: Yes ☐ No ☐

Allergies: Yes ☐ No ☐

Details:

_____

Current Medications: Yes ☐ No ☐

Provide details:

_____

_____

Other precautions and/or contraindications present?

Yes ☐ No ☐

Provide details:

_____

_____

If precautions or contraindications identified have they been discussed with a medical officer?

Yes ☐ No ☐

Advice given by medical officer:

_____

_____

_____

_____

_____

_____

_____

_____

Other issues addressed:

_____

_____

_____

▪ Purpose of medication and adverse effects explained	Yes ☐ No ☐
▪ Counselling and education provided where medications are supplied for later use	Yes ☐ No ☐
▪ Informed consent obtained from individual / guardian	Yes ☐ No ☐
▪ Individual / Guardian has been provided with NSW Health Fact Sheet	Yes ☐ No ☐
▪ Individual / Guardian has been provided with Patient Information Sheet(s)	Yes ☐ No ☐
▪ Individual / Guardian advised to inform their doctor of the treatment at the next visit	Yes ☐ No ☐
▪ Contact / Guardian has been supplied with medications	Yes ☐ No ☐
→If not provided, to be collected by……...……from……..…	

Medication and presentation:	**Dosage and route:**	**Amount supplied:**
RN's name:	**RN's signature:**	**Date:**

Following supply of medication / immunoprophylaxis, the Medical Public Health Officer is to check this medication record documenting the supply and CONFIRM BY SIGNING this entry WITHIN 24.

Medical Officer's name:	**Medical Officer's signature:**	**Date:**

11. INFECTIOUS DISEASES, IMMUNISATION AND RELATED MATTERS 11.41

This form will be used as: ☐ PHU Prescription Fax Form **OR** ☐ Standing Order Form
(*if used as a Standing Order Form, Medical Officer to sign as soon as possible)* **Index case ID…….**

Surname: Address:	First Name MRN *(where applicable)* DOB __/__/__ Age: Sex M / F Phone:	Pregnant: Y / N Breastfeeding: Y / N Allergies: Y / N Details: Interacting Medications: Y / N Details:	Medication: Dose and frequency: Dose administered: Amount supplied: If not supplied, to be collected by ……. from……	Adverse Effects explained: Y / N Informed Consent obtained: Y / N Fact sheet supplied: Y / N Information sheet(s) provided: Y / N Advised to inform GP on their next visit: Y / N
Name: Designation:		Signature	Date	
Surname: Address:	First Name MRN *(where applicable)* DOB __/__/__ Age: Sex M / F Phone:	Pregnant: Y / N Breastfeeding: Y / N Allergies: Y / N Details: Interacting Medications: Y / N Details:	Medication: Dose and frequency: Dose administered: Amount supplied: If not supplied, to be collected by ……. from……	Adverse Effects explained: Y / N Informed Consent obtained: Y / N Fact sheet supplied: Y / N Information sheet(s) provided: Y / N Advised to inform GP on their next visit: Y / N
Name: Designation:		Signature	Date	
Surname: Address:	First Name MRN *(where applicable)* DOB __/__/__ Age: Sex M / F Phone:	Pregnant: Y / N Breastfeeding: Y / N Allergies: Y / N Details: Interacting Medications: Y / N Details:	Medication: Dose and frequency: Dose administered: Amount supplied: If not supplied, to be collected by ……. from……..	Adverse Effects explained: Y / N Informed Consent obtained: Y / N Fact sheet supplied: Y / N Information sheet(s) provided: Y / N Advised to inform GP on their next visit: Y / N
Name: Designation:		Signature	Date	

Medical Officer's Signature:……. Print
Name:……..Date:……..

8.4 Tamiflu® (oseltamivir) Patient Information Sheet

Read this sheet together with the Consumer Medicine Information Sheet for Tamiflu®

What Tamiflu® (Oseltamivir) is used for

Tamiflu is a medicine used for the treatment and prevention of influenza (an infection caused by the influenza virus). It has no effect on the common cold or other respiratory virus infections.

Tamiflu belongs to a group of medicines that attack the influenza virus and prevent it from spreading inside your body.

Tamiflu is absorbed to the key sites of influenza infection and treats the cause. Taking Tamiflu can help you feel better faster. You will also be less likely to develop complications of influenza, such as bronchitis, pneumonia and sinusitis.

Do not give Tamiflu to children under the age of one year.

How much to take

Take Tamiflu exactly as has been prescribed.

Instructions for taking Tamiflu

- Tamiflu is available as capsules or syrup
- You have been prescribed ***(Please check the appropriate box)***:
  - ☐ Tamiflu twice a day for five days as **treatment** for influenza.
  - ☐ Tamiflu once a day for 10 days as **prevention** for influenza.
- Tamiflu should be taken with food
- For young children, the dose can be mixed with soft food e.g. yoghurt, honey to disguise the taste of the medicines.
- Tamiflu should be started as soon as possible.

You should <u>not</u> take Tamiflu if you:

- Have had an allergic reaction to Tamiflu
- Are undergoing haemodialysis.

Tell your nurse or doctor if:

- You are pregnant or breast-feeding
- You have any type of kidney disease.

Adverse effects of Tamiflu

Some people feel unwell with nausea and vomiting or stomach ache. Mostly these are mild and transient. Taking Tamiflu with food can reduce these adverse effects.

<u>Tell your doctor if you notice anything else that is making you feel unwell, even if it is not listed above.</u>

Interactions with other medicines

Tamiflu has no significant interactions with other medications

8.5 Relenza® (zanamivir) Patient Information Sheet

Read this sheet together with the Consumer Medicine Information Sheet for Relenza®

What Relenza® (Zanamivir) is used for

Relenza is a medicine used for the treatment and prevention of influenza (an infection caused by the influenza virus). It has no effect on the common cold or other respiratory virus infections.

Relenza belongs to a group of medicines that attack the influenza virus and prevent it from spreading inside your body.

Relenza is delivered directly to the primary site of infection in the lungs. It works by attacking the influenza virus. Using Relenza can help you feel better faster. You will also be less likely to develop complications of influenza, such as bronchitis, pneumonia and sinusitis.

Do not use Relenza in children under the age of five years.

Instructions for taking Relenza

- Relenza comes as a fine powder in small pockets (known as blisters) in a round foil sheet (disk)
- You have been prescribed ***(please check the appropriate box)***:

  ☐ Relenza 2 inhalations (1 blister / inhalation) twice daily for five days – as <u>treatment</u> for influenza

  ☐ Relenza 2 inhalations (1 blister / inhalation) once daily for 10 days – as <u>prevention</u> for influenza
- Relenza requires the use of the Diskhaler to deliver the medicine in the blister directly to the lungs. Use one blister for each inhalation.
- Relenza should be started as soon as possible.

Using the Relenza Diskhaler

The medicine in your Relenza Disk is taken by breathing it in using the Relenza Diskhaler. Follow the instructions for use provided in the box containing the Diskhaler.

You should <u>not</u> use Relenza if you:

- You have had an allergic reaction to zanamivir or lactose.

Tell your nurse or doctor if:

- You are pregnant or breast-feeding
- You have asthma or any other breathing problems.

Adverse effects of Relenza

Most people using Relenza find that it causes no problems. However, very rarely, some people feel unwell with shortness of breath, wheezing, swelling of the face or in the mouth or throat, an itchy raised skin rash, skin that may blister, peeling of the skin, fainting and light headed.

<u>Tell your doctor if you notice anything else that is making you feel unwell, even if it is not listed above.</u>

Interactions with other medicines

Relenza has no significant interactions with other medications.

8.6 Rifampicin Patient Information Sheet

Read this sheet together with a Consumer Medicine Information Sheet for rifampicin

Rifampicin is an antibiotic that can be given to those in close contact with a person who has developed a meningococcal infection. The purpose of this antibiotic is to clear any meningococcal germs being 'carried' in the throats of contacts so that they cannot lead to meningococcal infections in other people.

This ‘clearance’ antibiotic cannot treat someone who is already developing the infection, so you still need to look out for symptoms and signs of meningococcal disease. (See Fact Sheet)

Instructions for taking rifampicin

- Rifampicin is taken twice a day for two days (a total of four doses are needed). It is available as tablets, capsules or syrup.
- Rifampicin should be taken on an empty stomach, either half an hour before eating or two hours after eating.
- Rifampicin should not be taken at the same time as antacids. Take rifampicin at least 1 hour before taking antacids, if antacid therapy is required.

You should not take rifampicin if you:

- Are allergic to rifampicin
- Have severe liver impairment (with jaundice)
- Are alcoholic or
- Are pregnant.

If rifampicin is unsuitable, you will need to take another antibiotic to get rid of the meningococcal germs. The nurse will discuss this with you.

Adverse effects of rifampicin

The most common adverse effects are gastrointestinal symptoms, such as nausea, vomiting, and cramps or rash. Rifampicin can colour body fluids a red / orange colour, so urine, faeces, sweat and tears may become orange-red. People who wear soft contact lens should use glasses while taking rifampicin as rifampicin may permanently stain them.

Other adverse effects are rare and very unlikely as the course of rifampicin is very short.

Tell your doctor if you notice anything else that is making you feel unwell, even if it is not listed above.

Interactions with other medicines

Rifampicin can interact with many drugs. It is important that you inform the nurse or public health officer if you are taking any prescription, over the counter or complementary medicines before you take rifampicin.

Rifampicin can reduce the effectiveness of oral contraceptives. While taking rifampicin, women taking the oral contraceptive pill should continue to take the active pills, omitting any pill-free or sugar pill interval and continuing for at least seven days after the last dose of rifampicin before stopping the active pills for the normal pill free or sugar pill interval. They should talk to their nurse, pharmacist or doctor if they are unsure of what to do. They should also use additional barrier contraception, such as condoms, while taking rifampicin and for four weeks after the last dose of rifampicin.

8.7 Ciprofloxacin Patient Information Sheet

Read this sheet together with the Consumer Medicine Information Sheet for ciprofloxacin

Ciprofloxacin is an antibiotic that can be given to those in close contact with a person who has developed a meningococcal infection. The purpose of this antibiotic is to clear any meningococcal germs being 'carried' in the throat of contacts, so that they cannot lead to the meningococcal infections in other people. This ‘clearance’ antibiotic cannot treat someone who is already developing the infection, so you still need to look out for symptoms and signs of meningococcal disease (see Fact Sheet).

Instructions for taking ciprofloxacin

- The dose of ciprofloxacin is a **single** dose taken in tablet form.
- The tablet should be swallowed whole with a full glass of water.
- Do not take the tablet if you have taken antacid / indigestion medicines or medicines containing iron or mineral supplements within the previous four hours. Wait until four hours have passed.

You should not take ciprofloxacin if you:

- Have had a previous allergic reaction to ciprofloxacin
- Are pregnant or are breast-feeding.

If ciprofloxacin is unsuitable, you will need to take a different antibiotic to get rid of the meningococcal germs. The nurse will discuss this with you.

Adverse effects of ciprofloxacin

Adverse effects are unlikely as only a single dose of ciprofloxacin is being taken. A few people may feel unwell after taking ciprofloxacin with nausea (feeling sick) or vomiting, mild diarrhoea; or dyspepsia (heartburn).

A **very** uncommon adverse effect is a severe allergic reaction. If you develop facial swelling, tightness in the throat, breathing difficulties, severe itching or a rash, you should seek medical attention immediately (ring 000).

Tell your doctor if you notice anything else that is making you feel unwell, even if it is not listed above.

Interactions with other medicines

Ciprofloxacin may interact with some medicines. If you are taking any other medications you should check with your doctor or pharmacist before taking ciprofloxacin. It is quite safe to take ciprofloxacin if you are taking the oral contraceptive pill.

8.8 Ceftriaxone Patient Information Sheet

Read this sheet together with the Consumer Medicine Information Sheet for ceftriaxone

Ceftriaxone is an antibiotic that can be given to those in close contact with a person who has developed a meningococcal infection. The purpose of this antibiotic is to clear any meningococcal germs being 'carried' in the throat of contacts, so that they cannot lead to meningococcal infections in other people.

This ‘clearance’ antibiotic cannot treat someone who is already developing the disease, so you still need to look out for symptoms and signs of meningococcal disease.

Ceftriaxone is given as a single injection into muscle tissue, such as in the thigh or buttock. Ceftriaxone is safe in pregnancy and in breastfeeding women.

You should not have ceftriaxone if you:

- Are allergic to ceftriaxone or other cephalosporin antibiotics or
- Have ever had a severe or immediate allergic reaction to penicillin antibiotics.

Adverse effects of ceftriaxone

Adverse effects are unlikely as only a single dose of ceftriaxone is being given. A few people may feel unwell after receiving ceftriaxone with pain at the injection site; diarrhoea, feeling sick, vomiting; headache or dizziness.

A **very** rare adverse effect is an allergic reaction - if you develop facial swelling, tightness in the throat, breathing difficulties, severe itching or a rash you should seek medical attention immediately (ring 000).

Tell the nurse if you notice anything else that is making you feel unwell, even if it is not listed above

8.9 Information for Measles contacts: Measles Mumps Rubella (MMR) Vaccine

What is MMR Vaccine?

MMR vaccine is given at age 12 months and again at 18 months of age to immunise children against measles, mumps and rubella. MMR vaccine is also given to susceptible people who may have been exposed to cases of measles. MMR vaccine can make the body produce antibodies against measles and will protect against the disease developing if it is given within 72 hours after exposure to the virus.

How safe is it?

MMR is an extremely safe vaccine. Although the MMR vaccine is made using proteins related to egg, it is safe to provide the vaccine even in people with known allergies to eggs. MMR vaccine should not be given to pregnant women, those with previous allergy to MMR vaccine, or people with impaired immunity such HIV patients and those having cancer treatment.

Because autism usually starts to be noticed when a child is one to two years of age, which is when MMR is given, there was a suggestion of a link between MMR and autism. A great number of studies have been carried out and consistently show NO link to autism.

Can I still get measles?

MMR vaccine usually gives good protection against measles. Even so, some people will still get measles, although the illness is likely to be milder than usual. People receiving MMR vaccine should continue to watch for the symptoms of measles, which include **fever**, **cough**, **sore eyes** and a **red, blotchy rash**. If you or your child develops these symptoms, please call your family doctor. Your doctor will be able to advise you about the appropriate steps to take.

Adverse effects of MMR

The most common side effects are tenderness and redness at the site of injection, which may persist for several hours afterwards. Malaise, fever and / or rash may occur 5-12 days after vaccination, lasting 2-3 days. Fever can be managed with paracetamol. Rare side effects include swelling of the lymph glands (lymphadenopathy), swelling of the parotid glands which are salivary glands on the side of the face (parotitis), joint pain (arthralgia) and allergic reactions including rash (urticaria) and swelling of the lips or tongue (angio-oedema). Very rarely, reduced platelets in the blood (thrombocytopenia) and anaphylaxis – a severe allergic reaction – can result. In case this occurs we ask you to wait at the clinic for 15 minutes after your injection.

Tell the nurse if you notice anything else that is making you feel unwell, even if it is not listed above.

8.10 Information for Measles contacts: Normal Human Immunoglobulin

What is normal human immunoglobulin?

Normal human immunoglobulin is an injection that contains antibodies against a number of infections and is given to susceptible people who may have been exposed to cases of measles. If given early enough, it can prevent or reduce the severity of illness in these people.

To be effective, the correct dose of normal immunoglobulin must be given. The dose is calculated according to the person's weight, up to a maximum of 15mL.

How safe is it?

Normal immunoglobulin is prepared from blood donated to the Australian Red Cross Blood Service, and is screened and treated to ensure that it does not contain HIV, hepatitis B or hepatitis C viruses.

Normal immunoglobulin can be given safely to healthy people of all ages, including babies and pregnant women. It should not be given to people who have had a previous allergic reaction to it, or who have disorders of their immune system affecting the production of certain antibodies.

Can I still get measles?

Normal immunoglobulin usually gives good protection for three to four weeks against measles. Even so, some people will still get measles, although the illness is likely to be milder than usual. People receiving the injection should continue to watch for the symptoms of measles, which include **fever**, **cough**, **sore eyes** and a **red, blotchy rash**. If you or your child develops these symptoms, please call your family doctor. Your doctor will be able to advise you about the appropriate steps to take.

Adverse effects of normal human immunoglobulin

The most common side effects are tenderness and muscle stiffness at the site of injection, which may persist for several hours afterwards. Sometimes there may be redness at the injection site or a fever. Rarely, there may be allergic reactions including rash (urticaria) and swelling of the lips or tongue (angio-oedema). Very rarely, anaphylaxis – a severe allergic reaction – can result. In case this occurs we ask you to wait at the clinic for 15 minutes after your injection.

Should I get vaccinated against measles as well?

Normal immunoglobulin can reduce the effectiveness of certain "live virus" vaccines, including measles-mumps-rubella (MMR), if these vaccines are given too soon afterwards. Ideally a person should wait for five months before being immunised with these vaccines. Please speak to your family doctor or immunisation clinic before you or your child are next immunised.

Tell the nurse if you notice anything else that is making you feel unwell, even if it is not listed above.

INFLUENZA – NSW HEALTH INFLUENZA PANDEMIC PLAN (PD2016_016)

PD2016_016 rescinds PD2010_052

PURPOSE

The primary purpose of the NSW Health Influenza Pandemic Plan (the *Plan*) 2016 is to provide guidance to NSW Health staff and agencies on how to effectively prepare for and respond to an influenza pandemic, in order to minimise the adverse health impacts on the NSW population and reduce the burden and disruption to health-related services in NSW.

The *Plan* also aims to contribute to whole-of-government response activity to reduce the adverse social and economic impacts associated with an influenza pandemic in NSW.

The *Plan* is intended to be flexible enough to provide guidance on the response to a large outbreak of any highly transmissible respiratory pathogen with significant morbidity and mortality.

MANDATORY REQUIREMENTS

NSW Health agencies and services must ensure that District level and health facility level pandemic plans align with the planning assumptions, emergency management principles and planned strategic response activities outlined in the *Plan*. A pandemic plan checklist for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) is provided in Appendix 8 of the *Plan*.

IMPLEMENTATION

Preparing for and responding to an influenza pandemic is a whole-of-health responsibility. The *Plan* presents a range of state-level strategic options for NSW Health agencies and services in preparation for and response to an influenza pandemic, but does not provide operational detail.

Appendix 7 of the *Plan* outlines roles and responsibilities for all health-related agencies and services in NSW in preparation for and response to an influenza pandemic. Additional detail on roles and responsibilities for specific key response areas are provided throughout the document.

1 INTRODUCTION

This is the *NSW Health Influenza Pandemic Plan*. The plan provides a framework to aid the New South Wales health sector response to an influenza pandemic and to outbreaks of other respiratory pathogens with pandemic potential. The plan is always ‘active’.

This plan provides a strategic outline of a range of possible NSW Health response activities that will need to be tailored during an influenza pandemic response.

Supporting documents for specific functional or technical areas of the pandemic response are maintained separately by individual NSW Health agencies.

The development of this sub plan has been informed by the following pandemic plans:

- National whole-of-government influenza pandemic plan – *National Action Plan for Human Influenza Pandemic (NAPHIP)*
- National health influenza pandemic plan – *Australian Health Management Plan for Pandemic Influenza (AHMPPI)*
- NSW whole-of-government influenza pandemic plan – *NSW Human Influenza Pandemic Plan (NSW HIPP).*

An influenza pandemic will have a sustained impact over many months and a specific pandemic plan and different organisational arrangements drawing on existing public health systems are required. The aim is to ensure overall management of the health system whilst responding to the pandemic.

This plan will be reviewed:

- On conclusion of an emergency during which this plan was implemented
- On the introduction of any major structural, organisational or legislative changes which affect NSW Health or key stakeholders
- Under direction from the Health Secretary or Chief Health Officer
- Every five years.

Throughout this plan, 'NSW Health' refers to the broader NSW public health system including NSW Ministry of Health (MoH), Local Health Districts (LHDs), Sydney Health Networks (SHNs), and other health agencies such as the Clinical Excellence Commission (CEC), the Agency for Clinical Innovation (ACI), and shared services.

INFLUENZA AND OTHER POTENTIAL PANDEMIC VIRUSES

The influenza virus causes an acute viral disease of the respiratory tract. Influenza is primarily spread person-to-person by inhalation of and/or contact with infectious droplets, produced by infected people when they cough or sneeze.

Typical signs and symptoms of influenza include: fever, cough, myalgia, sore throat, headache, fatigue and chills. Infection may also occur without symptoms. Severe influenza-related complications include viral pneumonia or secondary bacterial pneumonia. Influenza may also cause a deterioration of chronic diseases such as chronic obstructive pulmonary disease or congestive heart failure.

Influenza is generally categorised into three types - A, B, and C – with outbreaks of influenza A and B occurring regularly every year. Seasonal influenza vaccination is an important intervention to reduce morbidity and mortality for groups at risk of severe disease, as listed in the *Australian Immunisation Handbook*.

Influenza viruses are characterised by distinct differences in their surface proteins (antigens). Both influenza A and B strains have a tendency to mutate leading to small changes in these surface proteins (antigenic drift). Novel influenza strains with pandemic potential may emerge when one strain undergoes a large mutation affecting its surface proteins or when different strains mix their genes in an infected host through genetic re-assortment (antigenic shift).

Only novel influenza A viruses have been known to cause pandemics. However other respiratory viruses with pandemic potential might also emerge or re-emerge (such as SARS coronavirus).

The population health impact of an influenza pandemic is determined by how readily it can be transmitted (i.e. transmissibility) and the seriousness of the illness it causes (i.e. clinical severity). The most severe pandemics are associated with a new influenza A virus that is both highly transmissible and causes severe illness, such as the 1918 'Spanish Influenza' pandemic. Pandemic influenza viruses that tend to cause milder illness can still have a major population health impact, as everyone in the community will be susceptible to infection (e.g. the 1957 A(H2N2) pandemic).

For a novel influenza virus to have pandemic potential it must meet three criteria:

- Humans have little or no pre-existing immunity against the virus
- The virus leads to disease in humans
- The virus has the capacity to spread efficiently from person to person.

This plan is designed to be flexible and adaptable enough to also guide the response during a severe influenza season or to another respiratory pathogen with pandemic potential. The key factors determining the specific response measures for a specific pathogen include its mode and ease of spread, whether it is transmissible prior to the onset of symptoms, and the severity of the illness it produces.

More information about pandemic influenza is available from NSW Health (*www.health.nsw.gov.au*) and the Department of Health (*www.health.gov.au*) websites.

KEY ASPECTS OF THE NSW RESPONSE

1.1 Objectives of the response

The key objectives of the pandemic response in NSW are to:

- Minimise transmission, morbidity and mortality of the pandemic virus in the NSW population
- Inform, engage and empower the public and health professionals to assist in the response to the pandemic
- Minimise the burden on the NSW Health system, health support services and partner agencies to respond to the pandemic
- Ensure that all health sectors work in partnership to provide a coordinated and timely response
- Maintain effective functioning across health services to manage other health issues during the pandemic response so as to achieve optimum health outcomes for the NSW population during a sustained influenza pandemic.

These objectives are in accordance with those outlined in the AHMPPI and NSW HIPP.

1.2 Principles guiding the NSW response

The principles guiding the overall pandemic response in NSW are as follows:

- ***Use of existing systems where possible*** – to avoid duplication and to ensure resilience of pandemic arrangements as far as possible (e.g. existing seasonal influenza surveillance systems, emergency department activity coordination).
- ***Flexible approach*** – to be responsive to the range of possible patterns of spread through NSW during a pandemic, and the spectrum of pandemic infections ranging from asymptomatic to severe illness.
- ***Proportionate response*** – to use pandemic response strategies that can be scaled up or down, proportionate to the clinical severity of the pandemic virus and to the needs of the NSW population.
- ***Recognising additional needs of at-risk and vulnerable groups*** – to ensure that additional health support is provided for groups at risk of severe disease, such as Aboriginal people and people with chronic conditions, and which recognises the needs of people from culturally and linguistically diverse backgrounds in NSW.
- ***National coordination*** – to work collaboratively with other jurisdictions to ensure national consistency in pandemic response measures wherever possible and be guided by the Australian Health Management Plan for Pandemic Influenza (AHMPPI).

1.3 Planning assumptions and scenarios

The NSW Health response will need to be flexible for a range of pandemic scenarios dependent on the clinical severity of infection caused by the pandemic virus, as summarised in Table 1.

Key planning considerations for a pandemic response include the following:

- ***Extended response time*** – healthcare services across the state need to be prepared for a marked increase in demand for healthcare services that may last an extended period of time.
- ***Unknown origin*** – a pandemic virus could emerge at any time of the year and anywhere in the world, including Australia. However, the most likely scenario is for a virus to emerge and be identified overseas, and then be imported into Australia by infected travellers over the next few weeks to months.
- ***Border screening ineffective*** – as infected travellers may have no symptoms on their arrival into Australia, border screening of incoming passengers is unlikely to be of benefit in preventing a pandemic influenza strain entering the country.
- ***Rapid community spread*** – a pandemic influenza virus may cause widespread community illness very quickly due to a short incubation period and the lack of existing immunity in the population. Once the pandemic strain enters NSW it is likely to spread to all parts of the state within a few weeks.
- ***Similar at-risk groups*** – it is reasonable to expect that population groups already known to be at increased risk of severe influenza infections will also be at increased risk during the next pandemic. The health needs of at-risk groups (such as pregnant women, people with chronic diseases) and communities with higher numbers of at-risk individuals (such as Aboriginal communities) need to be taken into account in planning for and responding to a pandemic.
- ***Early information critical for responses*** – epidemiological and clinical information about the novel virus – such as how severe the disease is, how readily it is passed from person to person, which people are most impacted (e.g. particular age groups, predisposing co-morbidities) – may be gained from both local and overseas experience. This evidence will, together with health service impact data, help to inform the implementation of health response strategies to minimise the rate of spread and reduce the overall impact of the pandemic.
- ***Multiple pandemic waves possible*** – experience with past pandemics suggests that there may be subsequent waves of infection in the months after the first wave dissipates. The impact of the pandemic virus in subsequent waves will be strongly influenced by the level of acquired immunity in the community and by decisions around influenza vaccination programmes.

Table 1: Planning scenarios for the NSW Health response to a pandemic

Level of clinical severity	Potential population health impacts	Potential health sector response measures/considerations [1]
Low E.g. pandemic virus causing mild illness with impact similar to a severe influenza season	• Majority of cases have illness of mild to moderate severity • At-risk groups may experience severe disease and death	• Early general public communications to inform and provide practical risk reduction measures • Targeted communications to groups at higher risk • Implement hospital surge management strategies to cope with increased demand as the outbreak spreads in the community • Close engagement with the primary care and community pharmacy sectors in response strategies
Medium E.g. pandemic virus causing mild to moderate illness in most but severe illness for different groups across the state	• Clinical presentations for influenza-like illness above what is expected for a severe influenza season • More severe disease and deaths in at-risk groups and young people • Healthcare staff absences may be high	• Social distancing measures may be considered • Early and frequent communications for the community and at-risk groups regarding response strategies • Optimise resources across health services to achieve overall health outcomes for the population • Consider implementing additional surge/demand management actions, such as delaying or reducing non-urgent activities, surge staffing, and alternative models of care • Continuing close engagement with the primary care and community pharmacy sectors in response strategies and consideration of alternative models of care • Diagnostic testing may need to be prioritised to effectively utilise resources • Antiviral and vaccine use focus on at-risk groups • Work with other government stakeholders to control spread
High E.g. pandemic virus causing severe illness across the state	• Clinical presentations for influenza-like illness may be very high in the population • Majority of cases in the community may experience severe illness • Death rates may be high for at-risk groups • Specialist and critical care capacity in hospitals may be challenged • Healthcare staff absences may be high	• Social distancing measures likely • Strong coordination and prioritisation to ensure hospitals maintain essential services • Surge staff strategies and alternate models of care to respond to high staff absences • Laboratory testing targeted to utilise resources effectively • Priority on supporting the health of at-risk groups, including Aboriginal people • Antiviral and vaccine policy may focus on preventing illness and transmission in the population • Potential use of overflow facilities within LHDs to support patient care and management, including residential care facilities and other suitable venues

1 Note that lower level responses also apply in higher level scenarios.

2 GOVERNANCE ARRANGEMENTS

2.1 National governance

National arrangements are detailed in the *AHMPPI* and the *NAPHIP*. Department of Health (DoH) oversees the national pandemic response, collecting and analysing national surveillance data and managing the National Medical Stockpile.

The Australian Health Protection Principal Committee (AHPPC) coordinates inter-jurisdictional health preparedness and the response to the pandemic. The NSW Chief Health Officer represents NSW on AHPPC.

AHPPC is supported by groups such as the Communicable Diseases Network of Australia (CDNA) and the Public Health Laboratory Network (PHLN), both of which have NSW Health representatives.

2.2 NSW whole-of-government governance

The *NSW State Emergency Management Plan* (*EMPLAN)* and the *NSW Human Influenza Pandemic Plan* (sub plan to *EMPLAN*) identify NSW Health as the lead (combat) agency, with decision-making authority, for any human infectious disease emergency.

Unlike other emergencies where NSW Health involvement as a supporting agency is coordinated by the State Health Services Functional Area Coordinator (HSFAC), when NSW Health is the combat agency (i.e. during a pandemic), it is the Incident Controller who leads the response. The Incident Controller is the Health Secretary.

Where a coordinated whole-of-government response is required, the Incident Controller and the State HSFAC will liaise with the State Emergency Operations Controller (SEOCON), under the provisions of *EMPLAN*.

The *Human Influenza Pandemic Plan* enables the formation of a peak strategic and policy decision-making body, of which the Minister for Health, Health Secretary and Chief Health Officer will be key advisors, to coordinate the whole-of-government response to a pandemic.

2.3 NSW Health governance

A pandemic will be managed using existing systems and resources as far as possible. The Health Secretary, as Incident Controller, will have overarching responsibility for Health's response to a pandemic and will establish an incident management team to oversee the response across the Health system.

Core members of the State Pandemic Management Team include:

- Health Secretary (Chair)
- Chief Health Officer/ Deputy Secretary Population and Public Health
- State HSFAC
- Deputy Secretary – System Purchasing and Performance
- Deputy Secretary – Governance Workforce and Corporate
- Deputy Secretary – Strategy and Resources
- Director – Public Affairs, Ministry of Health
- Chief Executive – Agency for Clinical Innovation
- Chief Executive – Clinical Excellence Commission
- Chief Executive – HealthShare NSW
- Chief Executive – NSW Health Pathology
- Chief Executive representation from metropolitan and regional NSW local health districts
- Additional representatives may be invited as required.

Pandemic-specific response groups (e.g. system performance, public health) may be implemented by the State Pandemic Management Team to manage state-wide coordination of their respective portfolio areas. These groups may choose to use an incident management system such as AIIMS as the basis of operational management arrangements. To avoid duplication of advice, requests and activity, it is essential that relevant information is communicated across response groups.

NSW Health Chief Executives remain responsible for the operation of their health services and can draw on the support of the State Pandemic Management Team and local emergency management resources.

Existing emergency management arrangements described in NSW HEALTHPLAN (PD2014_012) are available to support coordination of whole-of-health resources or provision of expertise as needed, however, during a pandemic, the provisions of this plan override those of HEALTHPLAN.

The State HSFAC will assist with coordinating any required reporting to the State Emergency Management Committee (SEMC) and support the Incident Controller as required.

Table 2 below summarises the key NSW Health governance arrangements in NSW during a pandemic.

Table 2: NSW Health governance arrangements during the pandemic

Role	Responsibilities
Health Secretary (Incident Controller)	• Overarching responsibility for pandemic preparation, response and recovery • Chair of the State Pandemic Management Team • Participates in peak NSW whole-of-government pandemic strategic and policy decision-making bodies • Incident Controller responsibilities as per section 7, #706 *EMPLAN*
Chief Health Officer (CHO)	• Liaises with the Minister for Health and the Health Secretary to provide advice and make recommendations regarding response management • NSW representative on the Australian Health Protection Principal Committee • Member of the State Pandemic Management Team • Participates in peak NSW whole-of-government pandemic strategic and policy decision-making bodies
State Health Services Functional Area Coordinator	• Supports the Incident Controller as requested, including liaising with State Emergency Operations Controller (SEOCON) regarding whole of government support • Member of the State Pandemic Management Team
State Pandemic Management Team	• Coordinates strategic management of NSW Health's response to a pandemic • For membership see previous page
LHD/SHN Chief Executives	• Responsible for LHD/SHN preparation for, operational response to and recovery from a pandemic
LHD/SHN Health Service Functional Area Coordinators	• Support LHD Chief Executives with pandemic response activities as requested

3 PANDEMIC STAGES AND KEY RESPONSE STRATEGIES

The framework for pandemic management in NSW is one of *prevention*, *preparedness*, *response* and *recovery* (*PPRR*). This aligns with the response stages outlined in the *AHMPPI* and the NSW response arrangements detailed in this plan.

The *AHMPPI* response stages (summarised in Appendix 5) focus on pandemic preparedness and operational response for the health sector but also guide the whole-of-government response. The AHMPPI pandemic stages are independent of the global pandemic phases as declared by the World Health Organization (WHO).

A detailed summary of the key state-level NSW Health responsibilities at each stage of the pandemic are presented in Appendix 6.

3.1 Prevention

The period prior to the identification of a novel pandemic influenza strain affecting humans is an important time to optimise existing influenza surveillance systems and ensure they are applicable to pandemic responses. This includes laboratory surveillance to identify novel influenza strains with pandemic potential.

NSW Health also collaborates closely with the NSW Department for Primary Industries in its efforts to prevent and control outbreaks of influenza in animals to minimise the risk of transmission to humans.

3.2 Preparedness

During the preparedness stage, potential pandemic pathogens that have emerged would be under close monitoring and surveillance by international and national health agencies to allow a tailored and proportionate response.

Within NSW, pandemic preparedness requires active engagement and communication with a range of stakeholders including:

- Clinical groups in health facilities most affected, including emergency departments, infectious diseases, infection control and critical care
- Peak general practice groups and other primary care and pharmacy groups
- Other government agencies and community groups that may be impacted.

Preparedness of the health system requires development of the workforce, particularly through training in infection control and through participation in exercises testing responses to a range of pandemic scenarios.

Pandemic response capacity relies on, and builds upon, seasonal influenza response measures embedded in the health system. This includes robust infection control practices (such as hand-washing, respiratory etiquette, isolation of cases) and routine influenza vaccination for healthcare workers and at-risk populations. This also includes interventions to optimise emergency department performance at times of peak influenza activity in the community.

3.3 Response

Once a new human virus with pandemic potential has been identified a range of major pandemic response strategies will be considered. Under the AHMPPI, the response stage is delineated into four sub-stages including: *Standby, Initial action, Targeted action and Stand down* reflecting the need to tailor response activities according to the spread and impact of the pandemic virus in Australia.

The transition through pandemic response stages will be guided by emerging data on the clinical severity and transmissibility of the virus and its impact on the population. The decision to transition through the different stages will be taken by the Australian Government in consultation with states and territory jurisdictions. The Health Secretary in consultation with the State Pandemic Management Team will determine the transition through different response stages in NSW.

The *Standby stage* may vary considerably in duration depending on the spread of the pandemic virus once it reaches Australia. It represents a period of time to ensure enhanced arrangements are in place to coordinate the early response to the pandemic in NSW; for example, communications, governance, surveillance and any border activities if appropriate.

During the *Initial action* stage, detailed clinical and epidemiological data are gathered to understand the nature of the virus and its potential impact in NSW.

During the *Targeted action* stage, as the pandemic becomes more widespread and the demand on health care services increases, tailoring response measures will require regular review of data from disease surveillance and from monitoring of health system and workforce impacts. The effectiveness of any interventions implemented will be assessed to help ensure that the best use is made of the resources available to achieve optimum health outcomes for the population.

During the *Stand down* stage, the decreasing impact of the pandemic may not be the same across geographical areas or population groups in NSW. Targeted response measures may still be required for some LHDs with higher activity, as other areas wind down their activities and move into recovery.

3.4 Recovery

The states and territory jurisdictions have primary responsibility for managing the *Recovery* stage. All NSW Health agencies will work together to support health services and community recovery.

Considerations for LHDs/SHNs and other NSW Health agencies during the recovery stage include the need to plan for services and staff to transition back to “normal” levels/duties. This is an important stage to conduct intra- and interagency evaluations and lessons learnt exercises and incorporate these lessons into future plans and strategic policies.

Auditing and replenishing stockpiles of essential medical supplies and equipment is also a key activity during the recovery stage.

4 ROLES AND RESPONSIBILITIES

The MoH, which for the purposes of this plan includes Health Protection NSW (HPNSW), is responsible for state-wide strategic planning and the implementation of key response activities for a pandemic through the State Pandemic Management Team. This will require close collaboration between all NSW Health and partner agencies.

Appendix 7 outlines the specific responsibilities of MoH Divisions and key NSW Health supporting agencies.

LHDs/SHNs are responsible for planning and delivering health services for their populations according to the principles outlined in this plan. An implementation checklist for LHDs/SHNs is provided in Appendix 8 to support the development of a district-level operational plan for a pandemic.

All NSW Health agencies must undertake regular training, exercises and have business continuity plans, policies and guidelines in place for a pandemic. During the response stage, all NSW Health agencies will be required to provide relevant expertise and advice according to their portfolio. It will be important during a pandemic response to seek feedback and disseminate information through key networks.

5 COMMUNICATION

Timely and accurate communication with the public, healthcare workers, government agencies and industry will assist with maintaining a coordinated and controlled response to a pandemic.

The *AHMPPI* contains information on the national coordination and sharing of information and strategies for how this information is communicated to health stakeholders and the public during the pandemic response.

5.1 Communicating with the public

At the national level, the coordination of the content, delivery and timing of communication messages for the public will be crucial for ensuring confidence in our response to the pandemic. The National Health Emergency Media Response Network (NHEMRN) is responsible for developing and disseminating national communication messages and adaptations for specific audiences.

The NHEMRN is made up of all state and territory health department media units, relevant government agencies, national medical colleges, National Aboriginal Community Controlled Health Organisation (NACCHO) and parts of the private sector directly involved in emergency management.

The Australian Government's Department of Foreign Affairs is responsible for issuing travel warnings to Australians during the pandemic.

In NSW the Public Information Functional Area Coordinator (PIFAC), established under *EMPLAN*, coordinates public information messages on behalf of all government agencies during a multi-agency coordinated emergency response. During a pandemic, the Health Communications Controller works closely with the PIFAC.

MoH Public Affairs Unit will coordinate the response to media enquiries, including the development and dissemination of key messages on behalf of NSW Health at the state level. MoH Strategic Relations and Communications Branch will be responsible for the development and dissemination of state-wide resources and healthcare awareness campaigns in collaboration with MoH Population and Public Health Division. MoH Public Affairs Division and Strategic Relations and Communications Branch will support the Health Communications Controller to develop an integrated communication plan, including use of new media, to ensure coordination of all state-level communications during a pandemic.

The Health Communications Controller in close liaison with the PIFAC will coordinate the timing and release of national messages via NHEMRN during a pandemic.

Health content experts (e.g. public health or clinical services) will work with the Health Communications Controller to develop consistent state-wide public information messages delivered by a qualified spokesperson.

A pandemic can result in a large surge of inbound calls from the public to LHDs. LHDs should plan for options that help utilise existing local telecommunications infrastructure to manage demand as far as possible during a pandemic. If the surge of inbound calls to either the LHDs and/or MoH substantially increases, the Public Health Controller may activate contact centre capacity. The PIFAC in liaison with the Health Communications Controller may also activate the state Public Information Centre.

Some culturally and linguistically diverse (CALD) populations will require tailored and clear messages to address specific health concerns. MoH will work with health partner agencies, including the Aboriginal Health and Medical Research Council of NSW, NSW Multicultural Health Communication Service, NSW Refugee Health, community elders and leaders, to develop a consistent state-wide and coordinated approach to developing and disseminating information and resources for CALD groups during the pandemic.

LHDs should coordinate public messages of local relevance (including those specific for CALD populations) with the approval of the Health Communications Controller.

MoH will work with NSW Multicultural Health Communications Service to ensure that the state-wide NSW Health Care Interpreter Service is briefed as early as possible during a pandemic, so that it can respond accordingly to any increased demand for interpreter services.

5.2 Communicating within the NSW health system

During a pandemic, information about changes to specific aspects of the NSW pandemic response such as infection control recommendations, clinical services, and case definitions will need to be quickly and reliably communicated to healthcare workers, including staff working in NSW Health agencies, Aboriginal health services and community healthcare providers such as GPs and community pharmacies.

The State Pandemic Management Team will coordinate dissemination of relevant information to NSW Health agencies via key contacts (such as Chief Executives, Directors of Clinical Operations, LHD HSFACs, Public Health Unit (PHU) Directors or LHD emergency operations centres).

MoH in collaboration with the DoH will disseminate national messages regarding key pandemic response actions (e.g. change in pandemic stage) to general practitioners (GPs) and community pharmacies.

MoH communicates with the primary health care community (e.g. GPs, Aboriginal health services, community pharmacies) both through their peak bodies and existing reference groups and through direct communications, such as GP practice fax alerts. The National Health Services Directory may also be utilised for emailing information as required. MoH will continue to convene meetings with the peak private hospital groups and aged care facility agencies (e.g. Aged and Community Services NSW and ACT) to keep them informed about pandemic influenza planning developments and to encourage them to adopt appropriate pandemic management policies in their facilities.

The Centre for Aboriginal Health (NSW Health) will convene an Aboriginal Medical Services Advisory Group to consult with Aboriginal health services during a pandemic.

LHDs/SHNs are responsible for maintaining and utilising existing networks and channels of communication to notify local service providers, including any private hospitals, of any changes in key pandemic response activity during a pandemic. LHDs/SHNs are responsible for managing communication with their employees. These messages will complement those being released by the NSW and Australian governments but will add tailored local messages as appropriate.

5.3 Communicating with key government agencies and industry

The Health Communications Controller will liaise closely with cross-government agencies.

The PIFAC is responsible for coordinating communications to business and industry across NSW in consultation with the MoH and Health Communications Controller and other relevant agencies. This would ensure agencies or services providing contractual services to the NSW Health system (e.g. waste disposal and cleaning contractors) are adequately informed of any changes to the pandemic response in NSW.

6 MITIGATION OF TRANSMISSION

6.1 Infection control

The overall aim of infection control measures is to reduce exposure to and transmission of a pathogen. The *AHMPPI* outlines several infection control strategies for managing a pandemic virus in healthcare facilities and in the community.

There is good experimental evidence to demonstrate that influenza is transmitted directly through infectious droplets (i.e. from coughing and sneezing) or indirectly through contact with surfaces contaminated by respiratory droplets (e.g. skin, clothing or objects).

The risk of transmission can be greatly decreased by:

- Individual measures (e.g. hand hygiene and respiratory etiquette)
- Appropriate use of standard, contact and droplet infection control precautions
- Appropriate use of PPE (e.g. gloves, gowns, eye protection and respiratory protection, as appropriate)
- Organisational environmental measures, including: signage; triaging and patient management; isolation rooms and/or cohorting of patients; increased environmental cleaning; and staff vaccination when available.

6.2 Healthcare facilities

Many infection control methods are applied on an ongoing basis, as outlined in the NSW Health *Infection Control Policy* (PD2007_036). More stringent methods may be used across the health system during a pandemic, as outlined in *Minimising Transmission of Influenza in Healthcare Facilities guideline* (GL2010_006).

If there is a reasonable risk of airborne transmission, additional airborne precautions may need to be added to existing infection control measures in healthcare facilities.

In the setting of a pandemic with medium to high clinical severity, enhanced infection control (such as additional environmental cleaning) and isolation measures (e.g. visitor screening) may be recommended to protect at-risk inpatients from transmission of pandemic influenza within healthcare facilities. Minimum standards for environmental cleaning in healthcare facilities are outlined in the NSW Health *Environmental cleaning policy* (PD2012_061).

Through ongoing workforce training schemes, LHDs are responsible for ensuring all personnel working within facilities of their district are equipped with adequate infection control skills.

6.3 Community resources

Communication materials (e.g. pamphlets, online factsheets, mass media advertisements, social media campaigns and signage) in community settings can be effective tools for promoting good infection control practices in the community.

Members of the general community will also require information on strategies to minimise their risk of exposure to influenza and to reduce the risk that they will transmit the virus to others in households, schools, workplaces and public spaces. This may include guidance on early treatment to reduce the infective period.

MoH will work with LHDs to ensure this information is distributed to members of the general public through appropriate channels and in a timely fashion (see *Communication section*). Information provided to primary and community health care providers will include recommendations on clinical assessment and management, including infection control, laboratory testing, antiviral treatment and vaccination.

6.4 Social distancing

Social distancing is a community-level intervention to reduce normal physical and social population mixing in order to slow the spread of a pandemic throughout society, as described in the *AHMPPI*. Minimising the number of contacts of an infectious case can help reduce transmission of the pandemic virus. A range of social distancing interventions are discussed in the *AHMPPI* (pgs. 143-152), including school and/or workplace closures, cancellation of mass gatherings and home isolation and quarantine of cases and contacts (see section below).

The decision to implement widespread and significant social distancing measures would be carefully considered by national and state whole-of-government processes. The implementation of social distancing measures in NSW would depend on the timing and stage of the pandemic response, along with the transmissibility and clinical severity of the pandemic virus.

Depending on the extent to which social distancing measures are applied, the effect on workforce absenteeism and the disruption to daily life may be considerable. The compliance with and benefits of social distancing measures are likely to be highest when the disease is clinically severe.

MoH in partnership with the PIFAC will develop and disseminate public messages emphasizing the rationale and importance of following social distancing procedures as appropriate.

6.5 Home isolation and quarantine

During a severe pandemic, symptomatic individuals may be recommended to remain in home or hospital isolation and this may be extended to exposed contacts (i.e. home quarantine). Both methods are important ways of reducing further virus transmission. Voluntary measures are preferred as compliance is generally high when the community is provided with the rationale behind the measures. Public health powers are an option to enforce quarantine or isolation and this may be considered in the context of a pandemic virus associated with severe clinical outcomes.

A key aspect of emergency preparedness is encouraging self, family and community resilience to improve individuals' ability to self-manage in home isolation (for cases) and quarantine (for contacts, if recommended). This may include the promotion and use of community resources such as a plan for a home emergency kit and emergency pantry list.

This guideline also outlines a range of strategies for health agencies on how to collect surveillance data from cases and contacts in home isolation and quarantine. This includes the use of phone calls and/or SMS systems, as well as NCIMS to collect and record epidemiological data.

Support in sourcing alternative accommodation for large numbers of people would be provided by the State Emergency Operations Controller under the arrangements detailed in the *NSW HIPP*. However, this is unlikely to be a useful measure during a pandemic and would only be recommended in extreme circumstances.

It is essential that the health and welfare needs of those in home isolation and quarantine are adequately addressed. Arrangements for accessing support from other NSW agencies are detailed in the *NSW HIPP*.

7 HEALTHCARE DELIVERY - FACILITIES

Hospitals and other healthcare facilities will need to consider a range of service options to enable them to continue to deliver optimal health outcomes to the population, both for pandemic and non-pandemic patients. Communications within and between LHDs to share information on approaches to service delivery will be important in identifying the best service delivery options for each facility.

During the pandemic response, CEs may wish to consider a range of healthcare facility models to assess, manage and treat pandemic patients according to the spread and potential impact of the virus.

- During the *Initial action* stage, when the pandemic virus has only just emerged in NSW, LHDs may wish to consider enhanced ED triage for patients presenting with ILI and/or respiratory complications.
- During the *Targeted action* stage, as the pandemic virus spreads more widely in the community, LHDs may need to consider alternative models of care that preserve the capacity of EDs to respond to other patients with acute care needs either within or outside of the facility.

LHDs/SHNs should liaise with private health and aged care about key response strategies utilised during a pandemic in NSW.

Private hospitals are encouraged to adopt pandemic planning and management policies similar to those outlined in this plan. Private hospitals providing public services should prepare their plan together with the relevant LHD.

LHDs should incorporate EDs, critical care units and PACs into their business continuity planning for responding to a pandemic. These business continuity plans should include consideration of the need for additional resources to support:

- Staffing in critical demand areas
- Infection control, including PPE
- Medical supplies and equipment (e.g. ventilator equipment and medications).

Facility managers in LHDs should review food and linen production and distribution requirements during a pandemic, in consultation with HealthShare NSW in order to support the clinical management of patients within healthcare facilities.

7.1 Clinical management

During a pandemic, demand for acute care is predicted to be very high. Adjustments may need to be made to the routine delivery of hospital services to maximize the benefit of scarce resources in the most effective and ethical way. Principles guiding the management of demand and capacity within healthcare services include:

- That care given to people will be maximised within the available resources
- Plans should be consistent with the aim of preserving and maintaining essential healthcare services
- Changes to service delivery and clinical protocols should reflect changes in local and/or regional demand where appropriate
- Decisions regarding surge capacity and demand management should be coordinated at a strategic level within the health care service to ensure consistency of approach
- That a phased approach be used in scaling back any healthcare services to ensure demand management reflects the pandemic impact at the time
- Coordination by Health system support staff to ensure cross-district consistency of access is maintained.

Prior to the pandemic, LHDs and SHNs should identify all acute services that they provide, how services might be prioritised and plan for alternative mechanisms of service delivery where necessary. This planning work should encompass all local health service providers.

In developing plans for healthcare demand management during a pandemic, LHDs and SHNs should consider inter-related elements of healthcare services, including:

- physical aspects of capacity (e.g. beds, wards and ventilation equipment)
- hospital staff numbers (e.g. of clinical, allied health and administrative staff) and ability for staff to cross over to other areas
- clinical services and protocols (e.g. types of services and models of care).

While governance for service delivery changes within LHDs rests with LHD Chief Executives, state-wide agreement will be sought wherever possible for any major changes to services, such as criteria for admission, triage or discharge, or new clinical management guidelines. This will be with the aim of promoting equitable delivery of healthcare across all districts.

Groups of specialist physicians (e.g. infectious diseases, maternal and newborn care and critical care) will be consulted to provide expert advice on the appropriate clinical management of patient groups.

7.2 Emergency departments (EDs)

EDs are a critical part of the hospital response to a pandemic in NSW. The level of response needed by EDs should be based on data on the epidemiology of the pandemic virus and the capacity of EDs to respond.

Guidance on clinical models of care and the role of ED staff during a pandemic are provided in the Australasian College of Emergency Medicine (ACEM) guidelines on the *Management of severe influenza, pandemic influenza and emerging respiratory illnesses in Australasian Emergency Departments.*

EDs will need to monitor capacity to manage suspect and/or infected patients throughout the pandemic to help inform LHD planning in regards to the establishment or stand down of different models of care. For example, the ACEM guidelines include consideration of advanced screening stations outside EDs, designated ‘flu areas’ within EDs and/or establishment of stand-alone PACs (see below).

7.3 Pandemic assessment centres

Pandemic Assessment Centres (PACs) are stand-alone facilities, separate (physically and operationally) from existing hospital EDs, which are used for triaging and assessing individuals with ILI. PACs provide one option for healthcare facilities to respond to increased patient demand during a pandemic but they may not be the most appropriate option for all facilities, particularly where alternative strategies already exist.

PACs may be activated by LHDs/SHNs at any time. The Health Secretary, in consultation with LHD CEs, may also direct the opening of PACs.

The purpose of PACs is to ensure:

- EDs and GP surgeries are not overwhelmed with suspected influenza cases and can continue, as far as possible, with their routine business
- Hospital-associated transmission of influenza is minimised by ensuring potentially infectious patients visiting the clinic are kept separate from other patients seeking care in the hospital facility
- A standardised method for assessing and managing patients is adopted
- Anti-viral medication is commenced as required.

In the preparation period, each LHD should identify appropriate sites and develop a staffing and resource plan for PACs. As far as possible, staff for PACs should not be drawn from existing ED staff, or from intensive care or specialist units. Consideration should be given to sites suitable for a range of pandemic scenarios, from mild to severe.

MoH provides guidance on the set-up, operation and resourcing of PACs to support LHDs during the pandemic. MoH will provide a standardised PAC patient form to enable appropriate assessment of patients and collection of data to inform the response at the LHD and state level.

To operate PACs efficiently, LHDs/SHNs will need to ensure there is adequate staffing, IT, network and internet access to enable collection and reporting of PAC service data. LHDs should consider how to inform local healthcare providers of PAC locations and operating hours should the need arise. Private hospitals with EDs may also consider having plans for establishing PACs.

7.4 Critical care services

Critical care services may experience a significant increase in demand for personnel, specialised equipment (e.g. ventilators) and beds. Careful and detailed planning is essential for managing demand in intensive care units (ICUs), high-dependency units, paediatric intensive care units (PICUs), neonate intensive care units (NICUs) and medical retrieval services, as these services operate at or near full capacity on a regular basis.

The standard treatment for pandemic patients will mainly consist of antiviral medication (if indicated and available), antibiotics for secondary pneumonia, and supportive care. The use of mechanical ventilation or extracorporeal membrane oxygenation (ECMO) as treatment modalities for individual patients remains a clinical decision.

Communication will be essential between all critical care services in LHDs/SHNs and MoH to help build an epidemiological profile of the novel virus within clinical settings. MoH will engage and obtain strategic advice from the Medical Controller, ACI (including the Critical Care Taskforce), and the Sydney Children's Hospitals Network (SCHN, including the Paediatric Controller) on the prioritisation and delivery of critical care services for adults and children during a pandemic.

Complex ethical and clinical treatment issues can occur during a pandemic, especially when healthcare demand exceeds supply. Strategies for managing capacity and ensuring evidence-based and equitable care for patients requiring intensive care are outlined in NSW Health policy *Influenza Pandemic – providing critical care* (PD2010_028).

LHDs/SHNs may choose to designate other hospital areas (e.g. operating theatres or general wards) as intensive care surge areas. Some children may be able to be treated and managed at adult hospitals.

7.5 Isolation spaces within healthcare facilities

Isolation spaces are an important component of isolating patients with communicable respiratory infections to contain further spread of the infection. If isolation of individuals is not possible, healthcare facilities may determine that isolation by cohort can occur. Purpose-built isolation spaces, as well as alternate facilities, may be used during a pandemic.

Further guidance on isolation and cohorting of patients to control outbreaks is provided in the NHMRC (2010) *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (see B3.2).

7.6 Hospital in the home

Hospital in the home (HITH) services allow a range of clinical conditions to be effectively and safely managed without a person needing to stay in hospital. HITH services are already provided by many LHDs and SHNs and may be used or expanded during a pandemic response so that are sufficient beds available for patients who need to be in hospital for their care.

7.7 Overflow facilities

Overflow facilities are used to accommodate patients when it is impractical to manage them at home or in a hospital. Healthcare facilities, including private hospitals, would be used preferentially. However, schools, warehouses, convention centres, hotels or sports arenas may be alternative sites.

Overflow facilities may be needed during a long-lasting and/or large-scale health emergency. During a pandemic they may serve as facilities to care for the large additional number of patients requiring treatment and management. The care provided in overflow facilities is generally supportive rather than interventional.

Depending on the infrastructure, staff and capacity within LHDs, the care provided in overflow facilities could include:

- Acute care for cohorted patients
- Expanded ambulatory care (low-level care for non-pandemic patients)
- Palliative care (acute and low-level care).

Each LHD should identify initial overflow facility sites, and planning should detail the circumstances where and when overflow facilities would be established and how these facilities would be staffed appropriately. Geographic variability in attack rates may dictate that overflow facilities are not established in all LHDs simultaneously during a pandemic.

In the event of a severe and widespread pandemic in NSW, the Health Secretary may instruct LHD CEs to open overflow facilities to ensure delivery of essential health services.

7.8 Health workforce issues

Pandemics present significant workforce challenges for NSW Health. Different services may experience increased demand for staff at the same time (e.g. clinical, public health, administrative, support and human resources staff). Staff absenteeism during a pandemic has the potential to place significant further strain on the health workforce.

The risk of occupational acquisition of influenza infection by healthcare workers is low, relative to community settings. However, perceived safety at work is a critical determinant of staff willingness to work during pandemic events, particularly for workers responsible for the care of children in the home environment.

7.8.1 Staff management

A number of inter-related workforce issues have been identified as being particularly pertinent during a pandemic, including:

- The levels of personal protection deemed acceptable by healthcare workers
- Infection control and disease control issues directly impacting upon staff availability (such as quarantine of exposed workers)
- The availability of sufficient staff, including recruitment, retention and equitable allocation issues
- The capacity to support staff in preparing for, responding to and recovering from a pandemic.

Absenteeism levels will vary according to the severity, duration and timing of the pandemic. However, health services should prepare contingency human resource plans in the event of high levels of absenteeism. This should include both positions in critical health services and critical administration areas. Plans should be regularly disseminated and additional training may be needed to prepare staff to work under different conditions.

The *Public Health Workforce Surge Guidelines* (GL2014_003) have been developed to assist LHDs in understanding when and how to identify, recruit and utilise surge staff for public health aspects of the pandemic response.

To ensure continuity of government services during a pandemic, the NSW Government has a Memorandum of Understanding with Unions NSW which sets out employment conditions that would apply during the pandemic, including attendance, salary payments and ability to require staff to provide additional support outside their usual job description.

Human resource plans should:

- Advise staff that they may be called upon at short notice to temporarily work different hours, in a different location or in a different way
- Ensure staff are aware that requests for flexibility on their part will be made with regard to appropriate use of their skills and their award conditions (NB: only clinical staff should be assigned clinical roles during the pandemic)
- Determine minimum staffing levels sufficient to safely maintain services
- Identify part-time staff who can work additional hours
- Identify staff who are prepared to defer annual or long service leave
- Identify casual staff who can work additional hours (while at the same time appropriately managing worker fatigue)
- Identify displaced employees or those on ‘return to work’ plans who can be deployed
- Identify staff who have recently left the organisation and who can be temporarily engaged
- Identify staff who can provide non-clinical support and can be redeployed
- Identify agency resources which can be called upon
- Identify a manager/s and support staff to coordinate planning, communication, resource management and the orientation of staff.

Healthcare workers may believe that they are at increased risk of becoming infected themselves and/or transmitting infection to their friends and families. The adequacy of current Employee Assistance Programs and other systems to support the mental health needs of healthcare workers should be carefully considered and augmented if insufficient.

Managers in all NSW Health and affiliated organisations have a duty of care for staff under Work Health and Safety legislation to ensure that the exposure of healthcare workers to influenza is minimised, such as through appropriate infection control measures and use of PPE. Managers must ensure that all work health and safety risks are assessed and documented, in line with obligations under legislation.

Staff immunisation programs are an important risk mitigation strategy. All NSW Health agencies are required under the Policy Directive - *Occupational assessment, screening and vaccination against specified infectious diseases* (PD2011_005) - to ensure that staff in their district are appropriately screened and immunised (which includes offering seasonal influenza vaccination to all staff).

7.8.2 Education and training

The Health Education and Training Institute (HETI) will work in collaboration with MoH and LHDs to develop appropriate state-wide staff training programs relevant for the pandemic response. LHDs are responsible for regular delivery of staff education and training and for ensuring staff meet training requirements for pandemic preparedness and response as appropriate.

Specialised training may be required for the following groups:

- Front-line clinical healthcare staff such as paramedics and those working in EDs, ICUs and respiratory wards (e.g. refresher training in use of PPE)
- The public health workforce
- Laboratory services
- Primary healthcare and acute clinical staff
- Emergency services or other surge staff personnel supporting a pandemic vaccination clinic or overflow facility
- Clinical staff who will be assessing and managing patients in PACs (e.g. training in the use of clinical screening and triaging protocols).

In particular, critical care units including ICUs and High Dependency Units are staffed by personnel with specific medical or nursing intensive care training, many of whom work in more than one hospital, creating particular challenges for workforce surge. LHDs/SHNs must consider where to source additional personnel and provide additional training to ensure staff can work in intensive care (e.g. personnel trained in respiratory medicine or anaesthesia).

8 HEALTHCARE DELIVERY - COMMUNITY

Under *NSW HEALTHPLAN*, NSW Health may request assistance from health supporting agencies during a pandemic; these include residential care facilities, private health facilities, local government councils and primary healthcare networks. In preparation for a pandemic, MoH works with peak bodies, professional associations and other stakeholder groups to determine the most appropriate role for services that deliver healthcare within a community during a pandemic. Services may be asked to focus on maintaining core business or to take on specific pandemic-related roles depending on the severity of the pandemic.

Community healthcare providers may also be asked to participate in the deployment of alternative models of care to respond to clusters of illness in remote communities. The LHD in consultation with community health providers would be responsible for the implementation and operational management of alternative facilities or models of care in the community.

Other community healthcare providers (e.g. drug and alcohol services, dentists, physiotherapists or specialist rooms) should be prepared to implement screening, increase infection control and appropriately manage or defer attendance by people with ILI during a pandemic.

8.1 General practice

MoH works closely with primary care peak bodies in NSW to determine the most appropriate role for general practice during a pandemic. A key challenge for general practice will be the maintenance of routine services for patients when experiencing a potentially significant increase in demand during a pandemic. The Royal Australian College of General Practitioners (RACGP) has released the *Managing pandemic influenza in general practice* guidelines (as well as an implementation toolkit – see Appendix 4) which outline strategies to help GPs maintain business continuity during a pandemic. The RACGP has also developed Infection prevention and control standards for GPs and other community health providers which would be essential in the preparation and response to pandemic influenza.

LHDs/SHNs should work with their primary health networks to plan the local implementation of national and state pandemic response activities and to coordinate care between general practices and LHD facilities. GPs in rural and remote areas may have little support or relief available from other healthcare providers. LHDs/SHNs should consider and develop ways to work with GPs in rural and remote areas, and involve them in local pandemic planning. Additional roles for nursing staff in primary health networks in remote communities during a pandemic response should also be considered.

8.2 Community pharmacies

Community pharmacies may be asked to take on additional tasks or provide surge workforce capacity during a pandemic. Pharmacies are kept informed about pandemic phase changes through engagement between MoH and the NSW Pharmacy Guild and provided with advice to inform their customers about treatment for ILI.

MoH will consult with the NSW Pharmacy Guild and LHDs/SHNs to help identify any additional tasks (e.g. assistance with distribution of oseltamivir suspension and other anti-viral medications) that may be requested from community pharmacies.

8.3 NSW Ambulance and patient transport

It is anticipated that the NSW Ambulance workload will increase during a pandemic. This will require enhanced triaging of all patients to ensure NSW Ambulance is able to maintain core service delivery to emergency cases. NSW Ambulance is also responsible for providing coordination and communication processes across the service during emergency or campaign type operations. This includes close liaison with the NSW Health Non-Emergency Patient Transport (NEPT) Hub for the expected increase in non-emergency patient transports. Specific command and control operational arrangements are detailed in NSW Ambulance operational plans.

The State HSFAC may request support from the State Emergency Operations Controller for moving large numbers of people to alternate accommodation (e.g. relocating people from the airport that have been exposed to the virus during a flight). NSW Ambulance personnel may be best placed to assist with moving smaller groups of people.

HealthShare NSW is responsible for ensuring pandemic readiness for all Greater Metropolitan NEPT services; including business continuity and surge staff planning. Operational interagency liaison will occur between NSW Ambulance and HealthShare NSW and frontline supervisors during a pandemic.

8.4 Mental health services

Mental health services need to continue to provide core services (e.g. inpatient acute care, rehabilitation and emergency psychiatric services) during a pandemic as well as providing extra support services for mental health workers, other healthcare workers and members of the broader community. Mental health NGOs, GPs, peak bodies and consumer and carer organisations will be key stakeholders in planning and preparedness.

Individuals may develop short or long-term mental health concerns as a result of community anxiety, prolonged isolation or other significant changes to daily life experienced during a pandemic. The particular mental health needs of specific populations must also be considered. It will be important to ensure clear, consistent and timely public communication is produced and disseminated to reduce anxiety.

The psychological issues for healthcare workers in a pandemic will be significant, requiring clear, consistent and frequent communication to reduce community anxiety associated with exposure in the workplace. Many patients with mental health concerns are managed by clinicians in primary care. Early communication between the local LHD and GPs will be important to ensure smooth continuity of care.

The NSW Health Mental Health Line will be briefed on the pandemic and will be the main point of contact for those wishing to access or consult with mental health services. MoH may also activate the Mental Health Disaster Help Line if a specific service is required or if there are large numbers of people seeking assistance.

In order to continue to provide core mental health services to patients, alternative delivery mechanisms may be needed, including telephone or internet consultations and/or alternative access points for medication monitoring. Any decision regarding reduction of services would need to be made in consultation with the Mental Health Controller following full consideration of risk factors and the level of support available in the community.

The MoH Mental Health and Drug & Alcohol Office and LHD Mental Health Directors remain actively involved in pandemic planning to ensure mental health services are incorporated into LHD planning (e.g. developing protocols for the treatment of acutely mentally ill patients with pandemic influenza).

8.5 Correctional and detention facilities in NSW

Corrective Services and Juvenile Justice NSW (as part of the Department of Justice NSW) are responsible for the operational management of services and programs to manage adult and juvenile offenders respectively in corrective facilities or in the community in NSW. The Justice Health and Forensic Mental Health Network (JH&FMHN) as a state-wide specialty NSW Health network, maintains guidelines on supporting the health of adult and juvenile offenders during an influenza pandemic in NSW.

Correctional facilities present unique challenges in relation to social distancing and mitigating the impact of a pandemic. A range of strategies including screening prior to transport, isolation and quarantine are implemented by the JH&FMHN in consultation with Corrective Services NSW, Juvenile Justice NSW, the Department of Justice and NSW Police. JH&FMHN health facility centres, while not linked to specific hospitals, may also serve as PACs in consultation with the relevant LHD.

Immigration detention facilities are the responsibility of the Australian Government; however some detention facilities are contractually operated and managed by private providers. In the event of an influenza pandemic affecting detainees within NSW immigration detention facilities, NSW Health would collaborate with the Commonwealth to implement a range of strategies to support the health of detainees, such as case and contact follow-up, management and treatment.

8.6 Schools and children's services

The NSW Department of Education is responsible for early childhood centres, public primary and secondary schools as well as some adult tertiary education centres such as campuses of TAFE NSW.

During a pandemic, early childhood centres and schools may be a focus of social distancing measures (during the *Standby* and/or *Initial action stage*) to reduce the community-level impact of pandemic influenza, as children typically have higher infection rates, shed virus longer than adults and may be less capable of maintaining high levels of infection control (e.g. adequate hand washing).

It is important to note that school closures have only been shown to be moderately effective at reducing transmission rates and the timing and duration of closures would need to be carefully considered (see *AHMPPI*). Therefore a range of measures designed to help reduce social mixing of students in order to reduce transmission of the pandemic virus may be considered by MoH (e.g. cancellation of extra-curricular or after-school activities).

MoH would liaise closely with the NSW Department of Education, the Catholic Education Commission of NSW and the Association of Independent Schools of NSW to ensure the agreed implementation of any social distancing measures in early childhood centres and/or schools was timely, appropriate and communicated to relevant services and families in NSW.

8.7 Residential care facilities

People living in residential care facilities represent a potentially vulnerable population to the pandemic virus due to a variety of factors such as older age, disability, chronic illness and close living arrangements.

Most residential aged care services are the responsibility of the Australian Department of Social Services (DSS). However MoH and LHDs work closely with DSS and non-governmental organisations (e.g. Aged and Community Services NSW and ACT), facility managers and private providers in NSW on a regular basis to help protect the public health of residents through investigation and control of any infectious disease outbreaks.

All residential care facilities in NSW are encouraged to have plans in place for an influenza pandemic. CDNA maintains guidelines on the *Prevention and management of influenza outbreaks in residential care facilities*. Seasonal influenza outbreaks represent an opportunity for residential care facilities to test any plans, revise arrangements with health partners and incorporate any lessons learnt.

During a pandemic, MoH would work closely with the Commonwealth to ensure communications to residential care facilities in NSW regarding response strategies were coordinated in a timely and appropriate manner.

9 AT-RISK GROUPS

The *AHMPPI* acknowledges that some population groups will be at risk of severe morbidity or mortality from a pandemic virus. Depending on the clinical epidemiology of the pandemic virus, at-risk groups may include traditional seasonal influenza at-risk groups as listed in the *Australian Immunisation Handbook* , including infants, older people, people with chronic conditions, pregnant women and Aboriginal people.

Other population groups may also be at increased risk of influenza complications during an influenza pandemic because their health needs may not be met by traditional or mainstream health services, or they may have difficulty accessing health services and emergency resources. This includes some people from culturally and linguistically diverse backgrounds, including refugees, and the homeless.

LHDs need to consider how to identify and support at-risk populations in their district to ensure timely and appropriate information and healthcare is given during a pandemic. This will include appropriate models of care for ensuring that at-risk groups can access anti-viral medication and/or vaccination during a pandemic. Engaging and building relationships with local GPs, multicultural health networks, community and other care providers will be important in preparing to support the health needs of at-risk groups during a pandemic.

9.1 People with chronic diseases

During a pandemic, MoH would work with the ACI, NSW Pharmacy Guild and LHDs/SHNs to ensure people with chronic conditions are adequately supported in the community to manage their conditions. Public messaging may be used to encourage people with chronic conditions to maintain their treatment and seek advice for exacerbations.

The NSW Chronic Disease Management Program (CDMP) is a free service delivered by LHDs which targets NSW adults who have difficulty managing their condition and are at risk of hospitalization. The CDMP model supports care coordination and integration across the primary health care sector. LHDs should work with local GPs and other community providers (e.g. pharmacies) to develop effective business continuity and workforce surge plans that explore the best use of the CDMP and/or alternative models of care that support people with chronic conditions in the community.

9.2 People from culturally and linguistically diverse (CALD) backgrounds

During a pandemic, MoH would leverage off existing relationships with the NSW Multicultural Health Communication Service, NSW Refugee Health Service and the NSW Healthcare Interpreters Service to ensure the health needs of people from CALD backgrounds are supported. These services provide established pathways of communicating with multicultural families, children and young people, older people and people living in rural areas.

Strategies to support culturally appropriate communication with CALD groups during a pandemic are outlined in the *Communications* section of this plan. MoH would also work with the NSW Multicultural Health Communication Service and NSW Refugee Health Service to ensure that other not-for-profit organisations (e.g. Ethnic Community Council) and ethnic medical associations (e.g. Australian Chinese and Vietnamese Medical Associations) are briefed on the key pandemic response strategies over time so that support services could be provided if appropriate. The NSW Community Relations Council can provide links with community leaders in different CALD groups across NSW if appropriate.

LHDs/SHNs should ensure district level pandemic plans incorporate profiling, mobilisation and health services appropriate for CALD groups during a pandemic. Partnership arrangements in the delivery of health services for CALD groups during a pandemic should also be outlined, such as non-governmental organisations, primary health networks and community outreach services.

It will be important to ensure CALD groups are aware of strategies that will help them mitigate any risk of contracting or transmitting pandemic influenza within their community, such as infection control practices and social distancing measures, and how to access locally appropriate health services for prevention or management of pandemic influenza (e.g. PACs and pandemic vaccination clinics). This might include promotion and use of multilingual resources, local interpreter services, bi-lingual GPs and local refugee health services (including paediatric clinics and refugee health nurses where available).

9.3 Other at-risk groups

Depending on the clinical epidemiology of the pandemic virus, other groups including infants, the elderly and pregnant women might also be at increased risk of severe morbidity and mortality.

Strategies to support the health needs of infants and the elderly in regards to outbreaks of pandemic influenza in early childhood centres and residential facilities are outlined in the *Healthcare delivery – community* section of this plan.

10 ABORIGINAL PEOPLE

Aboriginal communities are a particular focus for pandemic planning as they are characterised by having higher numbers of at-risk individuals (i.e. people at higher risk of severe complications from influenza infections) than the general community.

NSW Health also recognises the importance of embedding the needs and interests of Aboriginal people in the development, implementation and evaluation of all NSW Health initiatives, as described in the *Aboriginal Health Statement and Impact Guidelines* (PD2007_082). Consistent with the principle of working in partnerships, adequate and appropriate pandemic planning for Aboriginal communities will only be achieved through effective partnership arrangements.

There are a number of barriers for Aboriginal people to access mainstream health services, such as availability, location, cost and continuity of care. For a range of reasons there may be potential for wide-spread reluctance of Aboriginal people to present to EDs, PACs and other mainstream health services during a pandemic.

LHDs must ensure that appropriate services are available to mitigate the impact of pandemic influenza in Aboriginal communities.

MoH works with the Aboriginal Health & Medical Research Council (AH&MRC) and LHDs to determine the most appropriate service delivery role for Aboriginal health services during a pandemic. Aboriginal Community Controlled Health Services (ACCHS) should be engaged through established partnership arrangements at a district level. Collaborative planning arrangements with non-ACCHS providers of health and health-related services for Aboriginal people should also be developed and implemented.

PHUs and LHD Directors/Managers of Aboriginal Health can facilitate partnerships with ACCHSs for advice on pandemic planning and its cultural appropriateness for Aboriginal people and communities. The MoH Centre for Aboriginal Health is available as another source of advice on Aboriginal health policy and programs at the state level. Due to the strength of kinship and family relationships, LHDs also need to work with Aboriginal health services and community representatives to develop and promote appropriate social distancing methods.

MoH maintains detailed guidance on how these partnership arrangements with ACCHS and Aboriginal communities in NSW should work in regards to planning for and responding to a pandemic.

11 SURVEILLANCE AND MONITORING

CDNA is responsible for determining any national changes in the case definition of the pandemic virus to enable accurate identification of cases and contacts. The Chief Health Officer will advise LHDs, GPs and community pharmacies and other partner agencies of changes to the case definition. LHDs are responsible for informing health facilities as well as private hospitals and Aboriginal health services (in collaboration with the Centre for Aboriginal Health) within their district of changes.

MoH will be primarily responsible for conducting and coordinating surveillance data collection and timely reporting of data to DoH on behalf of NSW Health. DoH will facilitate development of data transfer protocols for this process and will feed back information and analyses to jurisdictions via CDNA and AHPPC. MoH will inform LHDs of any changes to surveillance arrangements as the pandemic progresses.

LHDs are responsible for conducting and coordinating the early and enhanced data collection on cases and contacts during the pandemic. This enhanced data collection is to be undertaken in parallel with the core responsibilities of LHDs during the pandemic, including the appropriate assessment, treatment and management of cases and contacts. Surveillance data will be a key component of health situation reports and reporting through any emergency operation centres established at state and LHD levels.

Surveillance arrangements

During the early response stage (i.e. *Initial action* stage*)*, detailed data on individual confirmed cases and household contacts will be needed to inform the national and state response to the pandemic as described in the AHMPPI.

Intelligence gathering within Australia will be less important if there is high quality surveillance information available characterising the severity and transmissibility of the pandemic strain from the studies carried out overseas prior to the arrival of the pandemic virus into Australia.

As the pandemic progresses and community transmission becomes established (i.e. *Targeted action* stage) it will be less important and less feasible to identify and follow-up each new case and their contacts. Surveillance activities will then focus on monitoring the impact of the pandemic on the community in general and on the health system in particular.

As the pandemic response transitions to the *Stand down* and *Recovery* stages, the new virus may remain circulating in the population and potentially become a new seasonal influenza virus. It will be important to continue to monitor the pandemic virus for a second wave of infection and/or for antiviral resistance using routine surveillance systems.

11.2 Surveillance systems and data

Wherever possible, existing routine surveillance systems will be used during the pandemic. This approach aligns with the *AHMPPI* and the Population Health Surveillance Strategy NSW 2011 to 2020. Routine surveillance for human influenza occurs year-round in NSW but increases during the winter influenza season.

The following systems may be utilised during a pandemic:

- ***Virological surveillance*** – identifying and monitoring virus types and strains over time. Laboratories across NSW notify confirmed cases of influenza to PHUs. In addition, several public and private laboratories contribute a proportion of virological samples sent each year to the World Health Organization Collaborating Centre (WHO CC) for Reference and Research on Influenza (Melbourne) for monitoring antigenic changes in the influenza virus.
- ***Syndromic surveillance*** – monitoring and detecting any increased presentations for ILI in emergency departments or in the community through general practice. Current examples include the Public Health Real-time Emergency Department Surveillance System (PHREDSS) and eGPS, a program to monitor ILI consultations in sentinel GP practices.
- ***Clinical surveillance in hospitals*** – for monitoring hospitalisations or ICU admissions related to severe respiratory disease for adults or children. Current examples include FluCAN (the Influenza Complications Alert Network) and the Australian Paediatric Surveillance Unit.
- ***Case and outbreak notification*** - PHUs receive influenza notifications from laboratories and reports of outbreaks of ILI in institutions such as residential aged care facilities. Notification data are managed with the state-wide Notifiable Conditions Incident Management System (NCIMS).
- ***Mortality surveillance*** - Death registration data from the NSW Registry of Births, Deaths and Marriages are reviewed for deaths attributable to pneumonia and influenza on a weekly basis. Statistical estimates are then produced to predict the number of influenza-related deaths against a baseline estimate of deaths occurring each year.

- ***Initial action stage / First Few 100 surveillance*** – for a limited period at the start of pandemic, LHDs may be required to assist with the national effort to actively follow-up suspected and confirmed cases of pandemic influenza and their household contacts to examine transmissibility of the pandemic virus, the severity of infections and the groups at risk of severe disease. This enhanced data will be managed in NCIMS and shared with the National Notifiable Diseases Surveillance System (NNDSS) under existing arrangements.
- ***Health facility impact monitoring*** – data on the capacity of healthcare services to manage demand (e.g. ED presentations/admissions and bed/ventilation capacity). The Patient Flow Portal currently managed by MoH provides data on bed capacity and patient flow/transfers at the health facility level. Impacts on other areas such as on ED performance, surgical waiting lists, and staff absenteeism will also need to be monitored.
- ***Detailed clinical surveillance in intensive care units*** – for monitoring severity and clinical outcomes of patients admitted to ICU with suspected or confirmed influenza and/or viral pneumonia.
- ***Vaccine distribution and monitoring data*** – if and when a pandemic vaccine becomes available the current vaccine distribution and monitoring system may need to be enhanced to monitor the distribution and uptake of pandemic vaccines.
- ***Adverse event following immunisation (AEFI) surveillance*** – the existing AEFI system will be utilised by DoH and MoH to monitor adverse events associated with any new pandemic vaccine, particularly adverse events that may not have been detected in pre-licensure vaccine trials.

In addition, other surveillance data may need to be collected depending on the severity of the pandemic and the response strategies utilised in NSW, including:

- International border monitoring (if implemented)
- Workforce absenteeism monitoring.

During the pandemic, routine and enhanced data collection may also need to be supported by additional targeted research studies. These studies are likely to be coordinated at a national level. Pandemic research conducted in NSW will be subject to the capacity and interest of different agencies in NSW, including universities, research institutes, LHDs and other Health agencies.

11.3 International border surveillance

The Australian Government is responsible for developing and implementing policies relating to international border control activities. Roles and responsibilities relating to airports are outlined in the *National Pandemic Influenza Airport Border Operations Plan* (FLUBORDERPLAN).

The suite of border measures that the Australian Government may consider during a pandemic are outlined in the *AHMPPI*. The Australian Government has broad quarantine powers supported by legislation, as listed in Appendix 3.

MoH would respond to requests from the Australian Government via AHPPC to provide assistance with international border control and related risk management activities and the implementation of any measures in NSW. MoH would notify LHD Chief Executives of any border assistance required.

MoH routinely works with relevant LHDs to support Biosecurity Officers (Australian Department of Agriculture and Water Resources) with their border health screening work at international points of entry (airports and seaports) as needed, including providing training and assessing referrals.

MoH supports South East Sydney LHD to conduct the Airports and Seaports Human Biosecurity Program with a focus on cruise ships and Sydney International Airport. South East Sydney LHD would likely take a lead role in supporting border agencies at Sydney International Airport if additional border surveillance activities were recommended.

12 LABORATORY

At the national level, PHLN provides expertise and national guidelines for public health labs involved in microbiological testing.

NSW Health Pathology has primary responsibility for maintaining appropriate provision of laboratory services across NSW during a health emergency, including a pandemic. NSW Health Pathology response plans should be referred to for more detail on laboratory roles and responsibilities.

Supporting NSW guidelines for a laboratory response to an emergency may also be developed to help prepare public and private laboratories to respond to a health emergency such as an influenza pandemic.

12.1 Operational aspects of the laboratory response

In order to have an adequate state-wide capacity to detect novel pandemic viruses in humans, certain laboratories have the capability and capacity to develop tests for novel viruses with pandemic potential.

Diagnostic laboratories face a risk of high demand for diagnostic tests throughout the pandemic, and may also have to deal with increased staff absences. Laboratories should regularly review business continuity plans in order to ensure their capability and capacity to respond to a pandemic.

- During the *Initial action* stage of the pandemic (i.e. before the pandemic virus becomes widespread in NSW), the emphasis of laboratory testing will be on early, accurate diagnosis of all cases to identify and determine the spread of the virus across NSW, and to inform case and contact management.
- During the *Targeted action* stage (i.e. as the pandemic becomes more widespread), the pre-test probability of the pandemic virus being the cause of the illness becomes high. Clinicians will need to be advised to restrict testing to cases where the result will directly impact on clinical management.
- Experience from the pandemic in 2009 suggests that there may be particularly high demand on laboratory capacity when there is widespread influenza activity in the community, even following advice to clinicians. Some screening of test requests may be required to prioritise testing.
- During the later stages of a pandemic, testing should focus on cases admitted to hospital, particularly those in at-risk groups, where the outcome affects clinical management of the patient. Testing may also be used to monitor for strain drift and antiviral resistance.

Serological testing using a specific test for the pandemic virus may be useful for retrospective diagnosis, particularly for severely ill patients for whom specimens were not collected or were negative for the virus. Serological studies may be considered to inform a more robust estimate of the prevalence of infection, and assist in formulation of vaccine strategy.

13 ANTIVIRAL MEDICATIONS

Antiviral medication may be administered to cases to reduce the severity and duration of infection and to shorten the period when the patient is infectious. The medication is most effective if taken within 48 hours of symptom onset. Antiviral medications can be used for treatment of cases, and for both pre-exposure and post-exposure prophylaxis.

During a pandemic, antiviral medications, including those held within the National and NSW stockpiles, will be prioritised for treatment.

Widespread use of antiviral medications as prophylaxis (either pre-exposure or post-exposure) is not recommended as this may deplete a critical treatment resource. The limited use of anti-influenza medication as prophylaxis may be recommended by AHPPC for certain priority groups, such as at-risk contacts or healthcare workers treating pandemic influenza patients during a particularly severe pandemic.

MoH in consultation with LHDs, ACI and other clinical care networks will make decisions around prioritisation of antiviral medications for prophylaxis in NSW based on national recommendations.

Access to antiviral medication for young children pre-prepared as a suspension (i.e. in liquid form) is likely to be limited. If required, hospital pharmacies and some community pharmacies in NSW will be able to compound oral antiviral medication suspension. MoH would work with the peak pharmacy bodies and LHDs/SHNs to ensure access and timely distribution of this medication during a pandemic.

Recommendations for the use of antivirals in NSW will depend on the epidemiological and virological characteristics of the virus (e.g. severity, transmissibility, antiviral resistance, and antiviral efficacy), pre-existing immunity in the community, vaccine availability and logistical constraints.

MoH will provide LHDs, community pharmacies and primary health care providers with clear and timely guidance on antiviral medication use (e.g. agreed target groups, indications for use, dosage, precautions, storage, transport and disposal) as early as possible during the pandemic response. Clinicians can search the NSW Health website for more information on these medications if needed.

The *State-wide Standing Order for Supply or Administration of Medication for Public Health Response* policy (PD2013_035) outlines the arrangements for NSW Health registered nurses to administer and/or supply antiviral medication to cases and contacts for the purpose of treatment or prophylaxis in the community, such as at PACs, residential aged care facilities, or schools.

14 VACCINATION

Vaccination against a novel pandemic virus is a key response activity outlined in the AHMPPI. As soon as a pandemic virus is identified, work begins to produce a customised pandemic vaccine. Due to the lead-time required to manufacture a new vaccine, it may take many months after the emergence of a pandemic before there is enough vaccine for the Australian population.

In addition to customised pandemic vaccines, candidate pandemic vaccines may be available from DoH. Candidate vaccine seed strains have been developed for the avian-origin and swine-origin influenza virus sub-types. The effectiveness of these vaccines will depend upon the match between the seed strain and influenza strain causing the pandemic.

The use of candidate vaccines will depend on many factors, including early virological data, timing and spread of infection in Australia, availability of vaccine and predicted impact of the pandemic. It might be decided these vaccines would be prioritised for at-risk groups and/or healthcare workers during the initial action response stage of the pandemic.

The principles of vaccine prioritisation for the states and territory jurisdictions will be discussed collaboratively through the AHPPC. DoH will coordinate distribution of pandemic vaccines to states and territories. MoH will coordinate the distribution of vaccine to nominated vaccine dispensers (e.g. LHDs/SHNs, GPs) in NSW.

The national pandemic vaccine distribution strategy will be influenced by the amount of vaccine available and the stage of the pandemic when it becomes available. If the vaccine only becomes available after the first wave of pandemic has passed then there will be a preference for using existing vaccine delivery systems, particularly involving general practice.

If an initial supply of a pandemic vaccine becomes available during a pandemic and is recommended to be distributed as part of the outbreak response then this likely to be most effectively delivered through LHDs and SHNs.

LHDs /SHNs are responsible for developing strategies to provide pandemic vaccination to the public within their district in the outbreak setting, in addition to their usual staff vaccination programmes.

Provision of both candidate and pandemic-specific vaccines can be via several models coordinated by LHDs/SHNs depending on the severity of the pandemic virus and vaccine supply. MoH maintains guidelines for LHDs/SHNs regarding the establishment and operation of vaccination clinics during a pandemic.

LHDs/SHNs will be asked to plan for two vaccination scenarios according to MoH guidelines: (i) vaccination of priority groups with a candidate or pandemic-specific vaccine, (ii) mass vaccination for the wider LHD population with a pandemic specific vaccine. It will also be important that LHDs/SHNs consider the needs of at-risk groups in their population when planning vaccination clinics according to these scenarios

LHDs/SHNs should collaborate with local health service and community providers to plan for appropriate models of pandemic vaccine delivery that meet the needs of their population in accordance with MoH guidelines. This may include vaccination through general practice clinics, community centres (e.g. schools or sporting clubs) or through Aboriginal Community Controlled Health Services (ACCHS).

LHDs/SHNs will need to plan for appropriate vaccine clinic locations that allow for adequate crowd control, patient flow and space to facilitate patient assessment, vaccination and observation. LHDs/SHNs will also need to consider staffing arrangements to ensure adequate numbers of immunisers are available to participate in vaccination clinics.

Staff at general practices and community health centres – including GPs, practice nurses and nurse practitioners – represent a skilled workforce capable of supporting pandemic vaccine delivery and administration. LHDs/SHNs should work with primary health networks in their district to plan for inclusion of these staff in the delivery of vaccination clinics as appropriate. Community pharmacists registered in NSW to administer influenza vaccines may also be utilised.

A pandemic influenza vaccination campaign may overlap with the annual seasonal influenza campaign. MoH will provide any specific state-wide instructions about coordinating both vaccination campaigns simultaneously.

15 NATIONAL AND STATE MEDICAL STOCKPILES

Medical stockpiles are strategic reserves of medicine and equipment designed to allow rapid access to standardised items that may not be available in a timely manner through routine supply channels due to increased national or international demand.

The Australian Government is responsible for maintaining the National Medical Stockpile (NMS) and for developing related deployment plans for these items to states and territories. The Chief Health Officer is able to request deployments from the NMS. If national demand is significant, requests may need to be prioritised across the states and territory jurisdictions.

MoH maintains the State Medical Stockpile (SMS) of essential supplies, such as PPE and antiviral medications, for NSW and is responsible for developing deployment plans for these items to LHDs.

HealthShare NSW is responsible for routine procurement of goods and services for LHDs in NSW. During a pandemic, warehousing and distribution of health supplies and uptake of essential items will be monitored by HealthShare NSW. When essential items (e.g. PPE) are no longer available through routine procurement channels, MoH will provide advice to LHDs regarding requesting SMS items.

LHDs are responsible for planning local distribution of resources provided to LHD facilities. In some situations, MoH may ask LHDs to help distribute goods to other healthcare facilities within their area.

APPENDIX 1: ACRONYMS AND ABBREVIATIONS

ACI	Agency for Clinical Innovation
AH&MRC	Aboriginal Health & Medical Research Council
AHMPPI	Australian Health Management Plan for Pandemic Influenza
AHPPC	Australian Health Protection Principal Committee
CALD	Culturally and linguistically diverse
CDNA	Communicable Diseases Network Australia
CE	Chief Executive
DoH	Department of Health (Commonwealth)
EDs	Emergency departments
EMPLAN	NSW State Emergency Management Plan
GP	General practice
HEMU	Health Emergency Management Unit
HSFAC	Health Services Functional Area Coordinator
HPNSW	Health Protection NSW
ICU	Intensive care unit
ILI	Influenza-like illness
JH&FMH	Justice Health and Forensic Mental Health
LHD	Local health district
MoH	NSW Ministry of Health
NAPHIP	National Action Plan for Human Influenza Pandemic
NCIMS	Notifiable Conditions Incident Management System
NHEMRN	National Health Emergency Media Response Network
NMS	National Medical Stockpile
PHLN	Public Health Laboratory Network
PHREDSS	Public Health Real-time Emergency Department Surveillance System
PHU	Public health unit
PIFAC	Public Information Functional Area Coordinator
PPE	Personal protective equipment
SERM Act	State Emergency Rescue Management Act
SCHN	Sydney Children's Hospitals Network
SHN	Specialty health network
SMS	State Medical Stockpile
WHO	World Health Organization
WHOCC	WHO Collaborating Centre for Reference and Research on Influenza

APPENDIX 2: GLOSSARY

AIIMS	Australasian Inter-Service Incident Management System provides an emergency management structure that enables seamless integration of activities and resources of amongst and between agencies when applied to an emergency.
Antiviral medications	Antiviral medications decrease the severity and duration of influenza infections, and reduce the risk of illness in exposed individuals.
Combat agency	The agency identified in *EMPLAN* as the agency primarily responsible for controlling the response to a particular emergency (source: *SERM Act*).
Candidate pandemic vaccine	A vaccine based on a strain of influenza virus considered to have pandemic potential. This vaccine may provide partial protection if it develops into a pandemic strain that is easily transmissible between humans (source: *AHMPPI, 2014)*
Customised pandemic vaccine	A customised pandemic vaccine is a vaccine tailored to a specific pandemic virus strain. It cannot be developed until the next pandemic virus emerges (source: *AHMPPI 2014*).
Health services (NSW)	Health services refer to any medical, hospital, ambulance, paramedical, community health or environmental health service or any other service relating to the maintenance or improvement of the health, or restoration to health, of persons or the prevention of disease in or injury to persons in NSW(source: *Health Administration Act, 1982* No 135, pg. 2).

	This definition specifically refers to the administration of NSW Health services (see below).
First Few 100	FF100 is a surveillance protocol developed by the Australian Government for collection of detailed epidemiological and clinical data on the first few hundred confirmed cases (& their household contacts) of pandemic influenza (source: *AHMPPI 2014).*
NCIMS	Notifiable Conditions Incident Management System – routine database for recording and collecting epidemiological data on cases of notifiable diseases in NSW.
NSW Health	The expression "NSW Health" may be used to describe the Ministry and any other body and organisation under the control and direction of the Minister or the Health Secretary. This includes local health districts, pillars, shared services and other affiliated health agencies, such as NSW Ambulance, HealthShare NSW, Health Infrastructure, NSW Health Pathology, eHealth and St Vincent's Health network.
NHEMRN	National Health Emergency Media Response Network – national peak committee (including jurisdictional health department communications teams) responsible for coordinating the development and dissemination of national communications during a pandemic. (source: *AHMPPI, 2014*).
Pandemic	A pandemic is an epidemic on a global scale. Only Type A influenza viruses have been known to cause influenza pandemics (source: *AHMPPI*, 2014).
Pandemic assessment centres (PACs)	PACs (formerly known as *flu clinics*) are specifically planned facilities that will be needed during a pandemic for medical assessment and management of people with suspected pandemic influenza (source: *AHMPPI 2014*).
Post-exposure prophylaxis	A dose/s of a drug (usually antibiotic or antiviral) given immediately after exposure to disease and before onset of illness (source: *AHMPPI,* 2014).
Pre-exposure prophylaxis	A dose/s of a drug (usually antibiotic or antiviral) given before exposure to a disease, to protect the person from being infected (source: *AHMPPI, 2014*).
Quarantine	The limitation of freedom of movement for a period of time of well persons who are likely to have been exposed to the virus to prevent their contact with people who have not been exposed (source: *AHMPPI, 2014*).
Sub plan	A sub plan is an action plan for a specific hazard, critical task or special event. It is prepared when the management arrangements necessary to deal with the effects of the hazard, or critical task or special events differ from the general coordination arrangements set out in the main or supporting plan for the area (source: *NSW EMPLAN*).
Surge capacity	Health service's to expand beyond normal capacity to meet an increased demand for clinical care (source: *UK DH, Managing Demand and Capacity guidance, 2009*)

APPENDIX 3: LEGAL FRAMEWORK

There are several key pieces of legislation supporting the NSW response to a pandemic.

Australian Government legislation

The Quarantine Act 1908

This Act aims to prevent the introduction of specified diseases into Australia and prevent the spread of such diseases within Australia.

The Biosecurity Act 2015

The new Biosecurity Act will commence on 16 June 2016, replacing the Quarantine Act 1908. Just as with the Quarantine Act, the biosecurity legislation will be co-administered by the Ministers responsible for Agriculture and Health.

National Health Security Act 2007

This Act provides for the exchange of public health surveillance information between the Australian Government and the states and territories, and, where relevant, the WHO.

NSW legislation

State Emergency Rescue and Management Act 1989 (as amended)

This Act details the emergency management framework in NSW.

Public Health Act 2010 and Regulation 2012

This Act outlines public health management in NSW, including notifiable diseases and infectious disease emergencies.

Health Administration Act 1982

This Act establishes the Health Administration Corporation and outlines the functions of the NSW Minister of Health and Health Secretary.

Health Records and Information Privacy Act 2002 (as amended)

This Act governs the management of health information in the NSW public and private sectors.

Health Services Act 1997 (as amended)

This Act outlines the structure of the NSW public health system.

Local Government Act 1993 (as amended)

This Act governs the functions (including regulatory functions) of local councils in NSW.

Poisons and Therapeutic Goods Act 1966 (as amended)

This Act lists poisons and drugs of addiction and states that Australian Government therapeutic goods laws apply in NSW.

Poisons and Therapeutic Goods Regulation 2008 (as amended)

This Regulation supports the *Poisons and Therapeutic Goods Act 1966* and authorises the Health Secretary with powers for emergency medication supply.

Protection of the Environment Operations Act 1997 (as amended)

This Act is the key piece of environment protection legislation administered by the Environment Protection Authority and allows the Government to set out explicit protection of the environment policies.

Work Health and Safety Act 2011 (as amended)

This Act aims to protect workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from workplace practices.

APPENDIX 4: ASSOCIATED POLICIES AND GUIDELINES

International plans

World Health Organization's Global Influenza Programme

National plans

Australian Health Management Plan for Pandemic Influenza (AHMPPI)

Australian Immunisation Handbook

National Action Plan for Human Influenza Pandemic (NAPHIP)

National Pandemic Influenza Airport Border Operations Plan (FLUBORDERPLAN)

Sector-specific guidance

Australasian College of Emergency Medicine – *Management of Severe Influenza, Pandemic Influenza and Emerging Respiratory Illnesses in Australasian Emergency Departments*

Communicable Diseases Network Australia – *Influenza infection: national guidelines for public health units*

Communicable Diseases Network Australia – *A practical guide to assist in the prevention and management of influenza outbreaks in residential care facilities*

National Health and Medical Research Council (2010) *Australian Guidelines for the Prevention and Control of Infection in Healthcare*

Royal Australian College of General Practitioners – *Managing Pandemic Influenza in General Practice*

Royal Australian College of General Practitioners – *Pandemic flu kit – implementation guide*

Royal Australian College of General Practitioners – *Infection prevention and control standards*

NSW whole of government guidelines and policies

Memorandum of Understanding between NSW Government and Unions NSW in relation to an influenza pandemic

New South Wales State Emergency Management Plan (EMPLAN)

NSW Human Influenza Pandemic Plan

NSW Health guidelines and policies

(Check NSW Health website for most recent versions)

Aboriginal health impact statement and guidelines (PD2007_082)

Child Wellbeing and Child Protection Policies and Procedures for NSW Health (*PD2013_007*)

Emergency Management Arrangements for NSW Health (PD2012_067)

Environmental cleaning policy (PD2012_061)

Infection control policy (PD2007_036) *[or most current version]*

Influenza pandemic – providing critical care (PD2010_028)

Influenza – Minimising transmission of influenza in healthcare facilities: 2010 influenza season (GL2010_006)

Leave matters for the NSW Health service (PD2014_029)

Notification of infectious diseases under the Public Health Act 2010 (IB2013_010)

NSW HEALTHPLAN (PD2014_012)

NSW Hospital in the Home (HITH) guideline (GL2013_006)

Occupational assessment, screening and vaccination against specified infectious diseases (PD2011_005)

Public Health Workforce Surge Guidelines (GL2014_003)

Public Health Emergency Response Preparedness Minimum Standards (PD2013_039)

Public Health Field Response Guidelines (GL2014_001)

State-wide Standing Orders for the Supply or Administration of Medication for Public Health Response (*PD2013_035*)

APPENDIX 5: AUSTRALIAN PANDEMIC RESPONSE STAGES

Stage	Sub-stage	Key national-level response strategies
Preparedness* No novel strain detected (or emerging strain under initial investigation)		• Establish pre-agreed arrangements by developing and maintaining plans; • Research pandemic specific influenza management strategies; • Ensure resources are available and ready for rapid response; and • Monitor the emergence of diseases with pandemic potential, and investigate outbreaks if they occur.
Response	**Standby** Sustained community person to person transmission overseas	• Prepare to commence enhanced arrangements; • Identify and characterise the nature of the disease (commenced in Preparedness); and • Communications measures to raise awareness and confirm governance arrangements.
	Action Cases detected in Australia Sporadic cases and/or outbreaks occurring in the community Widespread person to person transmission in community	Action is divided into two groups of activities: Initial (when information about the disease is scarce) • Prepare and support health system needs; • Manage initial cases; • Identify and characterise the nature of the disease within the Australian context; • Provide information to support best practice health care and to empower the community and responders to manage their own risk of exposure; and • Support effective governance. Targeted (when enough is known about the disease to tailor measures to specific needs.) • Support and maintain quality care; • Ensure a proportionate response; • Communications to engage, empower and build confidence in the community; and • Provide a coordinated and consistent approach.
	Stand down Virus no longer presents a major public health threat	• Support and maintain quality care; • Cease activities that are no longer needed, and transition activities to seasonal or interim arrangements; • Monitor for a second wave of the outbreak; • Monitor for the development of antiviral resistance; • Communications activities to support the return from pandemic to normal business services; and • Evaluate systems and revise plans and procedures.

Source: Australian Health Management Plan for Pandemic Influenza 2014

* The Prevention stage, although not detailed here, represents an ongoing stage of alertness and preparation for the next pandemic. This includes close collaboration between the human and animal health sectors to monitor viruses with pandemic potential and regular exercising of existing response arrangements.

APPENDIX 6: NSW RESPONSE ACTIVITIES BY PANDEMIC STAGE

PREVENTION
• Monitor for emergence of potential pandemic pathogens • Contribute to regional and global influenza surveillance • Contribute to research on pandemic influenza mitigation strategies • Monitor emerging evidence on influenza treatment and influenza outbreak control measures
PREPAREDNESS
• Promote respiratory etiquette and hand hygiene practices to the general public, particularly in relation to annual influenza season messaging • Promote infection prevention and control practices with healthcare workers, and maintain high levels of infection control for usual respiratory pathogens • Develop, test, revise and exercise pandemic plans for the health sector and across government • Ensure the State Medical Stockpile (SMS) is maintained • Support the development and maintenance of a health workforce with skills necessary for rapid deployment during a pandemic • Support NSW Health agencies to develop operational plans • Engage with primary care providers (especially GPs), the community pharmacy sector and other stakeholders • Optimise hospital performance during peak seasonal influenza activity
RESPONSE **Standby -** *Sustained community person-to-person transmission of a novel virus overseas*
• Initiate emergency management arrangements as required • Check stockpiles, pre-deploy essential items and plan use of resources and medical stockpile items (e.g. PPE, antivirals and vaccines, and resources to support their administration) • Enhance surveillance activities that enable early characterisation of disease • Commence communications to mobilise health services, emergency responders and to inform the public about the pandemic and key response strategies • Awareness campaigns developed to reflect the age and cultures of at-risk groups • Consider appropriate telephony surge options for the NSW Health service, including the identification and training of additional communications staff • Review and consider appropriateness of social distancing measures • Ensure laboratory capability/capacity, including specimen collection and transport are ready • Review support arrangements for home isolation of cases and home quarantine of contacts • Prepare primary and secondary care services for anticipated surge in patients (e.g. use of triage protocols, plans for cohorting and using infection control protocols and resources)
RESPONSE **Initial action -** *initial cases detected in Australia. Intelligence about the disease is scarce*
• Provide clinical management and public health guidelines to support health system response • Provide information through the PIC and SEMC to support the whole-of-government response • Contribute to border control measures as appropriate • Support the implementation of the enhanced surveillance arrangements in LHDs for early characterisation of the pandemic virus (e.g. First Few 100 surveillance studies) • Provide antiviral medication for cases (treatment) and/or contacts (prophylaxis) as appropriate • Monitor workforce surge requirements and consider deployments of staff across LHDs and seek inter-jurisdictional support where necessary

- Communicate with the public and healthcare workers to inform them of early response and actions that can help mitigate risk of exposure
- Develop targeted messaging and education for sectors directly affected by pandemic response measures (e.g. schools, public transport)
- Support effective governance arrangements with NSW Health agencies and other sectors/networks
- Support the implementation of candidate vaccine programs in LHDs if appropriate
- Consider implementation of a range of social distancing measures
- Implement appropriate NSW Health telephony surge options
- Isolate early cases and contacts in healthcare settings or in the community
- Implement strategies that support the health of at-risk groups in the community
- Prepare and/or deploy alternative models of care in the LHDs
- Focus laboratory testing resources on early and accurate diagnosis of cases

RESPONSE
Targeted action – *widespread activity in the community. Response measures tailored to specific needs based on available intelligence.*

- Support and maintain quality of care across health services (e.g. implement triaging protocols for EDs and ICUs, re-enforcing infection control measures)
- Provide antiviral medication for cases (treatment) as appropriate
- Support the implementation and management of whole of hospital initiatives, including alternative models of care, where appropriate and feasible
- Support the implementation of vaccination clinics in LHDs as appropriate for pandemic vaccines
- Focus surveillance activity on collecting core data from routine established systems, including health system performance data
- Communicate with the public and healthcare workers to help them understand changes in the pandemic response and actions that will help mitigate risk of exposure
- Implement strategies that continue to support the health of at-risk groups in the community
- Monitor and support health workforce surge requirements to maintain healthcare services
- Continue to promote infection control measures for health care workers and public
- Prioritise influenza diagnostic testing for patients where results will affect clinical management.

RESPONSE
Stand down – *manage the withdrawal of response strategies and transition to inter-pandemic arrangements*

- Consider additional support for maintenance of services in areas disproportionately affected
- Determine whether to cease enhanced activities and health response measures
- Continue to ensure that core data is collected from routine surveillance systems - including monitoring for second wave and/or antiviral resistance
- Ensure communication activities support return to normal business
- Plan evaluation and/or pandemic review exercises where relevant

RECOVERY
Support the return to 'normal business' and recovery activity in the community

- Contribute to community recovery (via State Emergency Recovery Controller if activated)
- Ensure surge and support staff recruited to work during the pandemic response are briefed and supported to return to their normal duties across NSW Health and partner agencies
- Conduct debrief and evaluation activity to inform future plans and policies
- Consider preparations for a subsequent pandemic wave

APPENDIX 7: PANDEMIC ROLES AND RESPONSIBILITIES

Agency or organisation	Responsible for coordinating aspects of pandemic planning and response at the state level, including but not limited to:
Ministry of Health	
Population and Public Health Division and Health Protection NSW	• Coordinating surveillance and monitoring activity, including early enhanced case finding and contact tracing in the *Initial action* stage • Developing and implementing isolation and quarantine guidelines • Developing public health communication resources in collaboration with the Strategic Relations and Communications Branch (SR&CB) • Health service planning for at-risk groups and Aboriginal peoples • Implementing international border measures in consultation with the State Pandemic Management Team and relevant LHDs • Deploying and assisting in the delivery of pandemic vaccine programs • Providing guidance and support to laboratories • Managing stockpile strategy • Managing antiviral and vaccine distribution • Developing policies to support operational management • Developing and running exercises with relevant stakeholders to test and improve operational plans for the pandemic response • Ensuring state-wide coordination of the public health response through the Public Health Controller
System Purchasing and Performance Division	• Monitoring and reporting on the impact of the pandemic on health system performance • Coordinating with LHDs on the management of emergency departments and other pandemic-related services • Coordinating the sharing of key learnings between LHDs and troubleshooting resource sharing and optimal resource allocation • Monitoring the impact of the pandemic on elective surgery • Providing expert advice on patient flow and emergency departments for public hospitals across NSW in conjunction with the ACI
Governance, Workforce and Corporate Division	• Supporting communications with the private healthcare sector (e.g. private hospitals) in collaboration with LHDs and MoH • Providing advice on the supply and administration of pharmaceuticals, and supporting links and communications with the NSW Pharmacy Guild, NSW Therapeutic Advisory Committee and hospital pharmacies • Providing legal advice regarding emergency legislation and the healthcare response • Developing pandemic-related workforce planning strategies and initiatives, including occupational health and safety policies for NSW Health agencies • Liaison with unions and other workforce groups • Managing Ministerial/Parliamentary requirements • Implementing communication strategies and resources to help keep healthcare workers informed about the pandemic • Developing and distributing state-wide health communication resources in collaboration with Population and Public Health Division • Supporting development of public awareness/notice campaigns and resources during the pandemic in collaboration with the Public Affairs Unit

Strategy and Resources Division	• Providing support, where required, for negotiating inter-government or cross-jurisdictional assistance • Assisting in the identification of and supporting liaison with primary health networks and groups • Supporting the following technical areas including preparing guidance, monitoring and communicating with networks and providing spokespeople: paediatrics, family and maternal health, aged care, disability, mental health & drug and alcohol • Supporting close liaison between the Chief Paediatrician/Paediatric Controller, the LHDs and MoH Population and Public Health Division • Supporting the Mental Health Controller
Public Affairs Unit	• Liaising with the Public Information Functional Area Coordinator • Managing the response to all press enquiries • Preparing press releases • Preparing spokespeople for media appearances • Acting as the focal point for liaison with National Health Emergency Media Response Network
NSW Health agencies	
Clinical Excellence Commission	• Providing infection control and patient safety advice and expertise to MoH • Developing state-wide strategies and resources (including training modules to rapidly up-skill staff) to maintain high levels of compliance with infection control and patient safety recommendations • Monitoring of and communicating with relevant networks • Monitoring and responding to potential quality and safety issues
Agency for Clinical Innovation	• Maintaining links with key clinical networks and providing clinical expertise on patient care • Developing targeted communication for specific medical specialities • Serving as primary point of contact with and providing secretariat support to clinical networks, including identifying emerging issues with networks • Maintaining close liaison with the Medical Controller
Health Education and Training Institute	• Coordinating the development of state-wide education and training packages in agreement with LHDs and MoH • Providing advice on the suitability of current online training resources (e.g. infection control) and the options for “just-in-time” training for surge staff prior to the pandemic
Bureau of Health Information	• Redeploying surge staff during a pandemic (e.g. biostatistical and research staff) where possible • Considering additional targeted research studies in NSW
HealthShare NSW	• Ensuring the supply and delivery of food, hotel, linen and cleaning services are maintained during a pandemic for LHDs, including the public hospital system and PACs • Coordinating state-wide procurement of clinical supplies including pharmaceuticals, consumables and equipment • Monitoring and reporting on system usage of items in short supply • Identifying and providing medical and disability equipment support to people in the community during a pandemic (e.g. home oxygen) • Considering appropriate use of the Greater Metropolitan Non-Emergency Patient Transport services to support the pandemic • Supporting the HealthShare NSW Controller

E-Health	• Maintaining strategies and procedures that both minimise state-wide information communication technology (ICT) service failure and allow for effective support for increases in clinical demand for ICT services during a pandemic
Local health districts (LHDs) / specialty health networks (SHNs)[1]	• Preparing and maintaining arrangements for surge staff capacity across all NSW Health employment categories • Operating and/or deploying surveillance systems for pandemic data collection and reporting as appropriate (e.g. FF100 surveillance studies) • Implementing models of care that allow for delivery of antivirals and vaccines • Supporting and maintaining quality of care across health services and implementing infection control measures as appropriate • Ensuring cleaning and waste management services are appropriate for pandemic influenza • Preparing and implementing arrangements with the Aboriginal Community Controlled Health Services and other key partners that provide health support for at-risk groups in the population • Undertaking engagement and seeking agreement with local government councils on possible support roles during a pandemic (e.g. recruitment of staff to support surge strategies and assist with delivering pandemic vaccination clinics) • Coordinating targeted local communication and supporting communication of state-wide messages • Coordinating consistent content of local health facility pandemic plans
NSW Health Pathology	• Communicating with public and private laboratories across the state regarding pandemic response arrangements, including testing capability/capacity, specimen collection and transport, supplies of reagents and consumables and timely reporting of results to clients • Supporting public reference laboratories with resources for surge response • Ensuring reference centres provide support to other laboratories for acquisition of pandemic-specific testing capacity • Considering, in conjunction with Health partners, prioritisation/suspension of non-emergency testing and outsourcing to an alternative provider based on clinical advice and technical and workforce constraints • Liaising with interstate laboratories for local testing close to state borders • Supporting the Pathology Controller and close liaison with the Public Health Controller
NSW Ambulance	• Ensuring pandemic readiness for all ambulance services across NSW (e.g. business continuity and surge staff planning) • Supporting the Ambulance Controller and close liaison between the Public Health and Medical Controllers during a pandemic response • Coordinating aeromedical services during the pandemic • Responsible through the Ambulance Controller for coordination of patient transport as defined in *NSW HEALTHPLAN*

1 For the purposes of this document when referring to LHDs we also include SHNs (i.e. Justice Health and Forensic Mental Health Network and the Sydney Children's Hospitals Network). However, there is recognition that the implementation of some emergency response activities may differ between LHDs and these two health entities due to a focus on providing healthcare for target at-risk groups within specific correctional or hospital settings respectively and with a lack of field deployment.

APPENDIX 8: CHECKLIST FOR LHD/SHN PANDEMIC PLAN

LHD Pandemic Plan				
Item	**Details**	**Completed**	**In Progress**	**Not Started**
Requirements of the plan	Currency - plan last revised (specify date)	…/…/…..	☐	☐
	Hierarchy - notes how the plan inter-relates to other relevant facility and LHD plans	☐	☐	☐
	Consistency – note how the plan relates to the LHD, state and national pandemic plans	☐	☐	☐
	Management by objectives – notes the objectives of the response at the district level	☐	☐	☐
	Roles and responsibilities – notes responsibilities of all stakeholders at the district level	☐	☐	☐
	Stages – outlines response activities at each stage of the pandemic response (i.e. prevention, preparedness, response, recovery)	☐	☐	☐
	Testing or exercises – outlines how and when (frequency) the plan and key response activities would be exercised	☐	☐	☐
Communication	Details networks for local dissemination of MoH information	☐	☐	☐
	Details how LHDs will communicate with private healthcare providers and other health partners in their district	☐	☐	☐
Surveillance and monitoring	Details arrangements for collection of enhanced data & follow up of first few cases and contacts of pandemic	☐	☐	☐
	Details arrangements for collection of key epidemiological and clinical data throughout the pandemic as agreed at the national and state level	☐	☐	☐
Laboratory arrangements	Identifies the process for the urgent transfer of clinical specimens to a reference laboratory	☐	☐	☐
Medical stockpiles	Describes arrangements to order, store and distribute national and/or state medical stockpile items locally within the district	☐	☐	☐
Mitigation of transmission	Includes reference to relevant national or state infection control guidelines, and/or gives specific instructions on how to implement these guidelines locally within the district	☐	☐	☐
	Details how local support will be provided to people in home isolation and quarantine (particularly early in the pandemic)	☐	☐	☐
Antiviral medications	Identifies how antiviral agents will be distributed and administered to patients according to MoH policy	☐	☐	☐
Vaccination	Details how vaccination clinics would be set up and operated with appropriate resources and staff	☐	☐	☐
Clinical management	Includes reference to guidelines or protocols for management of pandemic patients in health care facilities	☐	☐	☐

11. INFECTIOUS DISEASES, IMMUNISATION AND RELATED MATTERS 11.85

Clinical Management (ctd)	Includes reference to guidelines for the isolation / cohorting of large number of pandemic patients	☐	☐	☐
	Describes strategies to manage additional demand for clinical services at both the facility and LHD level	☐	☐	☐
Healthcare delivery-facilities	Includes plans for the screening and triage of pandemic patients through emergency departments	☐	☐	☐
	Includes reference to guidelines for the management of patients in critical care units (adults and children)	☐	☐	☐
	Includes detail on how pandemic and non-pandemic patients would be managed in facilities	☐	☐	☐
	Includes detail on the establishment, staffing, and resources required to operate a PAC	☐	☐	☐
	Considers alternative models of care for rural and remote healthcare providers	☐	☐	☐
Healthcare delivery - community	Plan specifically details the role of GPs, community pharmacies and primary health care networks	☐	☐	☐
	Plan considers how support might be provided to immigration detention facilities or other residential institutions for controlling outbreaks	☐	☐	☐
	Plan considers how support might be provided to local schools or early childhood centres for controlling outbreaks	☐	☐	☐
	Plan considers the role of community health providers in the maintenance of core mental health services	☐	☐	☐
Aboriginal people	Identifies way to engage and partner with Aboriginal Community Controlled Health Services in pandemic planning and response	☐	☐	☐
	Identifies way to provide appropriate models of care for Aboriginal peoples during a pandemic	☐	☐	☐
At-risk groups	Identifies ways to support the health needs of at-risk groups, such as people with chronic diseases and CALD groups during a pandemic.	☐	☐	☐
Workforce issues	Detail included on how on to manage staff shortages, particularly surge strategies for clinical and non-clinical staff	☐	☐	☐
	Identifies alternative workforce staff to assist critical areas during a pandemic response	☐	☐	☐
	Consideration of staff training needs and exercises	☐	☐	☐
Role of local government	Plan specifically details the support roles that local government councils will provide during a pandemic	☐	☐	☐
Recovery arrangements	Describes arrangements to return the health facility back to where it was prior to the emergency	☐	☐	☐
	Details arrangements to support staff welfare during the return to 'business as usual'	☐	☐	☐
	Details arrangements for conducting evaluation or lessons learnt exercises	☐	☐	☐

INFECTION PREVENTION AND CONTROL POLICY IN HEALTHCARE SETTINGS (PD2023_025)

PD2023_025 replaced PD2017_013

POLICY STATEMENT

Effective infection prevention and control is central for reducing the burden of healthcare associated infections and providing a safe working environment within the healthcare settings. All health workers must comply with infection prevention and control requirements to prevent, identify, manage, and control healthcare associated infections.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive outlines the mandatory infection prevention and control requirements for NSW Health Organisations including inpatient, outpatient, outreach.

All NSW Health Organisations must implement the requirements that are set out in this Policy Directive, including:

- clinical governance oversight of infection prevention and control program
- legal and legislative framework
- requirements for the infection prevention and control program.

Local infection prevention and control documents are to align with the principles outlined in this Policy Directive and are consistent with the principles and practice outlined within the following NSW Health publications:

- Infection Prevention and Control Practice Handbook
- COVID-19 Infection Prevention and Control Manual
- Respiratory Protection Program Manual
- NSW Health Policy Directive Cleaning of the Healthcare Environment (PD2023_018).

The full Infection Prevention and Control in Healthcare Settings policy is available at:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_025

COMMUNITY SHARPS DISPOSAL BY AREA HEALTH SERVICES (PD2008_004)

PD2008_004 rescinds PD2005_262.

The Policy Directive should be read in conjunction with:
PD2017_013, Infection Prevention and Control Policy
PD2017_026, Clinical and Related Waste Management for Health Services
GL2017_024, Needle and Syringe Program

INTRODUCTION

The purpose of the Policy Directive is to clarify services to be provided at public hospitals for the disposal of used needles, syringes, and other community sharps resulting from the self-management of medical conditions by members of the public. The Policy Directive applies specifically to public hospitals controlled by an Area Health Service. Similar services must be provided at Area Health Service facilities authorised as outlets of the NSW Needle and Syringe Program regardless of whether the person requesting the disposal service is a client of the Needle and Syringe Program.

"Community sharps" are sharps that have been generated by non-clinical activities. This category includes any instruments or medical devices that have sharp points or edges capable of cutting, piercing or penetrating the skin (for example needles, syringes with needles or lancets), that are designed for such a purpose, and that have the potential to cause injury or infection. In practice the items for which disposal is most commonly requested are syringes, insulin pen needles and lancets used by people in the self-management of diabetes and other medical conditions. However, other items of a similar nature are within the scope of the Policy Directive, including syringes used by injecting drug users.

Ambulatory care in a community setting has become increasingly accepted as a preferred management approach for people with chronic disorders. As a consequence, the disposal of sharps generated in the self-management of these conditions has moved from the healthcare facility clinical waste stream into local communities where domestic waste and recycling services are not designed to accept them.

The inappropriate disposal of community sharps can have a significant impact on workplace health and safety in many non-clinical occupations, particularly in local government and the waste and recycling industries. In many areas of NSW the options available for the disposal of community sharps by people with diabetes and other medical conditions requiring self-injection do not meet current principles and practices for infection control.

While the peer reviewed literature indicates that the potential for transmission of a blood borne virus from an injury involving a community sharp is extremely low, sharps injuries also expose the recipient to the emotional trauma associated with the possibility of disease transmission. Media reporting of these incidents can encourage the perception that harm minimisation initiatives like the Needle and Syringe Program are responsible for all adverse events involving community sharps.

NSW Health works with a range of partner organisations to improve the management of community sharps. Initiatives include publication of *Community Sharps Management Guidelines for NSW Councils*, and development of an information and resource website at http://www.communitysharps.org.au A copy of the Guidelines can be downloaded from the website. The Guidelines promote the concept of "shared responsibility" for the safe management and disposal of community sharps by major stakeholders involved in the life cycle of this equipment, including Area Health Services.

ROLE OF AREA HEALTH SERVICES

It has been NSW Health policy since 1 October 2002 that a community sharps disposal service must be provided at all public hospitals and authorised outlets of the Needle and Syringe Program, with the cost to be met from existing Area Health Service budgets. A shared responsibility approach to community sharps management requires that all Area Health Services provide appropriate services to manage the environmental impact of

community sharps, including their ultimate disposal. Many public hospitals have well-established procedures in place to accept community sharps from the public for disposal at no charge. Such a service may represent the only disposal option consistent with current infection control principles and practices available in those locations where the local council has not yet implemented community sharps disposal arrangements.

Area Health Services have discretion to determine the most appropriate and cost-effective service in each case. To minimise the risk of occupational exposure of hospital staff to community sharps during disposal, one preferred model is to provide a secure disposal bin capable of accepting the most commonly used sizes of sharps containers in a readily accessible part of the hospital grounds. This model removes the necessity for hospital staff to handle sharps containers, allows direct and confidential disposal by community members, and enables 24-hour access. It also avoids any inconvenience to members of the public if a designated staff member is not available to assist them with disposal. While there is no regulation or standard in NSW that applies to the design and construction of community sharps bins, *Community Sharps Management Guidelines for NSW Councils* (page 40) provides design criteria for large public place disposal bins to address duty of care and occupational health and safety considerations.

There is no legislative or other requirement in NSW that individuals use a sharps container that conforms to an Australian Standard for the storage, transport or disposal of community sharps. To stipulate the use of such containers for community sharps disposal at public hospitals may act as a significant disincentive to community members to follow safe disposal practice and potentially places other members of the community at risk of injury from inappropriate disposal. A well-designed public hospital disposal service for community sharps that does not require staff involvement in the disposal process will address occupational health and safety risks potentially associated with this practice and will avoid the need to stipulate that only sharps containers that conform to an Australian Standard will be accepted for disposal.

It should be noted that there is no requirement to provide a replacement sharps container to members of the public who choose to use the disposal service.

MINIMUM SERVICE REQUIREMENTS

The minimum requirements for a community sharps disposal service at a public hospital or authorised outlet of the Needle and Syringe Program are as follows:

1. There must be no charge to access the disposal service.
2. There must be reasonable access at public hospitals in regard to the location of the disposal service and times when the service is available. Consideration should be given to ensuring that short-term parking is provided in close proximity to the disposal point at hospitals where traffic is heavy and/or parking facilities are limited.
3. Persons requesting a disposal service must not be required to provide information or documentation of a personal or medical nature.
4. The service must adequately address the occupational health and safety of staff and contractors, and public safety considerations.
5. Persons who are not clients of the Needle and Syringe Program may choose to attend a needle and syringe service, drug and alcohol service or similarly identified facility in order to obtain a disposal service but must not be required to do so.

An Area Health Service is not required to provide a disposal service for commercial generators of clinical waste/sharps waste, or local government authorities, but at its discretion the Area Health Service may agree to do so under such conditions as it considers appropriate.

Once community sharps have been accepted or aggregated at a public hospital or authorised outlet of the Needle and Syringe Program the needles, syringes, lancets and similar equipment are classified as clinical waste and must be managed in accordance with Policy Directive PD2005_132, *Waste Management Guidelines for Health Care Facilities*.

PROMOTION OF SAFE DISPOSAL

To encourage safe disposal behaviour, patients who generate community sharps should be provided with accurate and consistent information on the importance of appropriate disposal and the location of community sharps disposal facilities provided by the Area Health Service. Staff in contact with patients who generate community sharps should ensure that this information is provided at the commencement of treatment or service access, and is reinforced during subsequent contacts. Referral of patients to their local council for information on the location of other community sharps disposal facilities in their area is also appropriate.

To facilitate this process it is recommended that each Area Health Service establish a coordinating committee or working group consisting of representatives from services or programs that have contact with patients or clients who generate community sharps, or have responsibility for workplace safety or public health issues. Stakeholders with an involvement in community sharps management include diabetes educators, renal unit staff, community health nurses, infection control staff, Public Health Units, and the Needle and Syringe Program.

A useful model for this approach is the Safe Disposal Committee established by the HIV and Related Programs Unit at South Eastern Sydney Illawarra Area Health Service. This multi-disciplinary Committee has operated for a number of years and has collaborated with hospital administrators to facilitate the installation of public access community sharps bins at public hospitals. The Committee includes representatives from local councils and stakeholders such as Diabetes Australia-NSW as well as Area Health Service representatives and has been active in promoting the safe disposal of community sharps to Area Health Service staff and local communities.

Further advice on current service models and minimum standards of service provision can be obtained by contacting the Senior Project Officer, Community Sharps, Mr David Baker, by email at david.baker@hnehealth.nsw.gov.au

67(5/08)

COMMUNITY SHARPS MANAGEMENT (GL2017_023)

PURPOSE

The *Community Sharps Management Guidelines* have been developed to help NSW councils assess and manage risks and minimise harm associated with unsafe or inappropriate disposal of community sharps. Councils, Local Health Districts, government and some non-government organisations all have a role in providing an effective disposal infrastructure and in encouraging safe disposal.

These guidelines replace the *Community Sharps Management Guidelines for NSW Councils* (2004).

KEY PRINCIPLES

Sharps which are generated by community members through self-administered healthcare or recreation are called community sharps. This includes needles, syringes, lancets and prickers resulting from self-injection at private residences and self-injection in public places that are not placed in a designated sharps container provided by a business, commercial or community service activity.

Although no single strategy will be appropriate for all local government areas, the following general principles apply to all community sharps disposal services and infrastructure.

Public health - A focus on improving public health for the whole community.

Harm reduction - A focus on management activities that promote better health, social and economic outcomes for both the individual and the community.

Collaboration - Consultation with partners including all levels of government, local health and social services, business groups, waste management contractors, residents and other stakeholders .

301(20/12/17)

Capacity building - Providing appropriate resources and encouraging the community and other stakeholders to maintain sustainable local community sharps management activities.

USE OF THE GUIDELINE

These guidelines promote a shared responsibility model that encourages engagement by NSW councils of a range of stakeholders to coordinate and deliver a local community sharps management program. Potential partners include state government agencies, medical equipment manufacturers, waste and recycling contractors, local businesses, non-government organisations, and local/regional healthcare services.

To download the guidelines please go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_023

301(20/12/17)

NSW NEEDLE AND SYRINGE PROGRAM (GL2023_002)

GL2023_002 replaced GL2017_024.

GUIDELINE SUMMARY

The NSW Needle and Syringe Program is an evidence based public health program that aims to reduce the transmission of bloodborne viruses. It provides sterile injecting equipment, peer support and healthcare navigation to people who inject drugs.

KEY PRINCIPLES

The Guideline outlines Needle and Syringe Program approval and authorisation requirements, service models, operation requirements and workforce development opportunities. This Guideline is applicable to all services and agencies delivering the Needle and Syringe Program in NSW.

NSW Health recognises the important public health contribution made by the Needle and Syringe Program. The following supports the aim and objective of the Needle and Syringe Program:

- Distribution of sterile injecting equipment
- Distribution of condoms and lubricants
- Provision and promotion of safe disposal of used injecting equipment
- Development of a peer workforce
- Development and delivery of education and health promotion programs, including peer support programs
- Provision of information and patient referrals to other health and welfare services, including primary health care and psychosocial support
- Provision of take-home naloxone and other overdose prevention strategies
- Vaccinations
- Hepatitis C (HCV), Hepatitis B (HBV) and Human Immunodeficiency Virus (HIV) testing
- Contribution to blood borne virus and other research and evaluation activities
- Provision of brief interventions

These activities aim to address barriers to accessing sterile injecting equipment, increase health education and reduce the experiences of stigma and discrimination faced by people who inject drugs.

The NSW Needle and Syringe Program guidelines are available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_002

345(18/01/23)

MANAGEMENT OF PEOPLE WITH HIV WHO RISK INFECTING OTHERS
(PD2019_004)

PD2019_004 rescinds PD2009_023

PURPOSE

This Policy Directive sets out roles, responsibilities and communication pathways for service providers that manage people with HIV who risk infecting others. It provides a management framework that recognises education, support and access to HIV antiretroviral treatment as effective and sustainable responses. The policy also gives directions on how to escalate responses when required.

MANDATORY REQUIREMENTS

- Management of HIV transmission risk behaviours must be consistent with the NSW *Public Health Act 2010*, *NSW Public Health Regulation 2012,* and *Public Health Amendment (Review) Act 2017.*
- Where a person presents with behaviours that risk HIV transmission, professionals and health entities must deliver services consistent with the roles and responsibilities set out in section 2 and the management framework in section 4 of this policy.
- Referrals to Police must be directed through the Ministry of Health on advice from the Panel for management of people with HIV who risk infecting others (the Panel) or the Panel Chair (section 6).
- Communication with other jurisdictions on public health matters about a person with HIV must be via the Chief Health Officer (CHO).

IMPLEMENTATION

Clinicians are responsible for:

Diagnosing clinicians are responsible for ensuring that their patients with HIV have access to the NSW HIV support program and five key support services, including:

- Treatment
- Psychosocial support
- Counselling on prevention of infection to others
- Support for partner notification
- Linkage to services including specialist and community services.

Local Health Districts (LHDs) are responsible for:

- Assigning a point of contact for people under management level 1 or above who can coordinate appropriate services and resources available within the LHD
- Implementing an effective work health and safety management system for staff that seek out a client in the community in unknown environments. This must be in line with the policy directives on Work Health and Safety: Better Practice Procedures and Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach.

The LHD point of contact is responsible for:

- Identifying a clinical case coordinator where complex issues present
- Seeking advice from the Panel Chair and where the Panel's advice is sought:
    - submitting reports as requested
    - ensuring that an appropriate LHD representative is available to present on the case at Panel meetings
    - implementing the Panel's recommendations.
- Monitoring and ensuring the person's ongoing engagement in care (including referral to other LHDs and coordination of referral to other jurisdiction when required)
- Implementing public health orders
- Acting as the point of contact for the Panel and the Ministry staff.

CPH, NSW Ministry of Health and Health Protection NSW are responsible for:

- Providing secretariat support to the Panel and coordinating communication between the Panel and the CHO. The Panel secretariat is responsible for:
    - seeking reports from the clinician or other service provider responsible prior to the Panel meetings
    - providing Panel meeting minutes to the CHO
    - communicating all recommendations to the LHD and preparing and sending a letter from the CHO to the LHD Chief Executive (CE) in a timely way.
- Referring HIV transmission risk issues brought by the LHD to the attention of the Ministry to the Chair and ensuring formal feedback is provided to the LHD in a timely and supportive way
- Obtaining and communicating advice from Legal and Legislative Services Branch as required
- Collaborating and partnering with HIV organisations, state-wide services and government departments to activate State-wide resources to ensure transmission risk behaviours of a person with HIV are minimised
- Managing notifications of patients with HIV infection and referrals to the HSP.

The Panel is responsible for:
Providing expert advice (through collaboration with LHDs) to clinicians, LHDs and the CHO on strategies to minimise transmission risks.

Panel Chair is responsible for:

- Providing advice and other responses to queries raised on public health risk concerns
- Referring cases to the full Panel where additional advice is needed
- Raising urgent or complex cases about alleged risks with the CHO via the Director, Population Health Strategy & Performance, CPH or their delegate.

Management of people with HIV who risk infecting others – Procedures

1 BACKGROUND

This Policy Directive provides a health system framework for managing people with HIV who risk infecting others.

Under the NSW *Public Health Act 2010*, people with a sexually transmissible infection (STI) (including HIV) are required to take reasonable precautions against transmitting their infection to others. Reasonable precautions against the spread of HIV through sexual activities are:

- Having a suppressed HIV viral load (less than 200 copies/mL), usually resulting from being on antiretroviral therapy (ART) ; or
- Using a condom; or
- Seeking and receiving confirmation from a sexual partner that they are taking HIV pre-exposure prophylaxis (PrEP).

ART is readily available to people with HIV in NSW.

HIV can also be transmitted by sharing drug injecting equipment (contaminated needles, syringes and other injecting equipment, and drug solutions). HIV transmission among injecting drug users can be prevented by never sharing injecting equipment. Though rare in NSW, HIV can also be transmitted from women with HIV to their unborn infants during pregnancy.

There are occasions where a person aware of their HIV infection fails to take precautions against transmitting HIV to others. Reasons for this vary, but generally include contributing factors like substance use and/or misuse, mental health issues, intellectual/cognitive impairment, and psychosocial vulnerabilities (like homelessness and/or social isolation).

In most cases, Local Health Districts (LHDs) can address these contributing factors through holistic and multidisciplinary case management. Case management can include providing access to counselling, education, housing providers, and disability pensions. Supportive measures (for example shopping vouchers) can also be used to encourage a person to initiate and adhere to ART. NSW Health funds a range of services that the LHDs can access to fund appropriate supportive measures. These services and their contact details can be found in Section 7.

As HIV is a chronic illness, preventing transmission may require practices that must be maintained over a life time of the person with HIV. Directive strategies are difficult to sustain and may result in negative outcomes like mistrust of health workers.

1.1 Public health orders

The NSW *Public Health Act 2010* has mechanisms to direct a person's behaviours under certain circumstances using a public health order. A public health order may require a person to be tested, undergo treatment or be detained. Only in rare circumstances, and typically after exhausting other options, public health orders can be used to detain or require a person to take specific actions.

Further information on public health orders is in Section 4.3.

1.2 Public health risks

A person with HIV may pose public health risk if they engage in behaviours that do not consider HIV infection implications for others. It is unlikely that a single risk incident (for example, failing to adhere to ART during a short, exceptional circumstance) would be considered a public health risk. Single risk incident should be managed at a local level (see Section 4.1).

To assess whether there is a public health risk, the following needs to be considered:

- Whether the person's risk behaviour is current and likely to continue (risk behaviour may include: having a viral load of more than 200 copies/mL, or engaging in condomless sex or having sex with a partner not on PrEP and/or engaging in unsafe injecting practices
- The person's understanding of their HIV status and how their behaviour risks transmission of HIV to others
- Whether the person understands how they can prevent transmitting HIV
- Whether the person has access to reasonable precautions like access to ART, condoms and sterile needles and syringes
- The person's adherence to ART, engagement in care (including regular monitoring of HIV viral load)
- The person's cooperation and engagement with services in managing their transmission risk.

ROLES AND RESPONSIBILITIES

Person with HIV

A person with HIV is ultimately responsible for managing HIV transmission risks. If a person with HIV injects drugs, they are ultimately responsible for safe injecting practices.

There has been widespread education and information publicly available about HIV prevention through safe sex and injecting practices for many years.

If a person with HIV is known to be placing others at risk of infection, then collaborative efforts by health and other services (including Housing, Family and Community Services and non-government organisations) to support HIV treatment initiation and adherence may help address the risk of transmission.

Clinicians

Diagnosing clinicians (both specialists and general practitioners) are responsible for ensuring that their patients with HIV have access to the NSW HIV support program and five key support services, including:

1. Treatment
2. Psychosocial support
3. Counselling on prevention of infection to others
4. Support for partner notification
5. Linkage to services including specialist and community services.

This includes:

- Advising the person on their obligation under Section 79 of the NSW *Public Health Act 2010* to take reasonable precautions against spreading their HIV infection
- Monitoring engagement of the person with HIV with health services and following up where the person fails to engage or disengages from care
- Referring patients with complex care needs to specialist assessment and support, e.g., HIV community teams, AIDS Dementia and HIV Psychiatry Service (Adahps), NSW Partner Notification Service, and alcohol and mental health services (in accordance with the management framework (Section 4 of this Policy Directive)
- Referring patients to the Chair (for cases involving concerns about HIV transmission risks).

Local Health Districts

Local Health Districts (LHDs) are responsible for:

- Assigning a point of contact for people under management Level 1 or above (see Section 4) who can coordinate services and resources that are available and appropriate within the LHD for people who risk infecting others with HIV. The point of contact should be a senior health professional in the LHD who can liaise with the NSW Ministry of Health (the Ministry) and other service providers.

The LHD point of contact is responsible for:

- Identifying a clinical case coordinator where complex issues present
- Seeking advice from the Chair of the Panel for Management of People Who Risk Infecting Others (the Panel). The Panel consists of experts appointed by the Ministry to advise on complex HIV risk management issues (see Section 2.6 of this Policy Directive)
- Where the Panel's advice is sought:
    - submitting reports as requested
    - ensuring that an appropriate LHD representative (e.g. a clinical case coordinator or case coordinator) is available to present on the case at Panel meetings
    - implementing the Panel's recommendations.
- Monitoring and ensuring the person's ongoing engagement in care and
    - where the person relocates to another LHD, referring and ensuring linkage to a relevant service
    - consistent with National Guidelines for the Management of People with HIV Who Place Others at Risk, informing the Centre for Population Health (CPH, at the Ministry) if certain people under management relocate to another state or territory, to coordinate a formal communication from the Chief Health Officer (CHO) to another jurisdiction.
- Implementing an effective work health and safety management system for staff that seek out a client in the community in unknown environments. This must be in line with the Policy Directives on Work Health and Safety: Better Practice Procedures and Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach
- Implementing public health orders
- Acting as the point of contact for the Panel and the Ministry staff to liaise with about a person with HIV with risk behaviours in their LHD
- Following up on actions relevant to the LHD from Panel's recommendations (including following up on the implementation of the public health order).

At any stage, the LHD can contact the Chair for advice about management of a patient with HIV who may risk infecting others.

Centre for Population Health, NSW Ministry of Health and Health Protection NSW

The CPH and Health Protection NSW are responsible for:

- Providing secretariat support to the Panel and coordinating communication between the Panel and the CHO. The Panel secretariat is responsible for:
    - seeking reports from the clinician or other service provider responsible prior to the Panel meetings
    - providing Panel meeting minutes to the CHO. The minutes will include the Panel Chair's (the Chair) advice on the referrals received between regular Panel meetings and the Panel's deliberations and advice on cases under assessment or management
    - communicating all recommendations to the LHD and preparing and sending a letter from the CHO to the LHD Chief Executive (CE) in a timely way. This includes communicating key recommendations to the LHD point of contact informally prior to the letter from the CHO to the LHD CE.
- Referring HIV transmission risk issues brought by the LHD to the attention of the Ministry to the Chair and ensuring formal feedback is provided to the LHD in a timely and supportive way
- Obtaining and communicating advice from Legal and Legislative Services Branch as required
- Collaborating and partnering with other agencies to activate State-wide resources (e.g. from other NSW State agencies) to ensure transmission risk behaviours of a person with HIV are minimised
- Managing notifications of patients with HIV infection and referrals to the NSW HIV Support Program.

Panel for the management of people with HIV who risk infecting others

The Panel is responsible for:

- Providing expert advice (through collaboration with LHDs) to clinicians, LHDs and the CHO on strategies to minimise transmission risks. The Panel's membership and Terms of Reference are in Appendix 1.

Panel Chair

The Chair is appointed by the CHO and is responsible for:

- Providing advice and other responses to queries raised on public health risk concerns
- Referring cases to the full Panel where additional advice is needed
- Raising urgent or complex cases about alleged risks with the CHO via the Director, Population Health Strategy & Performance, CPH or their delegate.

The Chair's contact details are available at Appendix 1.

PRIVACY AND CONFIDENTIALITY

Information about a person's HIV status, testing or treatment is 'health information', and is regulated by the NSW *Health Records and Information Privacy Act 2002* and the NSW *Public Health Act 2010.*

LHDs, the Ministry, Health Protection NSW and all other service providers involved in the care of a person with HIV are responsible for maintaining the person's confidentiality and privacy.

Medical practitioners must not include a patient's name or address in a notification to the Secretary of the Ministry under Sections 54 or 55 of the NSW *Public Health Act 2010,* if the information relates to a person's HIV status. Under Section 56, a person who, in the course of providing a service, acquires information that another person has HIV, has been or is to be, or is required to be tested for HIV, must take all reasonable steps to prevent disclosure of that information. However, information about a person's HIV status may be disclosed:

- When the person consents to disclosure, or
- To a person involved in providing care, treatment or counselling to the person concerned, or
- To the Secretary of the Ministry, if a person has reasonable grounds to suspect that failure to disclose the information would likely present a risk to public health, or
- In connection with administration of the NSW *Public Health Act 2010* or the regulations, or
- For the purposes of legal proceedings arising from the NSW *Public Health Act 2010* or the regulations, including any report of those proceedings, or
- In accordance with a requirement imposed under the NSW *Ombudsman Act 1974,* or
- In circumstances prescribed by the regulations

Maximum penalty for breach of Section 56 is 100 penalty units or imprisonment for 6 months, or both.

LHDs should put in place reasonable measures to ensure that information about a person's HIV status is only disclosed in line with the above.

It is recommended that precautions be taken to ensure the person's identity remains confidential to services directly involved in the patient's management. Correspondence with services involved in the person's management should refer to the person using an alias or anonymous reference. If de-identifying using a 2x2 name of the patient, it should be first two letters of the last name, followed by first two letters of the first name, all capital letters. A person's name must be fully de-identified when there are only two letters in the person's names. De-identifying the person in correspondence relating to the person's management is important to guard against unintended disclosure to unauthorised third parties, e.g. as a result of accidentally misdirected emails, unauthorised access to emails, loss of files etc.

HIV information should not be disclosed to police except in response to a warrant or subpoena (noting that, if information has been provided to the Secretary of the Ministry under Part 4 or 5 of the NSW *Public Health Act 2010*, the Secretary of the Ministry cannot be compelled to disclose the information). If police request information about a person's HIV status or medical history in the context of an investigation of an allegation of intentional transmission of HIV, advice should be sought from the Ministry (CPH and Legal Branch).

Patient consent is required if a medical practitioner wishes to disclose a HIV positive patient's identity to the patient's sexual partner(s) or drug use contact(s). A signed consent is advisable in these circumstances. This does not limit the patient's attending medical practitioners' ability (in accordance with clause 39B of the *Public Health Regulation 2012)* to inform sexual partner(s) or drug contact(s) that they may be at risk of contracting HIV, without disclosing the HIV positive patient's identity. See Section 4.1.3.

For further information on privacy, see: Privacy Manual for Health Information at http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx

THE MANAGEMENT FRAMEWORK

The management framework for people with HIV who risk infecting others includes following levels:

Management level	Summary of case management
Local management	The client is managed by the treating clinician(s) who can obtain advice from the Chair as required.
Level 1 supported management	The client is managed by the treating clinician(s) with support from the Panel. The client may be issued with a letter of warning.
Level 2 public health order	The client is managed by the treating clinician(s) with support from the Panel. An authorised medical practitioner has issued the client with a public health order, placing conditions about their behaviour, treatment, health care, and/or supervision or requiring the client to be detained.

Each level is discussed in detail below.

Initial steps: counselling, education and support

The clinician is primarily responsible for a person's HIV health care. The clinician is responsible to provide (or refer) a person with HIV to support and counselling at the time of diagnosis. This includes counselling on public health responsibilities and safe sex and injecting practices.

If a person is alleged to be behaving in a way that endangers, or is likely to endanger public health, as a first step, the clinician should clarify the person's understanding of their public health responsibilities and provide counselling and education to support behavioural change.

In some cases, the clinician may refer the patient to an experienced sexual health/HIV counsellor for regular and intensive counselling.

The involvement of other service providers may also assist. Where possible and appropriate, a community organisation with peer group involvement or relevant cultural knowledge and/or translator services should be involved to advise or support appropriate behaviour by the person.

If the behaviours or other issues presenting are likely to result in management challenges, the clinician should refer the case to the Chair.

The Chair is responsible to advise and support the clinician to effectively manage risks. The clinician will need to create a supportive environment where health promoting messages are clearly and frequently reiterated and the consequences of behaviours that place others at risk are spelt out. The means of prevention (including for instance, condoms, sterile needles and syringes and information) should be readily and easily accessible, along with access to regular health checks, testing and ART. Where a patient does not have a sustained undetectable viral load, the clinician should regularly discuss the risk to new partners, their access to PrEP (long term) or post-exposure prohylaxis (short term) and any contacts that need follow up because of their HIV infection risk.

Case conferencing

A case conference is often useful in developing a comprehensive care plan for the person. The complex needs often arise from cognitive/behavioural and/or mental health issues.

Case conference should involve all local services engaged in the care of the person. Services that should be included are:

- Adahps or other outreach teams (depending on the person's place of residence) – to assess and manage the person's risk behaviours
- Where possible, the Public Health Unit/Sexual Health Service (as nominated by the LHD) – to facilitate the involvement of service directors in the case conference, particularly when underlying problems, such as drug, alcohol and mental health issues contribute to the risk behaviours
- Aboriginal health worker or Multicultural HIV and Hepatitis Service (MHAHS) to advise when cultural issues are present and consideration should be given to getting interpreter services when language barriers present.

This case conference should not replace case conferences which occur in the context of good multidisciplinary clinical care for patients with chronic illnesses. The purpose of this case conference is to discuss issues relevant to the HIV risk and risk management.

Contact tracing or partner notification

The diagnosing clinician (or a delegate under their direction) must ensure that contact tracing (also known as partner notification) of sexual and/or needle sharing partners is conducted in accordance with appropriate ethical and legal standards.

Further guidance on contact tracing can be found on https://stipu.nsw.gov.au/wp-content/uploads/GP-Contact-Tracing-Tool.pdf. Local sexual health services or the NSW Sexual Health InfoLink (SHIL) can also provide further guidance on partner notification. The NSW Sexual Health InfoLink can be contacted on 1800 451 624.

Seeking advice from the Chair

At any stage, LHDs and service providers can contact the Chair where there are complexities or the person of concern has risk behaviour despite LHD and/or clinician having given advice or taken other steps . The Chair can provide direct advice to the LHD, or may choose to seek advice from the Panel.

The Chair will consider a range of matters including the public health risk, credibility of the information, the person's competence or co-morbidities, steps taken by the local clinician/local service, involvement of appropriate services, and the likelihood that local actions may succeed.

Level 1: Supported management

Cases concerning current or ongoing HIV transmission risks can be referred to the Chair for advice.

If the Chair considers on the basis of the information available, that the person may need management with support from the Panel, then a meeting of the Panel will be convened to discuss the case.

As the Panel has an advisory role, even though a case may be accepted under Panel management, the LHD remains responsible for public health and clinical care/case management functions. This includes where cases are complex or need longer term management strategies.

The LHD point of contact and the CPH will support effective communication between the LHD and the Panel.

Letter of warning

The Panel may recommend sending a letter of warning to the person of concern.

The letter of warning's purpose is to ensure that the person is aware of their responsibilities and to prompt a change in risk behaviours. It will also outline the person's public health responsibility to take reasonable precautions, options for preventing HIV transmission, and other expectations that the person should respond to (e.g. participating in counselling, attending HIV clinical services).

The clinician, Clinical Nurse Consultant, or the Public Health Unit must deliver the letter of warning in person, with discussion to ensure that the person understands the content of the letter. If appropriate and necessary, an Aboriginal health worker or MHAHS should be involved to overcome language barriers.

The directions in the letter of warning remain valid for two years from its issue unless revoked earlier. The Panel must consider at its meeting whether the person is complying with the directions in the letter of warning and whether further actions are required.

Before a letter of warning can be issued, there needs to be evidence of the person knowingly placing another at risk of infection. The evidence may include detectable viral load, lack of engagement with services, and/or psychosocial factors (e.g. sex work, homelessness, mental health issues) that may instigate risk taking behaviours.

Panel's ongoing assessment

The Panel will consider the follow up reports on the person's management at each of its regular meetings.

Officers of the Ministry's Legal and Regulatory Services can provide advice on these issues. Approaches to Legal and Regulatory Services should be made via the CPH.

Discharge from supported management

The Panel can decide to either continue to monitor the person's management or discharge them from Panel support, depending on:

- Whether actions recommended by the Panel were implemented
- The effectiveness of the actions implemented
- Whether the risk behaviours have stopped or have been reasonably managed
- Whether there is continuing information or evidence that the person is endangering others
- An assessment of the likelihood that the person will continue to present transmission risks.

CPH will communicate the discharge of the person from the Panel support to the LHD point of contact in a timely manner.

Level 2: Public health order

A public health order under the NSW *Public Health Act 2010* should be considered on a case-by-case basis. It should only be considered when such an order is judged the most effective way to prevent risk to public health, and where all other management options have been unsuccessful.

Where the Panel recommends that a public health order is issued, the Chair should verbally advise the CHO without delay, in consultation with the CPH, Health Protection NSW and Legal Branch. The LHD point of contact and Public Health Unit Director or delegate should meet to provide advice on public health orders if required.

A public health order can be modified on the subsequent recommendation of the Panel.

A public health order may require the person to do one or more of the following:

a) To refrain from specified conduct
b) To undergo specified treatment (including ARTs)
c) To undergo counselling by one or more specified persons or by one or more persons belonging to a specified class of persons
d) To submit to the supervision of one or more specified persons or of one or more persons belonging to a specified class of persons
e) To undergo specified treatment at a specified place.

A public health order may also require a person with HIV to be detained at a specified place for the duration of the public health order, and specify what the person is required to do during the detention. A public health order detaining a person on the basis that their HIV status and sexual activity presents a genuine risk to public health expires automatically at the end of 3-business days after the person is served with the order. The 3-day detention period can possibly be extended if an application is made to the NSW Civil and Administrative Tribunal (NCAT) to extend the detention period, and the person under the order is served with copies of the application to NCAT. NCAT will then be required to hold a hearing into the reasons for the detention, and has the power to confirm the public health order, vary the public health order and confirm it as varied or revoke the order under Section 64 of the NSW *Public Health Act 2010*.

Making the public health order

Authorised medical practitioners may make public health orders under Section 62 of the NSW *Public Health Act 2010.* Authorised medical practitioners are: the CHO or a registered medical practitioner authorised by the Secretary of the Ministry to exercise the functions of an authorised medical practitioner under Division 4 of the NSW *Public Health Act 2010.*

An authorised medical practitioner must take into account the principle that restriction of the liberty of the person should be imposed only if such restriction is the most effective way to prevent a real risk to the public. An authorised medical practitioner may issue a public health order if satisfied on reasonable grounds that a person:

- Has HIV; and
- Is behaving in a way that poses a risk to public health (e.g. has a detectable viral load and engages in condomless sex or has sex with a partner not on PrEP, and/or engages in unsafe injecting practices).

The public health order should specify what the person with HIV is required to do and the duration of the order.

The LHD point of contact has responsibility for implementing a public health order and advising the CHO that it has been served to the person.

Key decisions and record of decisions

The Chair must record the advice provided to LHDs, clinicians and others in a file note, and report to the Panel on advice provided to LHDs, clinicians and others at the Panel meetings.

The Chair is responsible for ensuring that the rationale, decisions and recommendations are made both at the Panel meeting and outside the meetings. The recording of these will normally be made by the Panel secretariat in the form of confidential minutes, which are reviewed and approved by the Chair.

Accurate record keeping is required in all instances.

CUSTODIAL SETTINGS

If a person under the Panel's management is remanded in custody by NSW police (while awaiting a court hearing or following a court sentencing), the Panel will consider whether they remain under the management or be discharged, on a case by case basis.

Corrective Services NSW is responsible for securing the person and the Justice & Forensic Mental Health Network (JH&FMHN) is responsible for the healthcare of the person.

The Panel may provide advice to JH&FMHN having consideration for:

- The inmate's confidentiality, legal and safety issues
- The level of negotiation required with the JH&FMHN, Corrective Services NSW and/or Juvenile Justice NSW.

Where an inmate has been known to the Panel, it is important to ensure planning occurs prior to their release from the prison. JH&FMHN, in conjunction with the CPH must inform the LHD where the person is likely to live after release. JH&FMHN and the LHD should follow a discharge plan to ensure that the person is not lost to care. The inmate should be managed under the Persons in Custody HIV Referral Project, a joint initiative between Adahps, JH&FMN and the HIV community teams that connect inmates who are HIV positive to an appropriate service in the area where they will live on release.

REFERRAL TO NSW POLICE

Intentionally or recklessly infecting a person with HIV is a serious criminal offence under the NSW *Crimes Act 1900*.

The LHD should contact the CPH through the Panel secretariat:

- Immediately where there are clear grounds for a charge involving intentionally causing serious bodily harm
- After further examination and/or management strategies, of unwillingness to alter behaviour that may recklessly or negligently endanger or cause serious harm.

Any concerns or evidence of this type of behaviour (e.g. through partner notification) or of breaches of a public health order should be referred to the Ministry for consideration and appropriate action. This includes possible referral to the NSW Police Force, which must be done by the Ministry on advice from the Panel or the Chair. Charges for intentionally infecting others with HIV trigger Level 1 management under the Panel.

Members of the public, who believe they may have been intentionally or recklessly infected with HIV, may choose to report to the police directly.

USEFUL CONTACTS

Panel Chair
The Chair of the Panel is the Director of Sydney Sexual Health Centre. The Sydney Sexual Health Centre can be contacted on 9382 7440.

In the event of absence of the Chair, contact the head of Sexually Transmissible Infections Programs Unit (STIPU), Sydney Sexual Health Centre.

Panel Secretariat
For information on Panel referrals and advice on this Policy Directive contact: MOH-BBVSTI@health.nsw.gov.au or 9391 9214.

Sexual Health Clinics

A list of Sexual Health Clinics and their contact details can be found on http://www.health.nsw.gov.au/sexualhealth/Pages/default.aspx or call the NSW.

NSW Sexual Health InfoLink (SHIL)

For guidance on partner notification, contact SHIL on 1800 451 624.

The HIV Support Program (HSP) and 5 key support services

Any doctor can self-request support from the HSP. Contact the NSW Health Communicable Disease Branch on 02 9391 9195 and ask to speak with an HIV Surveillance Officer. HSP coordinators strive to contact diagnosing doctors before the doctor gives an HIV diagnosis to a patient but this is not always possible.

Support services

- **Aboriginal Health & Medical Research Council –** Council to represent, support and advocate for Aboriginal communities on Aboriginal health.
  Contact: 02 9212 4777, ahmrc@ahmrc.org.au, http://www.ahmrc.org.au/

- **ACON –** Provides peer focused support to end HIV transmission among gay and homosexually active men and promotes lifelong health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people.
  Contact: 02 9206 2000, acon@acon.org.au, https://www.acon.org.au/

- **Bobby Goldsmith Foundation (BGF) –** Provides a range of support and interventions that address key determinants of poor health outcomes for people living with HIV. BGF provides direct financial and practical assistance, emotional support, financial counselling, housing, study and employment support to the most vulnerable and disadvantaged people living with HIV.
  Contact: 02 9283 8666

- **Multicultural HIV and Hepatitis Service (MHAHS) –** Organisation working with culturally and linguistically diverse (CALD) communities in NSW to improve health and wellbeing in relation to HIV, hepatitis B and hepatitis C.
  Contact: 02 9515 1234, info@mhahs.org.au, http://mhahs.org.au/index.php/en/

- **NSW Users and AIDS Association (NUAA) –** A community-based organisation governed, staffed and led by people with lived experience of drug use that provides education, practical support, information and advocacy to users of illicit drugs, their friends, and allies.
  Contact: 02 8354 7300, nuaa@nuaa.org.au, https://nuaa.org.au/

- **Positive Life NSW –** Promotes a positive image of people living with and affected by HIV with the aim of eliminating prejudice, isolation, stigma and discrimination.
  Contact: 02 9206 2177, contact@positivelife.org.au, www.positivelife.org.au

- **PozHet –** Organisation located and managed day-to-day through the Community HIV Service in the Sydney LHD to promote the health and wellbeing of heterosexual people with HIV, their partners and family across NSW through community education, peer support and linkage to health and social services.
  Contact: 1800 812 404, pozhet@pozhet.org.au, https://pozhet.org.au/

- **Sex Workers Outreach Project (SWOP) –** A peer education sex worker organisation focused on HIV, STI and hepatitis C prevention, education and health promotion for sex workers in NSW.
  Contact: 02 9206 2166, swopconnect@swop.org.au, https://swop.org.au/

Organisations to support management of people with HIV related cognitive impairment, multiple comorbidities and complex psychosocial issues

- **Adahps** – AIDS Dementia and HIV Psychiatry Services is a specialist state-wide tertiary outreach service for people with HIV related cognitive impairment, multiple comorbidities and complex psychosocial issues.
  Contact: 02 9382 8600, adahps@health.nsw.gov.au,www.health.nsw.gov.au/adahps

- **South East Sydney LHD Community HIV Outreach Team –** A multidisciplinary team including nurses, dieticians, social workers and an occupational therapist that provides health care services for people living with, or closely affected by HIV across the South East Sydney LHD and Illawarra Shoalhaven LHD.

  Contact: 02 9382 8666, SESLHD-HIVCommunityTeam@health.nsw.gov.au,
  http://www.seslhd.health.nsw.gov.au/HIV_Outreach_Team/aboutus.asp

- **South Western Sydney LHD HIV Outreach Team –** Provides multidisciplinary care for people living with HIV in the South-Western Sydney LHD. The team includes specialist physicians, psychiatrist, and health professionals in the areas of nursing, social work, and dietetics.
  Contact: 02 8738 8372, www.swslhd.health.nsw.gov.au/liverpool/immunology/HIV_AIDS.html

- **Sydney LHD Community HIV Service (Positive Central) –** Provides specialist allied health case management support for people with HIV, including occupational therapy, social work, physiotherapy and dietetics.
  Contact: 02 9395 0444, www.slhd.nsw.gov.au/communityhealth/HIVCommunity/services.html

USEFUL LINKS

National Guidelines for the Management of People with HIV Who Place Others at Risk

www.health.gov.au/internet/main/publishing.nsf/Content/B4D7BD21A78763EDCA257BF0001F951B/$File/hiv-at-risk.pdf

NSW Public Health Act 2010
https://www.legislation.nsw.gov.au/#/view/act/2010/127/full

STI contact tracing tool for general practice
https://stipu.nsw.gov.au/wp-content/uploads/GP-Contact-Tracing-Tool.pdf

APPENDIX: PANEL TERMS OF REFERENCE

The role of the Panel

The Panel provides expert advice to the CHO, LHDs, and specialist clinicians on managing people who risk transmitting HIV to others.

The person's LHD of residence is responsible for coordinating management strategies recommended by the Panel.

Panel membership

Permanent members of the Panel include:

- Chair, an individual with extensive experience in the clinical management of HIV and sexually transmissible infections
- A professional with expertise in the management of people with HIV and complex needs
- A representative of HIV community organisations
- A nominee of the NSW Public Health Directors network
- A professional ethicist.

The Director, Health Protection NSW or their nominee and Director Population Health Strategy & Performance, CPH or their nominee also hold Panel membership. Their role is to advise on NSW health policy, the relevant legislation and service options that may assist in resolving risks and in implementing the Panel's recommendations.

The CHO appoints Panel members and the Chair.

Panel membership is reviewed every two years.

The Chair and all participants in Panel meetings are indemnified by the NSW Treasury Managed Fund in relation to advice provided in the course of the work of the Panel.

The Panel secretariat is an officer nominated by the Executive Director, CPH.

Standards of conduct and conflicts of interest
Panel members must conduct themselves in a professional manner and abide by the NSW Health Code of Conduct while performing duties as part of the Panel.

Members must not disclose official information or documents acquired as a result of their membership, other than as required by law, or when the member has been given proper authority to do so.

Members must declare any actual or perceived conflicts of interest to the Committee Chair as they become known to the member. Conflicts of interests reported by members will be managed in accordance with Conflicts of Interest policy.

Context for the Panel
The Panel supports a well-established framework for managing people with HIV whose behaviours present a public health risk. The framework is based on the principle that most people with HIV are motivated to avoid infecting others and will respond to counselling, education, and access to resources for the prevention of transmission, and services supporting the specific needs of individuals.

The framework allows for a variety of management strategies proportionate to the risk of transmission. Less restrictive strategies will generally be the most sustainable and effective in the long term. To date, application of the framework has effectively stabilised behaviours, therefore averting the need for public health orders in most cases.

Panel Meetings
The Panel meets at least every four months, with additional meetings as needed. Panel members are expected to attend Panel meetings with teleconferencing reserved for exceptional circumstances.

At a minimum, the Panel will receive a report from the Chair on the activities and queries she received since the previous meeting, as well as the advice she provided and reports on progress of those being managed by LHDs with advice from the Panel.

Where the Chair initially assesses a new case as being likely to require intensive management, the person's clinician or referring LHD officer will complete an initial report and will present the case when initially discussed by the Panel. Where a case is under Levels 1 or 2 Panel Management, the LHD will nominate a case coordinator. The case coordinator will ensure that official reports are updated and submitted to the Panel when requested by the Secretariat.

The Chair will invite the clinician or case coordinator to Panel meetings to present on the case. The Chair may invite additional experts to contribute to the Panel's deliberations. Where a case remains under Level 1 management because of pending legal issues and there is no identified risk of transmission the clinician/case coordinator may not need to participate.

The Secretariat is responsible for coordinating the submission of Panel reports and maintaining minutes of the meeting. Minutes will be reviewed and approved by the Chair.

CPH will provide a summary of agreed actions to Panel members immediately after meetings, communicate about relevant actions that need follow up, and monitor implementation of the actions between meetings.

HIV, HEPATITIS B AND HEPATITIS C – MANAGEMENT OF HEALTH CARE WORKERS POTENTIALLY EXPOSED (PD2017_010)

PD2017_010 rescinds PD2017_009, PD2005_311

PURPOSE

Human immunodeficiency virus (HIV), hepatitis B and hepatitis C may be transmitted by significant percutaneous or mucosal exposure to infective blood or other infective body substances. Occupational exposure is defined as an incident that occurs during the course of a person's employment and involves direct contact with blood or other body substances. Such exposures may put the person at risk of acquiring a blood borne virus infection. The purpose of this Policy Directive is to assist Health Services to appropriately assess and manage a health care worker following an occupational exposure in order to prevent disease transmission.

MANDATORY REQUIREMENTS

All health facilities within the NSW public health system are required to implement this Policy Directive. It is also recommended that licensed private health care facilities have regard to this Policy Directive.

Facilities must ensure that:

- An efficient local system is established for reporting and managing potential exposures of HCWs (including non-LHD, non-hospital based health staff or volunteers) to blood borne viruses
- HCWs (including non-LHD, non-hospital based health staff or volunteers) and source patients have access to blood borne virus testing, as appropriate, following an occupational exposure
- Confidentiality is maintained for all testing and reporting relating to occupational exposures
- All staff are aware of whom to contact for advice regarding occupational exposures
- Expert advice is available to all HCWs (including non-LHD, non-hospital based health staff or volunteers) 24 hours a day following a potential BBV occupational exposure to enable rapid assessment and, if needed, timely administration of prophylaxis
- All occupational exposures are reported to SafeWork NSW as required under the *Work Health and Safety Act* (s35 and 36) and *Work Health and Safety Regulation* (cl699) (Refer to SafeWork NSW Factsheet http://www.safework.nsw.gov.au/media/publications/health-and-safety/when-to-notify-blood,-body-fluid-and-needlestick-exposure-incidents)
- HCWs are able to obtain the support to which they are entitled, including access to an Employee Assistance Program or workers compensation if appropriate as documented in NSW Policy Directive *Employee Assistance Program* (PD2016_045)
- The local Public Health Unit is notified in the rare event that hepatitis B or hepatitis C is transmitted from a patient to a health care worker.

Health care workers must ensure that:

- All exposures to blood and body substances are reported as per local protocols.

IMPLEMENTATION

Sections 2 to 5 describe the procedures to be followed by health care workers and health facilities in the event that a health care worker is potentially exposed to a blood borne virus following an occupational exposure.

1. BACKGROUND

1.1 About this document

Human immunodeficiency virus (HIV), hepatitis B and hepatitis C may be transmitted by significant percutaneous or mucosal exposure to infective blood or other infective body substances. Occupational exposure is defined as an incident that occurs during the course of a person's employment and involves direct contact with blood or other body substances. Such exposures may put the person at risk of acquiring a blood borne virus infection.

Adherence to infection prevention and control practices as outlined in the current version of the NSW *Infection Control Policy* remains the first line of protection for health care workers (HCWs) against occupational exposure to HIV, hepatitis B and hepatitis C. The policy and guidelines for the NSW Health Service on prevention of sharps injuries are documented in the NSW Policy Directive *Sharps Injuries – Prevention in the NSW Public Health System* (PD2007_052). The current version of the NSW Policy Directive *Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases* mandates that health staff directly involved in patient care and/or the handling of human tissue, blood or body fluids complete the full course of hepatitis B vaccination and provide their post vaccination serology result.

This policy directive outlines the procedures that should be followed in the event of an occupational exposure including:

- The immediate care to be taken by the exposed HCW
- An assessment of the risk of blood borne virus transmission
- Management of the exposed HCW including blood borne virus testing and post exposure prophylaxis.

1.2 Key abbreviations and definitions

Appropriately skilled officer – means a medical practitioner or nurse with expertise in the assessment of the risk of blood borne virus transmission and the management of the exposed HCW following an occupational exposure

anti-HBs – antibody to hepatitis B surface antigen

BBV – blood borne virus. Refers to HIV, hepatitis B and hepatitis C viruses.

HBV – hepatitis B virus

HBIG – hepatitis B immunoglobulin

HBsAg – hepatitis B surface antigen

HCW – health care worker. Refers to all persons working in healthcare settings who have the potential for exposure to infectious/potentially infectious body fluids. This also includes non-LHD, non-hospital based health staff and volunteers.

HCV – hepatitis C virus

HIV – human immunodeficiency virus

PCR – polymerase chain reaction

PEP – post exposure prophylaxis

Source - person from whom blood or body fluids originated

Window period – refers to the time after a person has been exposed and is the maximum time it takes for a test to give an accurate result

Legal and legislative framework

Health Services have obligations under the *Work Health and Safety Act* 2011 (NSW) and the *Public Health Act* 2010 (NSW) and their associated regulations.

2 IMMEDIATE CARE OF THE EXPOSED HEALTH CARE WORKER

After exposure to blood or other body substances the exposed HCW should as soon as possible do the following:

- Wash the exposure site with soap and water
- Undertake appropriate care of any wound(s)
- If eyes are contaminated then rinse them, while they are open, gently but thoroughly with water or normal saline
- If blood or other body substances get in the mouth, spit them out and rinse the mouth with water several times
- If clothing is contaminated remove clothing and shower if necessary
- Inform their line manager so they can immediately be relieved from duty and notify the appropriately skilled officer who is designated to conduct an urgent risk assessment on potentially exposed staff (as per local reporting procedures) to ensure that necessary further action is undertaken.

Sections 2 to 5 outline the procedures to be followed by health care workers and health facilities following an occupational exposure. Refer to Appendix A for a summary of these procedures and Appendix B for a summary of recommended laboratory testing.

RISK ASSESSMENT OF THE EXPOSURE

In the event of an occupational exposure, appropriately skilled officer/s should conduct a risk assessment immediately. The first step in the risk assessment is to establish the type of injury (see Table 1). Following this, consideration should be given to the body fluid involved (see Table 2).

Table 1: Risk of transmission of blood borne viruses from an infectious bodily fluid, by injury type (based on UK guidelines[1])

Level of risk	Injury type
Higher risk injury	• Deep percutaneous injury • Visible blood on sharps • Needle used on source's blood vessels
Lower risk injury	• Superficial injury, exposure through broken skin, mucosal exposure (usually splashes to eye or mouth) • Old discarded sharps • No visible blood on sharps • Needle not used on blood vessels e.g. suturing, subcutaneous injection needles
Injury with no risk	• Skin not breached • Contact of body fluid with intact skin • Needle (or other sharp object) not used on a patient before injury

Table 2: Body fluids and risk for blood borne virus transmission (based on UK guidelines[1])

Level of risk	Body fluid
Infectious (good evidence of BBV transmission following occupational exposure)	• Blood • Visibly bloody body fluids
Potentially infectious (risk of BBV transmission following occupational exposure unknown)	(In alphabetical order): • Amniotic fluid • Cerebrospinal fluid • Human breast milk • Pericardial fluid • Peritoneal fluid • Pleural fluid • Saliva in association with dentistry (likely to be contaminated with blood even when not visibly so) • Semen • Synovial fluid • Tissue fluid from burns or skin lesions • Vaginal secretions
Not infectious (unless visibly blood stained)	• Nasal secretions • Saliva (non-dentistry associated) • Sputum • Stool • Sweat • Tears • Urine • Vomit

Where the exposed HCW is uncertain about actions to be taken, the Blood and Body Fluid Exposure Phoneline (formerly the NSW Needlestick Hotline) may assist. The Blood and Body Fluid Exposure Phoneline is an information, support and referral service for NSW based health care workers who sustain needlestick injuries and other blood/body fluid exposures during the course of their work. The line is answered by an on-call nurse 7 days a week from 7am to 11pm and can be contacted on free call 1800 804 823 within NSW. The Exposure Phoneline is not a reporting or surveillance service.

4 MANAGEMENT OF EXPOSURES WITH NO RISK OF BLOOD BORNE VIRUS TRANSMISSION

Occupational exposures are not considered to have the potential for blood borne virus transmission if **either** the injury is classified as no risk (Table 1) **or** the body fluid is not infectious (Table 2). For such exposures, no further action with respect to the health worker is required other than an opportunistic assessment of his/her protection against hepatitis B in accordance with the current NSW Policy Directive *Occupational assessment, screening and vaccination against specified infectious diseases*. Post exposure prophylaxis (PEP) is not indicated and testing of the source patient is not required. Such workers should be advised that the potential side effects and toxicity of taking HIV PEP outweigh the negligible risk of transmission posed by this exposure regardless of the HIV status of the source patient. No HCV or HIV testing of the exposed HCW is required.

A risk assessment of the incident should be conducted and local documentation procedures should be followed after each potential exposure.

MANAGEMENT OF EXPOSURES WITH POTENTIAL FOR BLOOD BORNE VIRUS TRANSMISSION

An occupational exposure has the potential for blood borne virus (BBV) transmission if the injury carries a risk (see table 1) **and** the body fluid is infectious/potentially infectious (see table 2). Following all such exposures a risk assessment of the incident should be conducted.

Post exposure prophylaxis

Post exposure prophylaxis (PEP) is available following exposure to HIV and hepatitis B. It is recommended for all higher risk injuries involving an infectious/potentially infectious body fluid. It should be considered for lower risk injuries involving an infectious/potentially infectious body fluid (see Tables 1 and 2).

Greater efficacy is achieved the earlier prophylaxis is administered (ideally within 1-2 hours of exposure). The initiation of PEP should not be delayed while awaiting laboratory testing of either the source patient or the health care worker. The continuation of PEP should be reconsidered once laboratory results become available. Further information on PEP is found in section 5.2.3 (for HIV) and 5.2.4 (for HBV). Prophylaxis can be commenced up to 72 hours post exposure.

Risk assessment of the source patient

Following occupational exposures that carry a risk of BBV transmission, officer/s conducting the risk assessment should seek information on the BBV status of the source patient as soon as is practicable.

If the blood borne virus status of the source patient at the time of the incident is unknown, the staff conducting the risk assessment should arrange for the source patient to be tested as soon as practicable for HIV, HBV and HCV infection (refer to Table 3). Results of source testing will better inform the exposed HCW about the risk of transmission and where PEP has been initiated, inform the need for continuation. Informed consent for testing must be obtained from the source patient. The exposed HCW should not approach the source patient for consent. If the patient does not provide consent, testing cannot occur. Consent should also be sought for the results of testing to be provided to the exposed HCW.

Occupational exposures occurring during autopsies should be managed as set out in section 5.2.2.

Note that testing of the source patient for HBV infection is not required if the exposed HCW has previous documented evidence of immunity to hepatitis B (anti-HBs level ≥10 mIU/mL at any time or HBcAb positive). Viral load should be measured for source patients who are known, or discovered, to be infected with HIV, HCV or HBV. The source should be offered immediate referral to a specialist service if a previously undiagnosed blood borne virus is detected.

Table 3: Recommended testing of source patient [#]

- Combined HIV antigen and antibody immunoassay (fourth generation HIV test)
- Hepatitis B surface antigen (not required if HCW has hepatitis B immunity)
- Hepatitis C antibody*

[#] Viral load should be measured for source patients who are known, or discovered, to be infected with HIV, HCV or HBV

*Consider qualitative hepatitis C RNA testing if individual is at risk of hepatitis C infection as may be antibody negative in acute infection and remain negative for up to 12 months if immunocompromised.

Source potentially in the window period

If the source patient tests negative for BBV infection but reports a recent (within previous three months for HIV or six months for HBV and HCV) risk behaviour that places them at high risk for infection, he/she should be advised to seek medical attention if they develop signs and/or symptoms of primary infection. For their own health benefit, they should also be advised to undergo testing for that BBV six weeks and 12 weeks after the exposure. If the source is at risk of a recent hepatitis B or C infection final tests should be done at 24 weeks after exposure.

Follow up and documentation of source testing is not required by staff managing the occupational exposure as it will not influence the care of the exposed HCW (due to timing of results). Until such time as infection can be excluded in the source, the exposed HCW should be managed as for exposure to a positive source.

The risk assessment of the source patient is outlined in Table 4.

Table 4: Risk assessment of source patient (based on UK guidelines[1])

Level of risk	Source
Higher risk source	• Known to be infected with one or more blood borne viruses (viral load and treatment status unknown) • Known to have a detectable viral load for one or more blood viruses • Unknown viral load but known to have advanced or untreated blood borne infection • Blood borne virus status unknown and known risk factors*
Lower risk source	• Infected with a blood borne virus but known to have a fully supressed viral load • Unknown viral load but receiving long term antiviral treatment for blood borne virus with good adherence and known to be stable • Blood tests at/near to the time of the incident were negative for all three blood borne viruses but source reports ongoing risk factors for blood borne viruses • Blood borne virus status unknown but had no known risk factors for such viruses
Source with minimal or no risk	• Recent blood test that was negative for all three blood borne viruses and no recent risk behaviours reported

* Example of risk factor may include intravenous drug use, men who have sex with men, origin or unprotected sexual intercourse with a sexual partner from high prevalence area for either HIV infection, or hepatitis B or hepatitis C.

Source negative for HIV, HBV and HCV

In the event that the source undergoes testing and is found to be negative for HIV, HBV and HCV and does not report recent behaviour that may place them at risk of a blood borne virus then no further action is required. PEP, if commenced, should be discontinued. If there is reason to suspect the self-reported risk history of the source may unreliable or incomplete, the exposed HCW should be managed as per exposure to a positive source (refer to sections 5.2.3 to 5.2.5).

Source with unknown infectious status and source unable to be tested

If the status of the source is not known then the risk of the source being positive for HIV, HBV and HCV must be assessed from the available information relating to risk factors known to be associated with BBVs (e.g. intravenous drug use, male homosexual sex and origin or sexual partner from a high prevalence area). If there is a risk of the source being infected with HIV, HBV or HCV then the exposed HCW should be managed as per exposure to a positive source (refer to sections 5.2.3 to 5.2.5).

Source positive or potentially positive for HIV

Risk of HIV transmission from positive source patient

The overall risk of acquiring HIV infection following occupational exposure to HIV is low. The average risk of HIV transmission (without prophylaxis) after a percutaneous exposure to HIV infected blood has been estimated to be 0.3% (95% confidence interval (CI): 0.2-0.5%). [2] The risk of seroconversion following mucous membrane exposure is estimated to be 0.09% (95 % CI: 0.006%-0.5%) and the risk following non-intact skin exposure is estimated to be even lower. [2]

A case control study conducted by the US Centers for Disease Control and Prevention showed that significant risk factors for HIV infection were deep injury (odds ratio (OR) = 15, 95% CI: 6.0-41), injury with a device that was visibly contaminated with the source patient's blood (OR= 6.2, 95% CI: 2.2-21), a procedure involving a needle placed in the source patient's artery or vein (OR =4.3, 95% CI 1.7-12), and exposure to a source patient who died of the acquired immunodeficiency syndrome within two months afterward (OR=5.6; 95 %CI: 2.0-16)[3].

There have been no confirmed cases of HIV infection in a HCW following an occupational exposure in NSW since 1994 and nationally since 2002. Only one confirmed case of occupational HIV acquisition (involving a laboratory technician working with a live HIV culture) has been reported in the US since 1999[4]. There has only been one other case report of occupational HIV transmission in the developed world published since 2005. In this instance, a nurse acquired HIV following a needle stick injury from a patient (not previously known to have HIV) with a high viral load[5]. Due to delayed reporting of the incident, PEP was not given. Table 5 shows a summary of the occupational exposure registry reviews published in the international literature since 2005.

Table 5: Evidence of HIV transmission following occupational exposure

Country	Time period	No. of HCW exposures to HIV	No. HIV sero-conversions (rate)	Notes
Australia[6]	2000-2003	13	0 (0%)	Includes percutaneous and mucous membrane exposures. All given PEP
Brazil[7]	1997-2009	80	0 (0%)	Includes only percutaneous injuries. No information provided on PEP
Denmark[8]	1999–2012	276	0 (0%)	Includes percutaneous and mucous membrane exposures. All given PEP
Germany[9]	2010-2012	51	0 (0%)	Includes only percutaneous injuries. PEP (3 drugs, mean time to start 75 mins > exposure) given to 35/51 and for other 16 cases the source patient was known to have a viral load <20 copies/mL at time of incident.
Netherlands[10]	2003-2010	60	0 (0%)	Includes only percutaneous injuries. No information provided on PEP
Thailand[11]	1996–2014	84	0 (0%)	Includes percutaneous, mucous membrane and non-intact skin exposures. All offered PEP, completed in 62/84 instances.
United Kingdom[12]	2004-2013	1478	0 (0%)	Includes percutaneous, mucous membrane and non-intact skin exposures. 1135 (77%) given PEP.

Post exposure prophylaxis (PEP)

Based on evidence from animal models and what is known about primary HIV infection, there is a window of opportunity following exposure to HIV, during which antiviral medication may prevent infection. However, the evidence for efficacy of PEP in preventing HIV acquisition is limited[13,14]. A small US case-control study of HIV seroconversion in HCWs after percutaneous exposure published in 1997 provided the first evidence in humans that PEP seemed to be protective against infection[3]. This study found that zidovudine PEP was associated with an 81% reduction in the odds of infection after adjustment for relevant exposure risk factors. There have been 24 reports of PEP failure following occupational needle stick exposures in the literature[15]. In over three quarters of these instances, zidovudine only was used; only six instances of PEP failure in the context of occupational needle stick injury have been reported with multi-drug regimens with three of these occurring after 1999. Factors that may have contributed to the failure of the combination drug PEP include drug resistance (in 3 cases the HCW was found to be infected with a strain resistant to the PEP regimen), exposure to a high HIV viral load and delayed initiation of PEP.

Multi-drug regimens are now prescribed to prevent HIV infection following exposure. However, there is no definitive evidence to support a two versus a three-drug regimen. Instead, the additional benefit of a third drug must be weighed against the cost and potential harms.

While newer HIV antiretrovirals are less toxic and better tolerated than the older HIV drugs, adverse effects still occur. In addition, serious drug interactions can occur when antiretroviral agents are used with certain other drugs. More commonly reported side effects include nausea, vomiting, diarrhoea and fatigue. Rare, but important side effects of tenofovir include acute renal failure and proximal renal tubolopathy (Fanconi's syndrome). There is a small risk of rhabdomyolysis with raltegravir.

The need for HIV PEP depends on an assessment of the risk of transmission and consideration of the potential adverse effects. Where possible, information concerning the source's stage of HIV infection, viral load, resistance testing and history of therapy and medication adherence should be ascertained so that the most appropriate therapy and counselling can be offered. While the evidence supports a significantly lower risk of HIV transmission following sexual exposure to a source with an undetectable viral load, such evidence does not exist for occupational exposures. While it is assumed there is also an extremely low risk of HIV transmission, it is still reasonable for a healthcare worker who has had a higher risk exposure to a source who is HIV positive but with an undetectable viral load to complete the course of PEP. The recommended PEP regimen is outlined in Table 6. Refer to Appendix C for the antiretroviral drug regimens recommend by the Australasian Society of HIV Medicine.

Table 6: PEP recommendations following occupational exposure to HIV positive source

Injury type	Source viral load known to be undetectable	Source not on treatment or on treatment with detectable or unknown viral load
Needlestick injury or other sharps exposure	Consider 2 drugs	3 drugs
Mucous membrane or non-intact skin exposure	Consider 2 drugs	Consider 3 drugs

Any medical officer can prescribe a PEP starter pack (lasting 3 to 7 days). The recommended course of PEP is 28 days. A prescription for the remainder of the PEP course must be obtained from a clinician experienced in the administration of drugs for the treatment of HIV.

Where there is a risk that a woman may be pregnant, undertake a serum beta HCG urgently. If possible, contact an HIV experienced Infectious Disease or Sexual Health Physician before starting HIV prophylaxis for a woman who is pregnant or at risk of pregnancy. Where it is not immediately possible and the risk of contracting HIV appears to outweigh any potential risk for the pregnancy commence prophylaxis and advise making an appointment with an HIV experienced physician for the next working day. Truvada® and Combivir® are category B3 drugs which means that there is limited data relating to safety in pregnancy but no human evidence of harm.

Exposed HCW testing recommendations

It is recommended that 4th generation HIV antibody/antigen testing be conducted at 6 weeks. A negative test at 6 weeks is likely to exclude infection but the exposed HCW should be retested at 12 weeks to definitively exclude infection. HIV viral load tests have the capacity to detect early HIV infection before antibody development and should be considered following higher risk exposures to a higher risk source. Longer follow up with additional testing may also be indicated in complex cases (e.g. possibility of coinfection) as directed by an expert clinician.

Advice for the exposed HCW during follow up period

During the follow up period the exposed HCW should be advised:

- Not to donate plasma, blood, body tissue, breast milk or sperm
- To protect sexual partners by adopting safe sexual practices (use of condoms)
- To seek expert medical advice regarding pregnancy and/or breastfeeding
- To seek medical attention about any acute illness (i.e. fever, rash, myalgia, fatigue, malaise, lymphadenopathy, anorexia).

Modification to work practices (including avoidance of exposure prone procedures) is not required on the basis of an occupational HIV exposure.

Source positive or potentially positive for HBV

Susceptibility of the exposed HCW to HBV infection

In accordance with the current NSW Policy Directive *Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases* all staff who have direct contact with patients, deceased persons, blood, body substances or infectious material or surfaces/equipment that might contain these must complete a full course of hepatitis B vaccination and/or provide serological evidence of protection.

If the exposed HCW has a documented protective response (anti-HBs level ≥10 mIU/mL) at any time following completion of the vaccination course, then he/she is considered immune to hepatitis B and no further action (i.e. testing of the source patient or post exposure prophylaxis) is required regardless of the exposure. If the response to previous vaccination is unknown, the anti-HBs level of the exposed HCW should be determined as quickly as possible. If immunity status cannot be determined quickly then the HCW should be managed as a susceptible person until such time that evidence of immunity is available.

The following provisions relate only to those who are presumed susceptible to HBV infection (those with anti-HBs level <10 mIU/mL and who are hepatitis core antibody negative).

Risk of HBV transmission from positive source patient

The probability of infection following exposure to a susceptible person depends on a number of factors including the volume and infectiousness of the body fluids and the route of the exposure. Occupational HBV transmission primarily occurs via percutaneous and mucosal exposure to blood. Of viral parameters, the risk of infection best correlates with viral load (HBV DNA) rather than hepatitis B serology. The presence of hepatitis B e antigen (HBeAg) is a surrogate marker for high viral load.

In studies of hepatitis B susceptible HCWs who sustained injuries from needles contaminated with blood containing HBV, the risk for developing clinical hepatitis if the blood was both HBsAg-positive and HBeAg-positive was 22%–31%, and the risk for developing serologic evidence of HBV infection was 37%–62%. By comparison, the risk for developing clinical hepatitis from a needle contaminated with HBsAg-positive, HBeAg-negative blood was 1%–6%, and the risk for developing serologic evidence of HBV infection was 23%-37%.[17]

Post exposure prophylaxis (PEP)

Where indicated (see Section 5.1) HBV post exposure prophylaxis with hepatitis B immunoglobulin and vaccine should be offered to non-immune and non-infected individuals in accordance with the recommendations in the current edition of the Australian Immunisation Handbook (refer to Appendix D). Requests for hepatitis B immunoglobulin should be directed to the local hospital blood bank.

Source testing recommendations

If a source is known or found to be HBsAg positive, then HBeAg and quantitative HBV DNA testing of the source patient should be performed, with the consent of the source, so that the exposed HCW can be counselled appropriately about the risk of transmission.

Exposed HCW testing recommendations

The exposed susceptible HCW should undergo HBsAg testing at 6 weeks, 12 weeks and 24 weeks. In the rare event that an exposed HCW is newly diagnosed with HBV infection, the local Public Health Unit should be notified. Post-vaccination serological testing is recommended 4 to 8 weeks after completion of the vaccination course.

Advice for the exposed HCW during follow up period

During the follow up period the exposed HCW should be advised:

- Not to donate plasma, blood, body tissue, breast milk or sperm
- To seek medical attention if they develop signs and/or symptoms of acute hepatitis (i.e. anorexia, vague abdominal discomfort, nausea and vomiting, fatigue and/or jaundice)

The exposed HCW is not required to modify sexual practices provided that HBV PEP has been administered on time. Ideally the HCW should refrain from becoming pregnant until completion of the vaccination course. There are no restrictions regarding breastfeeding. Modifications to work practices (including avoidance of exposure prone procedures) are not required on the basis of an occupational HBV exposure.

Source positive or potentially positive for HCV

Risk of HCV transmission from positive source patient

Overall, the risk of HCV transmission following an occupational exposure is low. The probability of infection following exposure depends on a number of factors including the volume and infectiousness of the body fluids and the route of the exposure. The average incidence of anti-HCV seroconversion after accidental percutaneous exposure from a HCV-positive source is estimated at 1.8% (range 0-7%)[20]. The risk of transmission increases significantly if the source has a high viral load. A review of the recent published evidence of HCV transmission following occupational exposures is summarised in Table 7.

A case control study on the risk factors for HCV transmission in HCW based on UK data collected from 1997 to 2007, found that all HCV seroconversions followed percutaneous injuries[21]. As had been previously shown[22], the depth of injury was significantly associated with seroconversion and the majority of exposures involved hollow bore needles from a vein or artery contaminated with blood or blood stained fluid. Transmission rarely occurs from mucous membrane exposures to infective blood and there are only two published reports to date of HCV transmission to a HCW via non-intact skin exposure[23,24].

Post exposure prophylaxis (PEP)

Currently, there is no vaccination or post exposure prophylaxis that is effective in the prevention of hepatitis C transmission. However, treatment of acute hepatitis C infection is now highly effective. Early identification of infection is necessary to enable prompt referral and treatment.

Table 7: Evidence of HCV transmission following occupational exposures

Country	Time period	Number of exposures involving HCW and HCV positive source	Number of HCV seroconversions	Rate
Australia[6]	2000-2003	64 #	0	0%
Austria[21]	1995-2009	150*	0	0%
Brazil[7]	1997-2009	38#	2	5%
Denmark[22]	2003-2012	62	0	0%
Germany[9]	2010-2012	44*	1	2.3%
Italy[23]	2004-2006	26	0	0%
Korea[24]	2004 -2008	327	3	0.9%
Netherlands[10]	2003-2010	53	1	1.9%
United Kingdom[12]	2004-2013	2566	9	0.4%

*All percutaneous injuries with source known to be HCV PCR positive
#All percutaneous injuries involving large bore catheter needles

Source testing recommendations

If the source is known or found to be HCV antibody positive, then quantitative hepatitis C RNA testing of the source patient should be performed with the consent of the source, so that the exposed HCW can be counselled appropriately about the risk of transmission.

Exposed HCW testing recommendations

The exposed HCW should undergo qualitative HCV PCR testing at 6 weeks and HCV antibody testing at 6 weeks and 12 weeks. If results are negative at that time the HCW can be advised that the risk of transmission is negligible but an antibody test at 24 weeks post exposure should still be undertaken to confirm that transmission has not occurred. Given its low specificity, liver function testing is not recommended. In the rare event that an exposed HCW is newly diagnosed with HCV infection, the local PHU should be notified.

Advice for the exposed HCW during follow up period

During the follow up period the exposed HCW should be advised:

- not to donate plasma, blood, body tissue or sperm
- to seek medical attention if they develop signs and/or symptoms of acute hepatitis (i.e. anorexia, vague abdominal discomfort, nausea and vomiting, fatigue and/or jaundice)

The exposed HCW is not required to modify sexual practices. In most circumstances the HCW should refrain from becoming pregnant until HCV infection is excluded. There are no restrictions regarding breastfeeding. Modifications to work practices (including avoidance of exposure prone procedures) are not required on the basis of an occupational HCV exposure.

Testing of the exposed HCW

The exposed HCW should have baseline testing for HIV, HBV and HCV infections as detailed in Table 8. If the exposed HCW is known to be infected with one or more of these BBVs, then baseline testing for those BBVs is not required. Note that a HCW with previous HCV infection who has been successfully treated or who has cleared the virus spontaneously remains susceptible to HCV re-infection.

Informed consent must be obtained before testing can proceed. The exposed HCW needs to be informed that baseline testing:

- Determines whether they were infected before the exposure and can be done up to a few days after the exposure (there is no need for after-hours testing)
- Does not have to be done at the workplace. The HCW can seek testing at their GP or other offsite service but the reason for the test (i.e. following occupational exposure) should be documented.
- Although not urgent, is important in case of a worker's compensation claim in the rare event of seroconversion

If the HCW is not immune and not previously vaccinated against HBV, or not currently infected with HBV, then he/she should be vaccinated as outlined in The Australian Immunisation Handbook and in accordance with the current NSW Policy Directive *Occupational assessment, screening and vaccination against specified infectious diseases*.

The HCW should be offered immediate referral to a specialist service if a previously undiagnosed blood borne virus is detected. Refer to current version of the NSW Policy Directive *HIV, Hepatitis B or Hepatitis C – Health Care Workers Infected*. Immediate consultation with a HIV specialist is required in the event that the exposed HCW who had commenced HIV PEP is found to be HIV positive on baseline testing.

All occupational exposure incidents should be documented according to local procedures.

Table 8: Baseline testing of the HCW

HCW hepatitis B status unknown	HCW previously shown to be hepatitis B immune
• Hepatitis B surface antigen, hepatitis B surface antibody, hepatitis B core antibody • Combined HIV antigen and antibody immunoassay (fourth generation HIV test) • Hepatitis C antibody	• Combined HIV antigen and antibody immunoassay (fourth generation HIV test) • Hepatitis C antibody

Special situation: when a patient is exposed to the blood or body fluids of a HCW

In some instances, when a HCW is exposed to potentially infectious fluids from a patient, there is also exposure of the patient to the HCW's blood. For example, this might occur if the HCW experiences a used sharps injury and blood from the sharps injury comes into contact with the patient's open wound or mucous membrane. In this situation, in addition to the risk of BBV transmission to the HCW, there is also a potential risk of BBV transmission from the HCW to the patient. In such circumstances, the HCW should be managed as per Sections 2 to 5 as a potential source for the patient. The patient and their treating medical team must be informed of the incident as soon as possible after the exposure. Injuries to patients must be reported in the Incident Information Management System.

The Australian National Guidelines for the Management of Health Care Workers Known to be infected with Blood Borne Viruses minimize the risk that a patient will be exposed to the blood of an infected health care worker. In the event of an occupational exposure incident involving a HCW known to be infected with a BBV, refer to the NSW Policy Directive, *HIV, Hepatitis B or Hepatitis C – Health Care Workers Infected*.

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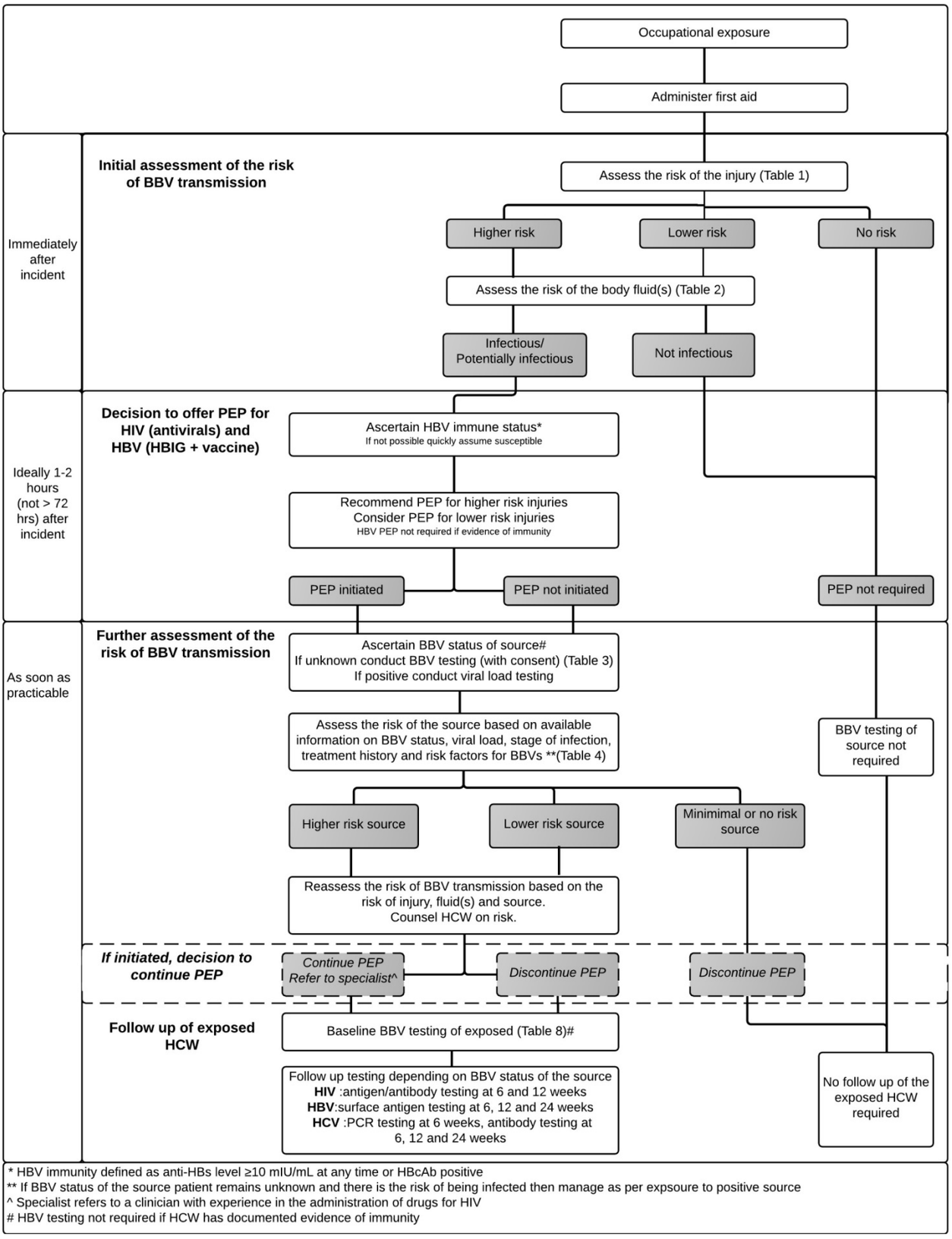
APPENDIX A: MANAGEMENT OF THE EXPOSED HCW FOLLOWING AN OCCUPATIONAL EXPOSURE



* HBV immunity defined as anti-HBs level ≥10 mIU/mL at any time or HBcAb positive
** If BBV status of the source patient remains unknown and there is the risk of being infected then manage as per expsoure to positive source
^ Specialist refers to a clinician with experience in the administration of drugs for HIV
# HBV testing not required if HCW has documented evidence of immunity

APPENDIX B: RECOMMENDED LABORATORY TESTING FOR THE EXPOSED HCW

BBV status of the source patient[#]	Time (in weeks) following BBV exposure		
	6 weeks	12 weeks	24 weeks
HIV positive	Combined HIV antigen and antibody (fourth generation HIV immunoassay)	Combined HIV antigen and antibody (fourth generation HIV immunoassay)	
HBV positive*	Hepatitis B surface antigen	Hepatitis B surface antigen	Hepatitis B surface antigen
HCV positive	Hepatitis C antibody, qualitative HCV PCR	Hepatitis C antibody	Hepatitis C antibody

[#] If BBV testing of the source patient at the time of the incident is negative but there is the possibility of being in the window period or BBV status of the source is unknown and there is a risk of being infected then follow up as per positive source.

* If the HCW is immune (i.e. anti-HBs level ≥10 mIU/mL or HBcAb positive) no further HBV testing is required regardless of the exposure or status of the source patient.

APPENDIX C: HIV PEP RECOMMENDATIONS

HIV PEP starter packs may very between facilities. The Australasian Society for HIV Medicine *(ASHM*) recommendations are provided here.

Recommendations for PEP following occupational exposure to HIV1

2-drug regimens*
Tenofovir 300mg with lamivudine 300mg (daily) *(TGA approved generic lamivudine may be used to reduce cost) OR Tenofovir disoproxil fumarate/emtricitabine 300mg/200mg (daily)

*Zidovudine, in combination with lamivudine, can be used in two-drug PEP combinations. The benefits of cheaper zidovudine cost are offset by the need for a twice-daily treatment regimen, higher incidences of gastrointestinal side effects, myalgia and headaches in comparison to the recommended regimens.

3-drug regimens
The preferred 2 drug-regimen PLUS dolutegravir 50mg (daily) OR raltegravir 400mg (bd) OR rilpivirine 25mg (daily with food)

Note: Refer to *Post Exposure Prophylaxis after Non-Occupational and Occupational Exposures: Australian National Guidelines 2nd Edition* for cautions in relation to specific antiretroviral medications

APPENDIX D HEPATITIS B PEP RECOMMENDATIONS

Management of non-immune HCWs following occupational exposure to a positive/likely positive HBsAg source2

Type of exposure	**Hepatitis B Immunoglobulin**	**Vaccine**
Percutaneous, ocular or mucous membrane	Single dose of 400IU by IM injection within 72 hours of exposure	1ml recombinant antigen by IM injection within 7 days* of exposure, repeated at 1 month and again 6 months post first dose

*The 1st dose can be given at the same time as HBIG, but should be administered at a separate site. Administration as soon as possible after exposure is preferred.

301(04/05/17)

1 Taken from the *Post Exposure Prophylaxis after Non-Occupational and Occupational Exposures: Australian National Guidelines 2nd Edition*

2 Taken from the Australian Immunisation Handbook, 10th Edition

MANAGEMENT OF HEALTH CARE WORKERS WITH A BLOOD BORNE VIRUS AND THOSE DOINGPERFORM EXPOSURE PRONE PROCEDURES

(PD2019_026)

PD2019_026 rescinds PD2005_162

PURPOSE

This Policy Directive prescribes how the *Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses 2018* (the National Guidelines) are to be implemented within NSW Health Organisations and Affiliated Health Organisations.

The objective of implementation of the National Guidelines is to ensure: patients are protected from acquiring a blood borne virus infection from a health care worker (HCW) during an exposure prone procedure (EPP); and, in the event that a HCW with a blood borne virus (BBV) infection may have exposed a patient to a BBV during an EPP, that patient notification and lookback are based on expert advice.

Adherence to this Policy will assist to fulfil the requirements of NSW Health under the National Guidelines.

MANDATORY REQUIREMENTS

All NSW Health local health districts and networks are required to implement this Policy Directive.

Local health districts and networks must establish an incident management team to undertake a risk assessment in all instances where a HCW with a blood borne virus has performed EPPs outside the criteria in the National Guidelines. Where the risk assessment suggests a potential risk of BBV transmission the incident must be referred to the NSW Health Blood Borne Viruses Advisory Panel (BBVAP). Where the HCW is knowingly non-compliant with the National Guidelines, then must be reported to the Australian Health Practitioner Regulation Agency (AHPRA) (section 2.1).

Health care facilities must specify a person to whom a HCW who performs EPPs should notify in the event that the HCW is diagnosed with a BBV infection. Health care facilities must protect the confidentiality and privacy of HCWs with a BBV infection, and support these HCWs in the workplace setting (section 2.2).

Local health district public health units must on receipt of a notification of a HCW who has performed EPPs while infectious with a BBV, provide this information to the designated person in the health facility in which the HCW works. Public health units must complete a risk assessment on any reports of a newly acquired BBV in an individual with a history of an EPP and no known risk factors for infection acquisition, and refer any cases where there is a potential risk of BBV transmission to the BBVAP (section 2.3).

HCWs must be aware whether procedures they perform are classified as exposure prone (section 2.4).

HCWs who perform EPPs are required to comply with the National Guidelines for BBV testing and annual declaration of compliance to AHPRA (section 2.5).

HCWs who are newly diagnosed with a BBV and who perform EPPs must cease EPPs immediately and inform the person identified in their health care facility. HCWs infected with a BBV who perform EPPs must comply with the National Guidelines in order to return to EPP work and must remain compliant when performing EPPs. They must immediately report all incidents of patient exposure to their blood to the identified person in their health facility (section 2.6).

Student HCWs in a discipline that undertakes EPPs must undergo BBV testing within 12 months prior to commencement of study. They must submit a form declaring that they have undergone BBV testing and meet the requirements of this policy directive to NSW Health before their first clinical placement, and notify the person identified in the health facility when newly diagnosed with a BBV if EPPs are to be undertaken during the placement (section 2.9).

IMPLEMENTATION

Health facilities are responsible for promoting awareness of the National Guidelines amongst their employees who perform EPPs.

Section 2 describes the responsibilities of NSW Health employers and HCWs employed in the implementation of the National Guidelines within NSW Health and in the investigation and follow up of incidents where the public may have been put at risk of BBV acquisition via an infected HCW.

Responsibilities under the National Guidelines apply to clinicians who diagnose and/or manage a HCW with a BBV infection, irrespective of whether they work for NSW Health or in the private sector. These include reporting to NSW Health where there is a potential public health risk that has not been reported to NSW Health by the infected HCW.

Management of health care workers with a blood borne virus and those doing exposure prone procedures

1 BACKGROUND

About this document

NSW Health has a duty of care to provide a workplace environment that is as safe as possible for both patients and health care workers (HCWs) by eliminating health and safety risks so far as is reasonably practicable, and if it is not reasonably practicable to do so, to minimise those risks.

Adherence to standard precautions as outlined in the current NSW *Health Infection Prevention and Control Policy* ensures that the majority of procedures in health care settings pose minimal risk of transmission of a blood borne virus (BBV) from an infected health care worker to a patient. However, while the risk is very low, there are certain procedures during which it is possible for human immunodeficiency virus (HIV), hepatitis B and/or hepatitis C to be transmitted to a patient. Such procedures are referred to as exposure prone procedures (EPPs). During EPPs it is possible that an injury to the HCW could unknowingly result in the worker's blood contaminating the patient's open tissues.

Conversely, when performing EPPs, HCWs are also at risk of being exposed to the blood of patients and so may unknowingly acquire a BBV from an infected patient. NSW Health Policy Directive PD2017_010 *HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed* assists health services to appropriately assess and manage a HCW following a known occupational exposure in order to prevent BBV acquisition.

The *Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses 2018* (the National Guidelines) were developed by the Communicable Diseases Network of Australia and endorsed by the Australian Health Ministers' Advisory Council in June 2018.

Registered HCWs in professions which perform EPPs must declare whether they are complying with the National Guidelines at the time of their health practitioner registration and annually at registration renewal, including that they are compliant with the testing requirements in the National Guidelines.

NSW Health policy is to follow the National Guidelines, and this Policy Directive outlines the implementation of the National Guidelines within NSW Health services. It should be read in conjunction with the National Guidelines.

Key definitions

Must - indicates a mandatory action that must be complied with.

Should - indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

Healthcare worker - persons, including students and voluntary workers who undertake procedures in public and/or private healthcare settings that normally involve patient care and/or contact with blood or other body fluids.

Infected healthcare worker - a HCW with a confirmed infection of one or more BBV

Blood borne virus – refers to HIV, hepatitis B and hepatitis C viruses.

Student – refers to a person enrolled at a university or other educational institution

Exposure prone procedures – are procedures where there is a risk of injury to the HCW resulting in exposure of the patient's open tissues to the blood of the HCW. These procedures include those where the HCW's hands (whether gloved or not) may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. Examples of EPPs are at Appendix 1 of the National Guidelines and included in Appendix 3 of this document.

Blood Borne Virus Advisory Panel - NSW Health Blood Borne Viruses Advisory Panel provides expert advice to the NSW Chief Health Officer on the assessment of potential public health risks related to transmission of blood borne viruses.

Legal and legislative framework

Health services have a duty of care to their patients and obligations under the *Work Health & Safety Act 2011* (NSW), the *Public Health Act* 2010 (NSW) and their associated regulations and the *Health Records and Information Privacy Act* 2002 (HRIP Act). Consideration must be also given to the requirements of Part 4A of the *Anti-Discrimination Act 1977 (NSW)* which deals with discrimination on the ground of disability and the *Disability Discrimination Act 1992* (Cth).

Registered medical practitioners have a responsibility to protect public health by complying with the Medical Board of Australia's *Guidelines for Mandatory Notifications* and *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

REQUIREMENTS UNDER THIS POLICY DIRECTIVE

The following sections describe the obligations for individuals and the procedures to be followed by health facilities, medical practitioners and educational institutions in fulfilling the requirements of this Policy Directive.

2.1 Local Health District Directors of Clinical Governance

Response when an infected HCW has performed EPPs outside the criteria for the specific BBV regarding care, treatment, monitoring and viral load as stipulated in the National Guidelines

The Director of Clinical Governance must:

- Establish an incident management team to collect relevant information and undertake a preliminary assessment of any risk of BBV transmission to patients. The team should include:
  - the head of infection prevention and control unit at the health facility;
  - the local public health unit;
  - the designated person from the health facility (refer to 2.2 below;)
  - a clinician with expertise in the relevant area; and
  - other members as appropriate (e.g. Staff Health, laboratory staff, other clinicians).
- Refer, via the public health unit, to the NSW Health Blood Borne Viruses Advisory Panel (BBVAP) any incident where the preliminary risk assessment suggests a potential risk of

BBV transmission in the health care setting

- Ensure any instances where a HCW has been diagnosed with a BBV and is non-compliant with the National Guidelines are reported to the Australian Health Practitioner Regulatory Authority (AHPRA) as this is placing the public at risk of substantial harm and therefore meets the criteria for mandatory reporting under the National Law (for further information see the Mandatory notifications guidelines for registered health practitioners 2014).

2.2 Health facilities

Management of an infected HCW

The health facility must:

- Promote awareness of the National Guidelines amongst their employees who perform EPPs (for example at orientation and infection control training).
- For students in disciplines that undertakes EPPs, verify each student's declaration form (Attachment 1) indicating that they are aware of and comply with the requirements of this PD and enter the information into ClinConnect1.
- Ensure that confidentiality of an infected HCW's BBV status is maintained as far as possible, even if the HCW has died or ceased practice.
- Ensure the rights of the infected HCW as employees are safeguarded.
- Ensure infected HCWs have access to appropriate expert medical advice as required (noting that some HCWs will seek expert medical advice outside NSW Health).
- Support an infected HCW to return to work in accordance with the NSW Policy Directive *Injury Management and Return to Work* (PD 2013_006) and the current Public Service Commission's document Procedures for Managing Non-Work Related Injuries or Health Conditions.
- Provide an environment in which HCWs living with a BBV know their privacy and confidentiality will be respected and maintained.

Response when a HCW has performed EPPs outside the criteria in the National Guidelines

The health facility must have local procedures in place to be followed in the event that a HCW who performs EPPs is newly diagnosed with a blood borne virus (BBV), or if a HCW with a BBV inadvertently exposes a person to their blood or performs EPPs outside the criteria in the National Guidelines. These procedures must:

- Specify who the HCW should notify (the designated person); this person should have an understanding of the principles underpinning this policy directive including confidentiality requirements, and have the authority to relieve the HCW of their EPP duties and appoint another HCW to fulfil these duties without breaching the HCW's confidentiality (e.g. Director of Medical Services or Director of Nursing).
- Direct that the incident be reported in a de-identified manner to the local health district Director of Clinical Governance.
- Direct that the incident be notified in a de-identified manner on the Incident Information Management System (IIMS).
- Indicate that the local health district, via the local public health unit, will liaise with Health Protection NSW and refer the incident in a de-identified manner to the Blood Borne Virus Advisory Panel (BBVAP) to seek advice on the need for patient notification and testing as appropriate.
- Ensure a system is in place for urgent BBV viral load testing of HCWs, if required, in the event of an incident in which another person is exposed to the blood/bodily fluids of an infected HCW (noting the facility may not be aware of the HCW's infection until such an

1 ClinConnect is a web-based application built to assist Districts Health Services (Local Health and Specialty Health Networks) and Education Providers manage all clinical placements in NSW Health facilities. It is used to book and manage placements in Nursing & Midwifery, Allied Health and Dental & Oral Health and used to record clinical placement activity for Medicine.

incident occurs and the HCW discloses their status).

Health facilities must also:

- Report, via the designated person, any instances where an infected HCW is knowingly non-compliant with the National Guidelines to the Australian Health Practitioner Regulatory Authority (AHPRA).
- Ensure that the confidentiality of the infected HCW is protected as far as possible.

2.3 Local Public Health Units must:

Response when a HCW has performed EPPs outside the criteria in the National Guidelines

On report that a HCW who performs EPPs is newly diagnosed with a BBV, or if a HCW with a BBV inadvertently exposes a person to their blood, or performs EPPs outside the criteria in the National Guidelines, the local public health unit must:

- Participate in the local health district incident management team to collect relevant information and undertake an initial assessment of the risk of BBV transmission to patients.
- In collaboration with Health Protection NSW, complete a detailed risk assessment on any reports of a newly acquired hepatitis B, hepatitis C or HIV infection in an individual with a history of an EPP and no known risk factors for infection acquisition.
- Refer via HPNSW to the BBVAP for advice on management of situations in which a preliminary assessment indicates a potential risk of BBV transmission in the health care setting.
- Receive and refer, as appropriate, reports where an infected HCW is knowingly non-compliant with the National Guidelines to the BBVAP for advice on the need for patient lookback.
- On receipt of a notification of a HCW who has performed EPPs while infectious with a BBV which indicates a serious threat to public health, and subject to s56 of the *Public Health Act 2010*, provide this information to the designated person (refer section 2.2) in the health facility in which the HCW works1.

2.4 Health care workers

Management of an infected HCW

All HCWs:

- Must be aware if any procedure that forms part of their (current or known future) duties is classified as an exposure prone procedure (EPP) according to the guidance in the National Guidelines.
- Should be aware of their BBV status, and if they have non-occupational risk factors associated with the acquisition of BBVs, they should have regular BBV testing2 according to standard guidelines (refer to national testing policies for HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV)).
- If infected with a BBV and compliant with treatment and monitoring set out in the National Guidelines, may continue to provide clinical care to patients and are not required to disclose their status if their work does not involve EPPs except in the very unlikely event that a patient is exposed to the HCW's blood/bodily fluids.

1 Disclosure by an organisation of information that a HCW who has performed EPPs while infectious is permitted under the *Health Records and Information Privacy Act 2002* if disclosure is reasonably believed to be necessary to lessen or prevent a serious threat to public health or safety. In the case of HIV infection, disclosure of the identity of the HCW can only be made to the Secretary under section 56(4)(c) of the *Public Health Act 2010* (on the basis that failure to disclose the information about a HCW with HIV and un-suppressed viral load who undertakes EPPs is likely a risk to public health).

2 All laboratory testing referred to in this policy are to be conducted in a NATA/RCPA accredited laboratory

2.5 Health care workers who perform EPPs

Management of an infected HCW

HCWs who perform EPPs must:

- Be familiar with the National Guidelines.
- Take reasonable steps to know their BBV status and undergo testing for HIV, HCV and HBV at least once every three years as set out in the National Guidelines.
- Make a declaration to the Australian Health Practitioner Regulation Agency (AHPRA) at the time of annual registration renewal, stating that they are compliant with the National Guidelines.

2.6 Health care workers infected with HIV, hepatitis B and/or hepatitis C who perform EPPs

Response when a HCW has performed EPPs outside the criteria in the National Guidelines

HCWs infected with HIV, hepatitis B and/or hepatitis C who perform EPPs must:

- Cease performing EPPs immediately and inform the person identified in their health facility local procedures if they are newly diagnosed with a BBV
- Seek ongoing care from an appropriately skilled medical practitioner (see section 2.8).
- Meet the criteria for viral suppression outlined in the National Guidelines for initial clearance to perform EPP.
- If cleared for EPP work by their treating medical practitioner, meet the ongoing health monitoring requirements described in the National Guidelines in order to continue EPP work.
- Make a declaration to the Australian Health Practitioner Regulation Agency (AHPRA) at the time of annual registration renewal that they are compliant with the National Guidelines.
- Seek medical advice if they experience a change in health condition which may affect their ability to practice.
- Immediately report all incidents to the designated (refer section 2.2) person in their health facility where he/she is aware of accidentally exposing a patient to their blood or bodily fluids, regardless of the risk of transmission.

2.7 Clinicians who conduct BBV testing for health care workers

The diagnosing clinician must:

- Refer a HCW who performs EPPs who is newly diagnosed with a BBV to an appropriate treating medical practitioner (see section 2.8).
- Counsel the infected HCW to notify the designated person (refer section 2.2) in their workplace, as required by the National Guidelines, if it is possible that he/she performed any EPPs while infectious.

In the event that the diagnosing clinician is aware that the HCW does not notify their workplace that it is possible that the HCW performed EPPs while infectious and there is a serious threat to public health or safety the diagnosing clinician must notify the local public health unit1.

1 Disclosure by an organisation of information that a HCW who has performed EPPs while infectious is permitted under the *Health Records and Information Privacy Act 2002* if disclosure is reasonably believed to be necessary to lessen or prevent a serious threat to public health or safety. In the case of HIV infection, disclosure of the identity of the HCW can only be made to the Secretary under section 56(4)(c) of the *Public Health Act 2010* (on the basis that failure to disclose the information about a HCW with HIV and un-suppressed viral load who undertakes EPPs is likely a risk to public health).

2.8 Medical practitioners who provide expert clinical care to BBV infected health care workers and student HCWs who perform EPPs

The treating doctor for the infected HCW who performs EPPs must:

- Be familiar with the National Guidelines and aware of the requirements and necessary skill sets of treating medical practitioners set out in the National Guidelines.
- Provide formal advice to the HCW regarding personal care, health monitoring and work practices (including initial and ongoing clearance to perform EPPs).
- Ensure a HCW who is newly diagnosed with a BBV receives counselling regarding potential impacts on future career (advice may be sought from the relevant professional college as needed).
- Encourage BBV infected HCWs who perform EPPs to notify the health service of their BBV status.
- Ensure that the HCW has scheduled appointments of appropriate frequency to meet the required level of monitoring and actively follow up missed appointments.
- Report concerns regarding HCW compliance with professional standards and/or breaches in compliance with the National Guidelines to AHPRA, as appropriate.
- Ensure that concerns regarding actual or potential exposures constituting a serious public health risk are reported to the local public health unit in a timely manner to enable a risk assessment of BBV risk to patients to be undertaken.[5]

2.9 Student health care workers in a discipline that undertakes EPPs

Disciplines that may undertake EPPs include: medicine; midwifery; paramedicine; dentistry and oral health.

Student HCWs of a discipline that undertakes EPPs must:

- Undergo testing for BBVs at commencement of study or within the 12 months prior to commencement.
- Follow the same BBV testing requirements as health care workers who perform EPPs (refer to Section 3).
- Submit a form (Attachment 1) declaring that they have undergone BBV testing and meet the requirements of this Policy Directive to NSW Health as part of the verification process before their first clinical placement.
- Ensure they undergo regular testing as outlined in this Policy Directive and submit further declaration forms to NSW Health, via their education provider's partner local health district
- Notify the person identified in the health facility local procedures when newly diagnosed with a BBV if EPPs are to be undertaken during the placement.

The educational institution for students of a discipline that undertakes EPPs must:

- Inform all students of the requirements of this Policy Directive
- Ensure that all students in the relevant disciplines are aware of the requirement to undergo BBV testing and complete a form declaring that they have undergone BBV testing and meet the requirements of the Policy Directive.
- Inform students of the process to have their declaration form verified by NSW Health
- Inform students that those who are non-compliant will not be able to attend clinical placements

MANAGEMENT OF HCWs

BBV testing for health care workers who perform EPPs

HCW who perform EPPs must take reasonable steps to know their BBV status and should be tested for BBVs at least once every three years as outlined in the National Guidelines.

It is the responsibility of the HCW to arrange BBV testing. Following the demonstration of immunity to hepatitis B, further HBV testing is not required.

HCWs who are classified as hepatitis B vaccine non-responders can continue to perform EPPs but must be retested in accordance with the National Guidelines and should seek advice following an occupational exposure to the blood/bodily fluids of a patient.

HCW who perform EPPs must make a declaration to AHPRA when applying for renewal of registration that they are complying with, and have been tested in accordance with the National Guidelines. The results of BBV testing will not be declared to, or recorded by, AHPRA.

The procedures that health services should follow to prevent disease transmission following an occupational exposure to a BBV are outlined in the NSW Policy Directive *HIV, Hepatitis B and Hepatitis C—Management of Health Care Workers Potentially Exposed*.

Health care workers infected with BBVs who perform EPPs

HCWs who are infected with BBVs are permitted to perform EPP work providing he/she:

1. Is under the care of an expert in the treatment of their BBV who also has an understanding of the regulatory framework for HCWs infected with BBVs, including the National Guidelines and this Policy Directive

   AND

2. Meets the criteria for initial and ongoing health clearance set out for each BBV in the National Guidelines as assessed by the HCW's treating medical practitioner

Clearance to allow an infected HCW to perform EPPs

Initial and ongoing clearance to perform EPP work is provided by the treating medical practitioner to the health care worker if the treating practitioner is satisfied that the criteria are met as stipulated in the National Guidelines. Expert assistance is available from the BBVAP (via the Director Communicable Diseases Branch) if required.

Non-compliance by an infected HCW

In accordance with the mandatory reporting requirements under the National Law and the National Guidelines the treating medical practitioner must notify the HCW to AHPRA if the HCW is putting the public at risk. If required advice can be sought from the local public health unit.

The treating medical practitioner must also inform the local public health unit if a serious risk to public health is suspected so that the public health unit can undertake a risk assessment (refer to Section 4).

Support for an infected HCW

Providing the individual is complying with the National Guidelines there is no requirement for an infected HCW who is permitted to perform EPPs to inform a health facility of their BBV status at the commencement of employment; however this is encouraged to facilitate an immediate response to an incident in which a patient is exposed to their blood or other infected bodily fluid. Note that

disclosure of the HCW's BBV status to relevant health facility/LHD staff is required in the event of such an incident (refer to Section 4).

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Should a HCW disclose their BBV status to their health facility, this information must be treated confidentially and appropriate support and advice provided to the HCW as required.

NSW Health services are required to have occupational rehabilitation programs in place consistent with the NSW Directive *Injury Management and Return to Work* (PD2013_006) to manage employees with a work related blood borne virus infection. This includes, where relevant, making every effort to provide alternative suitable employment both within NSW Health, and if that is not possible, external to NSW Health. Where the HCW acquired the BBV infection outside of work, the obligations of all public health facility employers are outlined in the Public Service Commission's document *Procedures for Managing Non-Work Related Injuries or Health Conditions* and includes where relevant the investigation of alternative positions within NSW Health and other agencies.

Should the HCW be required to take time off from their work duties due to their infection, the relevant health profession board and the relevant specialist college can provide support and advice on retraining and supervision on their return to work.

INVESTIGATION AND RESPONSE WHEN A HCW HAS PERFORMED EPPs OUTSIDE THE CRITERIA IN THE NATIONAL GUIDELINES

Newly diagnosed HCW who has performed EPPs

In the event that a HCW who performs EPPs is newly diagnosed with a BBV he/she must stop all EPP work immediately and seek medical care from an appropriately skilled practitioner. At the time of diagnosis, the HCW must notify the designated person (section 2.2) identified in their health facility local procedures if it is possible that they have been performing EPPs while infectious. The relevant professional college can provide advice as to the classification of procedures. If required, the newly diagnosed HCW can discuss the need to inform the health facility/LHD with their diagnosing doctor or the local public health unit.

In the unlikely event that the newly diagnosed HCW has been involved in an incident in the previous 72 hours where it was recognised that another person was exposed to the HCW's bodily fluid, decisions regarding the use of post exposure prophylaxis for HIV and HBV for the exposed person(s) should be made locally based on a risk assessment of the nature of the exposure as outlined in the NSW Policy Directive 2017_010 *HIV, Hepatitis B and Hepatitis C—Management of Health Care Workers Potentially Exposed*.

The health facility, in collaboration with the local public health unit, will collect information regarding the infected HCW (including relevant surgical procedures performed, infection control practices, any known incidents where another person was exposed to the HCW's blood and health monitoring information) in order to make an assessment of the risk of BBV transmission in the health care setting. (Refer to Appendix 1 for guidance.) Where there is the potential for BBV transmission, the public health unit, in conjunction with Health Protection NSW will refer the case in a de-identified manner to the Blood Borne Virus Advisory Panel (BBVAP). The HCW should be informed that their de-identified health and health practice information will be provided to the BBVAP.

The BBVAP will review the risk assessment (refer to Appendix 2 for the terms of reference for the BBVAP). The Chief Health Officer, on advice from the BBVAP, will make decisions regarding the need for a lookback1 investigation to identify any patients who may have acquired a BBV from the HCW. The health facility should ensure that the infected HCW is informed of this process.

1 A lookback is defined as the process of identifying, tracing, recalling, counseling and testing patients or HCW who may have been exposed to an infection in the health care setting in the *NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare 2010*.

BBV infected HCWs and lookback exercises

In the event that the Chief Health Officer, following receipt of advice from the BBVAP, requests that a lookback be undertaken, the infected HCW must be counselled by the health facility that relevant patients will be informed about a potential exposure to the blood of a HCW who is infected with a BBV in a non-identifying manner. In accordance with the *NSW Privacy Manual for Health Information*, only staff for whom it is considered necessary in order to carry out their work duties should be aware of the infected HCW's BBV status.

Disclosure of an individual HCW's BBV status to a patient is not necessary and the health facility has an obligation to ensure that confidentiality of an infected HCW's BBV status is maintained as far as possible even if the infected HCW has died, ceased practice or has been identified publicly.

Potential health care associated BBV transmission

All new HIV diagnoses are notified (using a name code) to Health Protection NSW which routinely collects risk factor information from the relevant clinician. Notifications of newly acquired hepatitis B and hepatitis C cases are routinely followed up for risk factor information by the local public health unit. If a patient presents with a newly acquired hepatitis B, hepatitis C or HIV infection after undergoing an EPP, and the origin of the infection is unclear, the local public health unit will complete a detailed risk assessment in conjunction with Health Protection NSW. Referral to the BBVAP for advice as to the appropriate public health action may occur depending on the outcome of the risk assessment.

Management of patients following exposure to blood/bodily fluids of an infected HCW

Infected HCWs who are performing EPPs as permitted within the National Guidelines, are required to report to the designated person (refer section 2.2) in their health facility any incidents in which a patient is known to have been accidentally exposed to their blood or bodily fluids.

In this situation, a detailed risk assessment should be done, in conjunction with the HCW's treating clinician and the local public health unit as outlined in the National Guidelines. This should include assessment of several factors including the most recent viral load of the HCW, the history of the HCW with a BBV including their adherence to treatment, the frequency and magnitude (if any) of fluctuations in their viral load and the presence of factors which might increase the HCW's viral load. If there is concern that the viral load of the HCW could be above the level stipulated in the National Guidelines, the health facility should arrange for the infected HCW to undergo urgent viral load testing. The local public health unit will work with the health facility to collect the information required for a detailed risk assessment and, in conjunction with Health Protection NSW urgently refer the matter to the BBVAP.

In consultation with the HCW's treating doctor, the BBVAP will make an assessment of the risk to the patient(s) based on the criteria outlined in the National Guidelines. Following the risk assessment, the BBVAP will make recommendations to the Chief Health Officer regarding the need for follow up of patient(s).

Where urgent decisions on the need for post exposure prophylaxis for HIV and HBV are required (potential patient exposures within the previous 72 hours), the facility should follow the risk assessment guidance in the NSW Policy Directive PD2017_010 *HIV, Hepatitis B and Hepatitis C, Management of Health Care Workers Potentially Exposed*

APPENDIX 1 Guide for assessing the risk of BBV transmission in the health care setting

When there is evidence that a HBeAg, HBV DNA, HCV PCR or HIV positive HCW has performed exposure prone procedure/s the following steps should be taken to determine if there is a risk of transmission from the infected HCW to others.

It should be noted that there are serious legal, human and financial implications of look-back exercises to identify and test patients on whom the infected health care worker performed invasive procedures. The health facility has an obligation to ensure that confidentiality of an infected HCW's BBV status is maintained as far as possible, even if the HCW has died or ceased practice.

The health facility should work with the local public health unit to collect the information required to determine if there is the potential for BBV transmission in the health care setting. This should be done in cooperation with the infected HCW and in a non-identifying manner.

Information required for a risk assessment includes:

- Relevant health monitoring information (such as viral load).
- The nature and history of the clinical practice of the HCW, including the type of procedural practice.
- Evidence of physical or mental impairment or behavior which could have affected the HCW's standard of practice.
- Evidence of poor infection prevention and control practice by the HCW or at the relevant health care setting during the time the HCW was likely infectious with the BBV (a formal infection control audit may be required).
- Known episodes of high risk exposure to a patient, for example sharps injuries (a review of previously reported occupational exposure incidents may be required) , and
- Any other relevant considerations.

The health facility, together with the local public health unit, will review this information and make an assessment of the potential for BBV transmission. Where there is a risk of transmission, the public health unit will refer the matter to the BBVAP for advice regarding a lookback. The health facility should inform the infected HCW that relevant de-identified information will be shared with the BBVAP for the purposes of determining if a lookback is required. The extent of any lookback will be decided by the BBVAP on a case-by-case basis using a risk-based approach.

APPENDIX 2 NSW Health Blood Borne Viruses Advisory Panel

Role of the Advisory Panel

The role of the NSW Health Blood Borne Viruses Advisory Panel (the Panel) is to provide expert advice to the NSW Chief Health Officer on the assessment of potential public health risks related to transmission of blood borne viruses. Its members come from a range of specialist fields to inform the response to a wide range of blood borne virus transmission health risks.

Purpose

The Panel will provide advice on the current scientific evidence on a range of issues related to the transmission of blood borne viruses and provide analysis of the potential public health risks.

Specifically the panel will:

- Provide advice regarding the implementation of the current version of the *Australian National Guidelines for the Management of Health Care Workers Known to be Infected with Blood-borne Viruses* (the National Guidelines).
- Undertake the function of the Expert Advisory Committee as defined in the National Guidelines, including providing advice on:
    a. the risk to patients; and
    b. the work practices of health care workers infected with a blood borne virus (BBV).
- Provide supplementary specialist occupational advice to physicians of health care workers infected with BBV, occupational physicians and professional bodies.
- Provide advice on the management, including the need for patient notification, of incidents involving:
    a. the investigation of potential BBV transmission in health care settings;
    b. inadequate reprocessing of instruments or equipment used in invasive procedures; and
    c. other incidents in health care settings where patients may have been exposed to a BBV.
- At the request of the Chief Health Officer, provide advice on other issues related to BBV transmission.

Governance

Chair

The Panel Chair is appointed by the NSW Chief Health Officer. The Deputy Chair is the Director of Health Protection NSW.

Code of conduct

Members will be required to agree to and sign a Declaration of Ethical Behaviour upon joining and membership renewal (every 2 years) and adhere to the NSW Health code of conduct as appropriate.

Confidentiality

Members will be required to sign a confidentiality agreement upon joining, and membership renewal (every 2 years). Information provided to members to inform their discussion is provided in confidence and is not to be disclosed to any third party.

Conflicts of interest

Members will be required to declare any potential conflicts of interest (real or perceived) upon joining. In addition conflicts of interest will be addressed as an agenda item at the commencement of each meeting, in light of the issues at hand, and recorded in the meeting minutes.

Decision making

The panel is an advisory body to the NSW Chief Health Officer. The panel will not be a decision making entity.

Membership

Membership will be by invitation of the NSW Chief Health Officer and will be reviewed every 2 years. Membership may include experts from within NSW Health, government agencies, academia, research organisations and industry.

Standing Panel members will include at least one:

- Infectious Diseases Physician
- Director, Health Protection NSW
- Virologist
- Occupational Health Physician
- Infection Control Practitioner
- Ethicist
- Public Health Unit Director
- Director, Communicable Diseases Branch

In addition, the Panel may also include ad hoc members from the following groups:

- A member of the professional group, relevant to the health care worker e.g. RoyalAustralasian College of Surgeons
- A health care worker advocate
- A hepatologist, immunologist or other appropriate medical expert

Nominated experts may be invited by the Chair of the Panel to be supplementary members of the Panel to attend meetings to provide specific advice in their areas of expertise on a needs basis for a period of up to 2 years, in conjunction with Panel membership review. Nominated experts will be asked to self-select a secondary contact for this purpose in the event that they are unable to attend a Panel meeting when required. These nominated members (and their secondary contacts) will be subject to the same code of conduct, confidentiality and conflict of interest requirements as other members.

Meeting frequency

The Panel will meet quarterly. Additional meetings will be arranged on a needs basis as issues arise (often on short notice). In these instances, the Panel may meet by teleconference to discuss specific blood borne virus related health risks or incidents.

Where practicable, advance notification and circulation of meeting papers and agenda will be carried out, however, due to the nature of the Panel and the potential urgency of issues to be addressed, meetings may be required to be carried out with less than 48 hours' notice.

Panel Structure

Where issues outside the scope of expertise of standing members arise, additional experts may be invited to participate in relevant meetings of the Panel.

Proxies

Due to the expertise based nature of the panel, proxies will not be accepted if a member is unable to attend a meeting.

Record of meetings

Minutes of the meetings will be prepared by the secretariat, and endorsed by the Panel Chair, prior to submission to the Chief Health Officer.

Referral of issues to the panel
Issues may be referred to the Panel by representatives of Local Health Districts, or by Health Protection NSW. All referrals are required to be submitted in the format of the pro forma referral brief.

A treating doctor may seek individual advice directly from the BBVAP on case management in relation to any aspect of this policy directive or the National Guidelines.

Remuneration

No sitting fees will be provided.

Secretariat

Secretariat support will be provided by Health Protection NSW via the Communicable Diseases Branch.

Terms of reference

The terms of reference will be reviewed every 2 years.

APPENDIX 3: Definitions and examples of EPPs
Non-exposure prone procedures (non-EPPs) are procedures where the hands and fingers of the HCW are visible and outside of the body at all times and procedures or internal examinations that do not involve possible injury to the HCW's hands by sharp instruments and/or tissues, provided routine infection prevention and control procedures are adhered to at all times.

Examples of non-EPPs include routine oral examination (gloved with mirror and/or tongue depressor); vaginal and rectal examinations (except where there is a possibility of pelvic fractures in trauma); insertion and maintenance of intravenous or central lines; incision of superficial abscesses and incision and drainage of superficial haematomas; percutaneous drainage of abscesses and haematoma under radiation or ultrasound guidance; minor suturing of uncomplicated skin lacerations; risk from handling sharps (such as handling needles and scalpels outside of a patient's body).

Exposure prone procedures (EPPs) are procedures where there is a risk of injury to the HCW resulting in exposure of the patient's open tissues to the blood of the HCW. These procedures include those where the HCW's hands (whether gloved or not) may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. [5, 76].

Examples of EPPs include:

- **Cardiothoracic surgery:** generally all cardiothoracic procedures.
- **Dentistry:** including maxillofacial surgery and oral surgical procedures, including the extraction of teeth (but excluding extraction of highly mobile or exfoliating teeth), periodontal surgical procedures, endodontic surgical procedures, implant surgical procedures.
- **Gynaecological surgery:** including perineal surgery, trans-vaginal surgery, and open abdominal gynaecological surgery.
- **Neurosurgery:** that involves exposure to sharp bone fragments e.g. trauma and some spinal surgery.
- **Obstetric or midwifery procedures:** including caesarean birth, instrumental birth, infiltration of the perineum with local anaesthetic, episiotomy, repair of an episiotomy or perineal/vaginal tear, application of a fetal scalp electrode, and fetal blood sampling.

- **Open surgical procedures:** including open abdominal or thoracic general surgery, open abdominal or thoracic vascular surgery and open urological procedures.
- **Orthopaedic procedures:** including procedures involving the cutting or fixation of bones or the distant transfer of tissues from a second site (such as in a thumb reconstruction), and open surgical procedures where there is the possibility of bone fragments and/or bone spicules, mechanical drilling is involved, or the procedure involves deep tunneling using sharp instruments.
- **Otolaryngology, head and neck surgery:** in particular bony facial reconstructive surgery (elective or after trauma).
- **Plastic surgery:** where it involves extensive cosmetic procedures that involve bony reconstruction or free tissue transfer involving bone or in the thorax.
- **Trauma:** including open head injuries, facial and jaw fracture reductions, extensive soft tissue trauma, rectal examination in the presence of suspected pelvic fracture, deep suturing to arrest haemorrhage and internal cardiac massage.

Examples of procedures that are generally considered to be non-EPP but have the potential to escalate to open or trauma procedures that will require access to a colleague who can perform EPPs include:

- **Minimally invasive procedures:** including laparoscopy, endovascular procedures, thoracoscopic procedures, Natural Orifice Transluminal Endoscopic Surgery (NOTES), cystoscopic procedures, arthroscopic procedures, and robotic surgery.
- **Trauma/emergency situations:** there is the risk in trauma/emergency situations that a previously non-EPP may escalate (and quickly) into an EPP. This context must be considered for paramedics, emergency department staff, and HCWs who work in rural or remote areas.

These lists are intended as a guide only and do not cover all eventualities and must be interpreted with caution. Moreover, it is recognised that variations in practice may exist in Australia, and may change over time. It is therefore recommended that the over-arching EPP definition given is used as the primary guidance when deciding whether a particular practice/procedure is exposure prone or not. The relevant specialist college can provide more detailed information about what procedures are considered exposure prone in their specialities. The relevant specialist colleges may recommend a greater frequency of BBV testing for their speciality, particularly when high risk EPPs are commonly performed, and their contact details are provided in Appendix 2: Roles of the National Guidelines.

Attachment 1: Blood Borne Virus Student Declaration Form
All student health care workers of a discipline* that undertakes exposure prone procedures (EPPs) must complete this document prior to their first clinical placement, and again after repeat testing has been undertaken every three years. Students will only be permitted to attend clinical placements if they have submitted this form.

The educational provider must ensure that all student health care workers of a discipline* that undertakes EPPs have completed this form and submitted it for assessment by NSW Health.

Declaration	Initials
I have read and understand the requirements of the *Australian National Guidelines for the Management of Healthcare Workers Living with Blood Borne Viruses and Healthcare Workers who Perform Exposure Prone Procedures at Risk of Exposure to Blood Borne Viruses* and the NSW Health policy *Management of health care workers infected with HIV, Hepatitis B or Hepatitis C and health care workers who perform exposure prone procedures*.	
Select either A or B ☐ A: I have undergone testing for blood borne viruses** (BBVs) at commencement of study in Australia or within the 12 months prior to commencement. ☐ B: I have undergone a repeat test for BBVs within a three year period from the date of my last test. The date of my test was: _____	
I agree to the following: • be tested for Hepatitis B, Hepatitis C and HIV at least once every three years. • have appropriate and timely testing and follow up care after a potential occupational exposure associated with a risk of BBV acquisition. • have appropriate testing and follow up care after potential non-occupational exposure, with testing frequency related to risk factors for virus transmission. • notify the person identified in the health facility local procedures if I am newly diagnosed with a BBV and will refrain from performing EPPs until a risk management plan has been developed by the NSW Health agency during the placement. • cease performing all EPPs if diagnosed with a BBV until the criteria in the *National Guidelines* are met.	

Declaration: I _____ declare that I comply with the requirements of the *National Guidelines* and that the information provided is correct.

Full name:	*Date of Birth:*	*Student ID:*
Email:	*Education Provider:*	
Date:	*Signature:*	

***Disciplines that undertake exposure prone procedures** include: medicine; midwifery; paramedicine; dentistry and oral health.
****Relevant blood borne viruses** are Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C.

OCCUPATIONAL ASSESSMENT, SCREENING AND VACCINATION AGAINST SPECIFIED INFECTIOUS DISEASES (PD2023_022)

PD2023_022 replaced PD2022_030

POLICY STATEMENT

All NSW Health organisations must establish systems to ensure that all workers are appropriately assessed, screened and vaccinated to reduce the risk associated with vaccine-preventable diseases in accordance with the risk category of their position.

These diseases include SARS-CoV-2 (COVID-19), diphtheria, tetanus and pertussis, hepatitis B, measles, mumps, rubella, varicella, tuberculosis and influenza.

SUMMARY OF POLICY REQUIREMENTS

All workers must be assessed, screened and vaccinated as required by the risk category of their position before they commence employment/ engagement or attend clinical placements in NSW Health facilities.

Each NSW Health agency must ensure that resources and appropriately trained assessors are provided to conduct assessments of compliance.

All workers and new recruits are required to receive 2 doses of a Therapeutic Goods Administration approved or recognised COVID-19 vaccine to commence employment/ engagement or continue to work within a NSW Health service.

A worker and new recruit will be considered compliant if they have a medical contraindication to all available Therapeutic Goods Administration approved or recognised COVID-19 vaccines and provide medical contraindication evidence in line with the policy requirements.

In addition, all Category A workers and new recruits are required to receive one dose of the seasonal influenza vaccine annually to be considered compliant.

Category A workers and new recruits who are non-compliant with seasonal influenza vaccination or have a medical contraindication to influenza or COVID-19 vaccinations must comply with all other infection control risk reduction strategies as directed while working in a Category A position.

Category A workers and new recruits must have completed the Tuberculosis (TB) Assessment Tool and the follow-up required.

For new recruits, compliance with this Policy Directive is at the individual's own cost (except for chest x-ray and/ or TB clinical review where required). Workers employed in existing positions must be informed of the requirements of this Policy Directive and any assessments, screening and vaccinations required to meet compliance must be provided as required at no cost to the worker.

Workers and new recruits who have been granted temporary compliance for hepatitis B or tuberculosis must complete the Undertaking/Declaration Form and comply with the requirements within 6 months for hepatitis B compliance, or, in the case of tuberculosis temporary compliance, attend chest x-ray surveillance and clinical reviews as required by the tuberculosis service/ chest clinic until discharged.

Ongoing compliance includes a diphtheria, pertussis, and tetanus (dTpa) booster every 10 years.

All job advertisements must advise potential applicants of the requirements of this Policy Directive and new and existing position descriptions must include the designated risk category of the position.

All students must be advised of the requirements of this Policy Directive prior to and at enrolment/ commencement of the course.

Compliance details must be recorded in VaxLink or ClinConnect (students and facilitators).

The full version of the Occupational Assessment, Screening and Vaccination against specified Infectious Diseases Policy and Procedures is available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_022

CREUTZFELD-JAKOB DISEASE RELATED INFORMATION SHARING
(PD2014_041)

PURPOSE

To facilitate patient and public health management of suspect cases of Creutzfeld-Jakob Disease (CJD) in NSW residents, a Deed between the Health Administration Corporation (for NSW Health) and the Florey Institute of Neurosciences and Mental Health (for the Australian National Creutzfeld-Jakob Disease Registry) has been endorsed for mutual sharing of information about suspect CJD cases in NSW.

This Policy Directive describes the information to be disclosed, and the disclosure procedure, for information to be provided from NSW Health to the Australian National Creutzfeld-Jakob Disease Registry.

MANDATORY REQUIREMENTS

NSW Health must notify suspected CJD cases and other variants of prion diseases, including variant CJD (vCJD), to the Australian National Creutzfeldt-Jakob Disease Registry (ANCJDR) for the purposes of national surveillance, exposure investigation, classification of the case, and to inform public health response.

IMPLEMENTATION

As required by the *Public Health Act 2010 (NSW*), doctors, hospitals and laboratories must notify suspected CJD cases and other variants of prion diseases, including variant CJD (vCJD), to the local public health unit, who will then inform the Australian National Creutzfeldt-Jakob Disease Registry (ANCJDR).

If the ANCJDR then requires additional information from a doctor, hospital or laboratory for a suspect CJD case in NSW, this must be provided.

The information to be disclosed, and the disclosure procedures for information to be provided by NSW Health and the Australian National Creutzfeld-Jakob Disease Registry (ANCJDR) are described in the following *CJD Related Information Sharing:Procedures, Section 2*.

1. BACKGROUND

1.1 About this document

Identification of suspect cases of Creutzfeld-Jakob Disease (CJD) is needed by public health to determine risks of transmission and to minimise these risks for public safety through infection control.

To facilitate patient and public health management of suspect cases of CJD in NSW residents, a Deed between NSW Health and the Australian National Creutzfeld-Jakob Disease Registry (ANCJDR) at the Florey Institute of Neurosciences and Mental Health (FNI) has been endorsed for mutual sharing of information about suspect CJD cases in NSW.

Under the *NSW Public Health Act 2010*, doctors, hospitals and laboratories must notify suspected CJD cases and other variants of prion diseases, including variant CJD (vCJD), to Health Protection NSW, who will then inform the ANCJDR for the purposes of national surveillance, exposure investigation, classification of the case, and to inform public health response.

Additional information may be requested by the ANCJDR from a doctor, hospital or laboratory for a suspect CJD case in NSW.

The information to be disclosed, and the disclosure procedures for information to be provided by NSW Health and the Australian National Creutzfeld-Jakob Disease Registry (ANCJDR) are described in *Section 2*.

1.2 Key definitions

Australian National Creutzfeld-Jakob Disease Registry (ANCJDR)	The ANCJDR was established in October 1993 in response to the recognition of four probable Australian human pituitary hormone related CJD deaths. The FNI is responsible for the ANCJDR under the auspices of a contract with the Commonwealth to determine all suspect cases of TSE in Australia.
Creutzfeld-Jakob Disease (CJD)	CJD is a fatal neurological disorder thought to be caused by the accumulation of abnormal proteins known as prions. Prions are transmissible under certain rare circumstances. CJD is part of a group of diseases known as Transmissible Spongiform Encephalopathies (TSEs), and has two main forms - classical (which includes sporadic, familial and iatrogenic cases) and variant CJD.
Authorised clinician	A NSW clinician who is an employee under the *Health Services Act 1997 (NSW).*
CJD Related Information Sharing Deed	The Deed provides the legal framework for sharing information about suspect cases of CJD between NSW Health and the ANCJDR.

1.3 Legal and legislative framework

1.3.1 *CJD Related Information Sharing Deed 2014*

A Deed describing the responsibilities of the Health Administration Corporation (for NSW Health) and the Florey Institute of Neurosciences and Mental Health (FNI) (for the Australian National Creutzfeld-Jakob Disease Registry) for disclosure of information between NSW Health and the ANCJDR, including the confidentiality obligations, return of information and other general aspects of the agreement. The disclosure information and disclosure procedure are described in an attached Schedule.

1.3.2 *Public Health Act 2010 (NSW)*

CJD, including vCJD, is a notifiable disease under the Act.

NSW Health Notifiable Disease Data Security and Confidentiality, PD2012_047

In accordance with this Policy Directive, NSW Health is permitted to release identifying data on the basis that, where available, the patient (or their 'authorised representative') has given explicit written permission for such release of information.

1.3.3 *Health Records and Information Privacy Act 2002 (NSW)*

In accordance with the Health Privacy Principles in the Act, NSW Health will, when reasonable, disclose confidential information to the ANCJDR.

1.3.4 *Health Services Act 1997 (NSW)*

A NSW Health authorised clinician defined as an employee under the Act may directly notify a possible case of CJD to the ANCJDR.

2. DISCLOSURE INFORMATION AND DISCLOSURE PROCEDURE

2.1 Responsibilities

2.1.1 NSW Health

Under the *NSW Public Health Act 2010*, doctors, hospitals and laboratories must notify suspected CJD cases and other variants of prion diseases, including variant CJD (vCJD), to Health Protection NSW, who will then inform the ANCJDR for the purposes of national surveillance, exposure investigation, classification of the case, and to inform public health response.

2.1.2 Florey Institute of Neuroscience and Mental Health (FNI)

The ANCJDR will:

- Undertake exposure investigation and final classification of suspected cases of CJD in order to determine the likely diagnosis, the cause of the disease in each case and if there are any implications for public health. For this purpose, ANCJDR will collect information from patients, with consent if possible, referred to the FNI by NSW Health, from treating clinicians and/or from the 'authorised representative', as necessary. The FNI will collect information about cases or possible cases in accordance with the Privacy Laws.
- Conduct public health surveillance for CJD in NSW residents to monitor trends in the incidence, risk factors and clinical outcomes of CJD and its various forms.
- Notify NSW Health of cases and publish annual summary data about NSW cases.
- Provide advice to individual clinicians about suspect, possible, probable or confirmed cases, recommending investigations or other follow up, including infection control measures, as required.
- Provide advice to NSW clinicians, NSW Health and NSW public health units about public health risks (specifically the risks of transmission of CJD to others) of any individuals referred to the ANCJDR, as required.
- Provide advice to NSW Health in relation to the incidence of CJD on an ongoing basis.

The FNI will not share any information with international bodies for the purpose of research or otherwise without the written permission of NSW Health. Any such information must be appropriately de-identified.

2.2 Disclosure Information

The information to be exchanged between NSW Health and the ANCJDR, including the following personal information, to the extent that this information is available:

<u>General cases</u>

1. Patient name
2. NSW Health unique identifier number eg Medical Record Number
3. Date of birth
4. Residential address at time of notification
5. Hospital at the time of notification
6. Treating doctor name and contact telephone number
7. Issues of concern/relevant public health issues

8. FNI outcome classification
9. Date and cause of death if applicable
10. Officer notifying outcome
11. Details of the patient's relevant medical condition(s), including investigations and relevant medical treatments.

Classical cases

12. History of relevant surgery, particularly neurosurgery or ophthalmic surgery or invasive neurological testing (including stereotactic EEG).
13. History of receipt of corneal transplant, or of receipt of human dura mater graft (particularly 'Lyodura' used in Australia between 1972 and 1987).
14. History of Treatment with cadaver-derived human pituitary hormones (used for treatment of short stature or infertility in Australia between 1967 and 1985).
15. History of receiving or donating blood, other blood products or organs.
16. History of dental or surgical care, renal dialysis, or other medical procedures, tattoos or piercings, or acupuncture.
17. Family history of similar illness.

Variant CJD

18. Screening for variant CJD risk factors including travel history and consumption of foods suspected containing beef or bovine products for any case of suspected or confirmed variant CJD.

2.3 Disclosure Procedure

2.3.1 Information from NSW Health to the ANCJDR

- A NSW Public Health Unit (PHU) will notify the ANCJDR of possible, probable or confirmed cases of CJD and its variant (vCJD) where the PHU is aware that no previous report has been made by the treating clinician.
- A NSW authorised clinician (to the extent that they are an employee under the *Health Services Act 1997* (NSW)) may directly notify a possible case to the ANCJDR.
- Where additional clinical information is required by the ANCJDR to classify a case or undertake the exposure investigation, the clinician or healthcare facility will be directly contacted by the ANCJDR.
- Information included under the Deed can be provided by the treating clinician or healthcare facility under the following circumstances:
  - With patient consent
  - With consent from the patient's 'authorised representative' in circumstances where the patient lacks capacity.

The *Health Records and Information Privacy Act 2002* sets out a list of people who can be an authorised representative on behalf of a patient who lacks capacity. This is set out in the Privacy Manual for Health Information (March 2015) as amended from time to time. It includes someone who has an '*enduring* power of attorney' for the individual or is a guardian.

- With consent from the patient's authorised representative or a close relative in circumstances where the patient is deceased. Once a patient has died, the authorised representative will be an executor or administrator of the deceased's estate which endures indefinitely. Powers of attorney and guardianship orders cease on death.

- In circumstances where consent cannot be obtained from the person, or their authorised representative (or is unreasonably delayed), exemptions set out in the *Health Records and Information Privacy Act 2002* (and the Privacy Manual for Health Information (March 2015), as amended from time to time) may be applicable in allowing the release of information under the Deed.

- If the ANCJDR encounters problems in obtaining information for a particular case, they may contact Health Protection NSW to request assistance under the auspices of the Deed.

2.3.2 Information from the ANCJDR to NSW Health

- The ANCJDR will report all notifications of possible NSW cases reported directly to the ANCJDR eg from clinicians, family members, or the CJD support group, or other individuals.
- The ANCJDR will report the final classification of NSW cases to NSW Health.

NSW FRAMEWORK AND STANDARD OPERATING PROCEDURE FOR HIV POINT OF CARE TESTING (GL2019_010)

GL2019_010 rescinds GL2015_018

PURPOSE

This Framework has been developed to guide the delivery of high quality, safe, sustainable and appropriate Point of Care Testing (PoCT) for HIV within NSW Health supported non-laboratory settings in NSW in order to increase uptake of HIV testing among high risk groups, increase the proportion of people who receive their test result, and reduce the number of people with undiagnosed HIV infection.

KEY PRINCIPLES

Point of Care Testing (PoCT) is one pathway to increase testing for HIV, particularly among high risk groups who can experience barriers to testing, including the need to attend a health service to access a test, time taken for test results to be available, poor access to health care providers, stigma and the risk of discrimination. PoCT addresses these barriers through increasing access, supporting autonomy, and providing convenience. PoCT should be offered where possible in conjunction with STI screening and/or conventional HIV testing.

Based on the epidemiology of HIV infection, PoCT for HIV is appropriate for gay men and other men who have sex with men (MSM). PoCT for HIV is generally not appropriate in populations with a low prevalence of undiagnosed HIV infection because of the lower positive predictive value of PoCT in these populations.

Only PoCT devices approved by the Therapeutic Goods Administration (TGA) can be used for HIV testing in Australia. Testing must be conducted in accordance with any product specific conditions placed on the test by the TGA. Information on approved tests and product specific conditions is available from the TGA website www.tga.gov.au.

For a PoCT site to be eligible to operate under the NSW Framework and participate in the NSW Health Quality Assurance and Safety package from the St Vincent's NSW State Reference Laboratory for HIV, it is required to use the NSW Health recommended HIV PoCT device.

A PoCT site that elects to operate outside the NSW Health Framework and the NSW Health Quality Assurance and Safety package would require a strong justification for using an alternative HIV PoCT device to that NSW Health recommended device. In these circumstances, each site should be assessed on a case by case basis and would be required to make a submission to NSW Health outlining the relative benefits of the alternative test with regards to service efficiency, client throughput and test performance for the particular site submitting the application.

USE OF THE GUIDELINE

This Framework is for NSW Health, other NSW Government departments, health professionals, others involved in the delivery of health services and non-government organisations involved in providing HIV related services.

To download the Guideline please go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_010

HUMAN IMMUNODEFICIENCY VIRUS (HIV) – MANAGEMENT OF NON-OCCUPATIONAL EXPOSURE (PD2015_005)

PD2015_005 rescinds PD2006_005.

PURPOSE

This Policy Directive outlines the service obligations of Local Health Districts (LHDs) in the management of individuals who have been exposed or suspected to have been exposed to HIV in a non-occupational setting.

Evidence suggests that the timely provision of post-exposure prophylaxis (PEP) following a non-occupational exposure may prevent subsequent HIV infection. Prescribing of PEP must be based on a careful risk assessment of the risk of HIV infection in accordance with the national guidelines *Post Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV* published in December 2013 ('National PEP Guidelines').

This Policy Directive should be read in conjunction with National PEP Guidelines, which provide comprehensive clinical guidance on PEP provision.

MANDATORY REQUIREMENTS

LHDs are responsible for the cost of drugs used in PEP, and for ensuring that prescribing is conducted in accordance with the National PEP Guidelines. LHDs must ensure that local PEP services address the time-critical nature of PEP assessment and commencement, and provide prompt referral and follow-up of all patients prescribed PEP.

Compliance with this Policy Directive is mandatory for all health care providers in receipt of funding from NSW Health, including Local Health Districts and Chief Executive Governed Statutory Health Corporations, and Affiliated Health Organisations (both declared and undeclared), and their staff.

IMPLEMENTATION

Chief Executives of LHDs, Statutory Health Corporations and Affiliated Health Organisations in receipt of funding from NSW Health are responsible for ensuring that:

- Local policies and procedures are in place to ensure provision of PEP in accordance with the National PEP Guidelines (Section 2).
- PEP drug provision is funded through the LHD.
- All staff are made aware of their obligations in relation to this Policy Directive; and
- All staff receive appropriate training to enable them to carry out their obligations in relation to this Policy Directive.

All staff must comply with this Policy Directive.

1. BACKGROUND

This Policy Directive specifies the service obligations of Local Health Districts (LHDs) in the provision of Post Exposure Prophylaxis (PEP) for non-occupational HIV exposure. It should be read in conjunction with the national guidelines *Post-Exposure Prophylaxis after Non-Occupational and Occupational exposure to HIV* published in December 2013[1] ('the National PEP Guidelines'), which provide comprehensive clinical guidance.

[1] http://www.ashm.org.au/pep-guidelines

There is evidence in relation to HIV that PEP may prevent infection[1], although there are currently no data from randomised controlled trials of PEP efficacy. The prescribing of PEP must be based on a careful assessment of the risk of HIV infection in accordance with the National PEP Guidelines. PEP should be prescribed as soon as possible after exposure and within 72 hours[2].

Drugs used in PEP are not currently funded through the s100 program. LHDs are responsible for the cost of drugs used in PEP, and for ensuring drugs are prescribed in accordance with the National PEP Guidelines. Treatment prescribed at a patient's first presentation, usually sufficient for one week, is a bridging step until the client is fully assessed by an authorised s100 prescriber or specialist affiliated with a designated HIV/AIDS Unit.

LHDs must ensure that PEP services address the time-critical nature of PEP assessment and commencement, and the need for prompt referral and follow-up of all patients who are prescribed PEP.

The occupational exposure of health care workers to the risk of HIV infection is dealt with in the NSW Health Policy Directive PD2005_311 *HIV, Hepatitis B, and Hepatitis C – Management of Health Care Workers Potentially Exposed.*

2. PROCEDURES FOR MANAGEMENT OF HIV NON-OCCUPATIONAL PEP

2.1 General requirements for Local Health Districts (LHDs)

LHDs are required to have policies and procedures in place that ensure provision of PEP in accordance with the National PEP Guidelines, including:

- Emergency response and assessment of the patient to ensure timely administration of PEP where indicated, as soon as possible after exposure and within 72 hours.
- Access 24 hours-a-day to expert advice and guidance on clinical best practice treatment and management of recent HIV exposure.
- Ready access to drugs used for PEP.
- Information about PEP for the patient.
- Informed consent of the patient.
- Prescribing and dispensing of medication.
- Baseline and follow up testing for HIV.
- Assessment of risk of exposure to other infections, with immunisation, testing and treatment as indicated.
- Provision of, or referral for, follow-up assessment and ongoing monitoring by an authorised s100 prescriber, or specialist affiliated with a designated HIV/AIDS Unit, preferably in the patient's local area.
- Referral to specialist counselling and peer support services where indicated.
- Referral to services that offer ongoing blood borne virus (BBV) and sexually transmissible infection (STI) testing and management, such as publicly funded sexual health services, as patients presenting for PEP are often at a high, ongoing risk for other BBVs and STIs.

2.2 HIV status of the source individual

Attempts should be made to contact the source and ask them to have an urgent HIV test. Where possible obtain information about the source individual including HIV status, and if HIV positive, including viral load, whether on treatment, which treatment, any treatment failures or known resistance.

[1] J Hoy, S Lewin, JJ Post, A Street. HIV Management in Australasia: A Guide for Clinical Care. Australasian Society for HIV Medicine, 2009.
[2] National PEP Guidelines at p.8

Initiation of PEP should not be delayed while establishing the HIV status of the source.

2.3 HIV status of the exposed individual

All candidates for PEP require baseline HIV antibody testing. Where possible, the results should be followed up within 24 hours.
Initiation of PEP should not be delayed while determining the HIV status of the exposed individual.

2.4 Management of possible exposure to other conditions

Hepatitis B
All patients presenting for PEP must be assessed for possible hepatitis B exposure, and tested and provided with immunisation including hepatitis B immunoglobulin where indicated[1].

Other conditions for which testing may be indicated, depending on the nature of the exposure, are listed below: See the National PEP Guidelines for a recommended schedule of baseline and follow-up testing for these conditions in conjunction with PEP assessment[2].

Sexually transmissible infections
Patients are to be tested for chlamydia, gonorrhoea, and syphilis, as indicated by the type of exposure.

Hepatitis C
Patients who are potentially at risk of hepatitis C infection after exposure require follow-up and specialist referral if seroconversion is detected.

Pregnancy
All women who have the potential to be pregnant on presentation for PEP should be offered pregnancy testing. Emergency contraception should be offered to women presenting for PEP who are at risk of pregnancy. Follow-up pregnancy testing should be offered at two weeks post-exposure where indicated. If the test is negative but pregnancy is still suspected, the test should be repeated in 1 week. Specialist advice must be sought urgently for women who require PEP and are pregnant or breastfeeding.

2.5 Recording information where a patient is assessed for PEP

Every assessment for PEP must be documented, regardless of whether PEP is commenced. The required information covers the time of the assessment and first dose (if prescribed), details, including date and time of the exposure, information about the exposed person (including any previous HIV test and result), information about the source, details of PEP discussion with the patient, referral, and follow-up arrangements. Further details are provided in the National PEP Guidelines[3].

2.6 Patient confidentiality

The confidentiality of the patient and the source must be maintained in accordance with the requirements of the *Public Health Act 2010* (NSW).

2.7 Quality assurance

LHDs must have a quality assurance process in place to monitor and review the effectiveness of arrangements for managing exposed individuals, including in relation to health outcomes for patients.

[1] National PEP Guidelines at p.15
[2] At p.8
[3] National PEP Guidelines at p.11

3. APPENDIX

3.1 Contacts and information for health care workers

List of NSW HIV s100 prescribers by suburb: http://www.ashm.org.au/hiv/prescriber-lists
Australasian Society for HIV Medicine
Tel: 02 8204 0700

NSW HIV Support Program
Tel: 02 9391 9195
Email: hivsupportprogram@doh.health.nsw.gov.au
Support for doctors and patients where the patient is newly diagnosed with HIV

Needlestick Hotline
Tel: 1800 804 823
Information and support for healthcare, paramedical, and emergency services workers, who sustain a needlestick injury and/or experience occupational exposure to blood and body fluids

NSW Sexual Health Infolink
Tel: 1800 451 624
TTY: 9221 6515

NSW Sexual Health Clinics
Phone the NSW Sexual Health Infoline for information about clinics and services in your area: 1800 451 624
http://www.health.nsw.gov.au/sexualhealth/pages/sexual-health-clinics.aspx

NSW AIDS Dementia and HIV Psychiatry Service
Tel: 02 9382 8600
http://www.health.nsw.gov.au/adahps/pages/default.aspx

Needle Cleanup Hotline
Arranges clean-up of dumped needles and syringes in public places anywhere in NSW
Tel: 1800 633 353

Community services
ACON
Tel: 1800 063 060
www.acon.org.au
Provides health promotion services specialising in people living with with HIV and lesbian, gay, bisexual, transgender and intersex (LGBTI) health.

NSW PEP Hotline
Tel: 1800 737 669
Information, assessment, and referral of people who may require HIV PEP following a high risk exposure (not an information line for general questions about HIV).
Multicultural HIV and Hepatitis Service
Tel: 02 9515 1234
Free call (NSW country): 1800 108 098
www.mhahs.org.au
A statewide service providing information and assistance for culturally and linguistically diverse communities.

NSW Users and AIDS Association (NUAA)
Tel: 02 8354 7300
Tel (NSW Country): 1800 644 413
http://www.nuaa.org.au/
Provides information and support for users of illicit drugs, and their families and friends, as well as needle and syringe program services.

PozHet
Information Line: 1800 812 404
http://pozhet.org.au/
Provides support for heterosexual people with HIV.

Positive Life NSW
Tel: 02 9206 2177
Free call: 1800 245 677
http://www.positivelife.org.au/
Provides support for people living with HIV.

Sex Workers Outreach Project
Tel: 02 9206 2000
www.swop.org.au
Provides sexual health information and support to people who engage in sex work.

HIV Information Line
Tel: 1800 451 600
Information, support, and referral, about HIV.

Legislation, policies and resources

National Guidelines for Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV. Australasian Society for HIV Medicine, 2013
http://www.ashm.org.au/pep-guidelines

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TUBERCULOSIS MANAGEMENT OF PEOPLE KNOWINGLY PLACING OTHERS AT RISK OF INFECTION (PD2015_012)

PD2015_012 rescinds PD2005_068.

PURPOSE

This Policy Directive provides a framework for the management of people with tuberculosis (TB) who knowingly place others at risk of infection.

Where persons with TB knowingly risk infecting others, the health system is responsible for taking action to protect the health of the public.

In circumstances where support, counselling and behavioural change techniques fail, the health service may be required to implement restrictive measures under *The Public Health Act 2010*.

MANDATORY REQUIREMENTS

All staff involved in the care of clients with TB must adhere to these principles.

IMPLEMENTATION

Chief Executives must ensure that:
- The principles and requirements of this policy are applied, achieved and sustained.
- Relevant staff are made aware of their obligations in relation to the Policy Directive.
- Documented procedures are in place to support the Policy Directive.

Clinicians:
- Must comply with this Policy Directive.

1. BACKGROUND

1.1 About this document

This Policy Directive provides a framework for the management of people with tuberculosis (TB) who knowingly place others at risk of infection.

The management framework established by this Policy Directive is based on the following principles and assumptions:
- The general public have the right to appropriate protection against the risk of infection.
- A range of factors, including long duration of treatment, medication side effects, perception of stigma and restrictiveness of daily treatment can impact on a person's willingness to accept and comply with TB treatment.
- Social and other health factors, including drug and alcohol dependence, mental health issues, housing concerns and work, family and other responsibilities can also impact on a person's willingness to accept and comply with TB treatment.
- Lessening of the risk of transmitting TB can be brought about by changes in individual behaviour with the help of counselling and education.
- Each person with infectious TB must accept responsibility for preventing the further transmission of the infection.

This Policy Directive explains the framework and process, through which the health system may encourage, facilitate and potentially enforce adherence to TB treatment.

The management of people with TB who knowingly risk infecting others may require intensive, individualised case management, a variety of responses to broader health and social service needs and an escalating series of behavioural management techniques including counselling, behavioural supervision, formal warnings and Public Health Orders, including, if necessary, detention or referral to law enforcement authorities.

1.2 Key definitions

TB is caused by bacteria from the *Mycobacterium tuberculosis* complex. The disease most commonly occurs in the lungs (pulmonary TB), although it can affect any region of the body (extrapulmonary TB). The pulmonary form is most infectious.

1.3 Legal and legislative framework

TB is a Category 4 Scheduled medical condition under the *Public Health Act 2010*. As such it is an offence for a person who has been diagnosed with TB, and is in a public place, to fail to take reasonable precautions against spreading the condition.

The *Act* contains a mechanism to restrict the behaviour of a person who has TB in certain circumstances, using a Public Health Order.

Authorised medical officers under Section 62 of the *Public Health Act 2010* are the Chief Health Officer, or a registered medical practitioner authorised by the Secretary of the NSW Ministry of Health to exercise the functions of an authorised medical practitioner.

2. THE MANAGEMENT FRAMEWORK

The management framework for people with TB who risk infecting others includes the following levels:

Management level	Summary of case management
1. Local management	• The person is managed by the treating clinician and TB service. Expert advice is sought locally as required.
2. Supported management	• The person is managed by the treating clinician and TB service with support from the NSW TB Program Expert Panel.
3. Public Health Order	• The person is managed by the treating clinician and TB service with support from the NSW TB Program Expert Panel. • A Public Health Order is in place which places conditions on the person in relation to their behaviour, treatment, healthcare and supervision.
4. Detention order	• The person is managed by the treating clinician and TB service with support from the NSW TB Program Expert Panel. • The person's movements are restricted by a Public Health Order which includes an order for detention.

Each level is discussed in detail below. Regardless of the level of management it is important that the person's confidentiality is respected and that any communication regarding the person and their management is restricted to those service providers who are directly involved in management of the issues.

2.1 Level 1: Local Management

2.1.1 Initial counselling, education and support

Counselling, education and support is an integral part of the management of all persons with TB, and must be provided from the time of diagnosis. Persons with infectious TB must receive culturally and linguistically appropriate counselling and education to ensure that they understand the public health significance of their diagnosis and the importance of complying with treatment and isolation. A professional interpreter should be used whenever relevant.

The treating clinician and local TB service are responsible for ensuring counselling and education is provided to the person with TB. The treating clinician and TB service should work in partnership with the client, and provide a supportive environment in which there is a mutual trust between the client and the healthcare workers. The person with TB must be given opportunity to voice concerns and ask questions about their treatment.

In the event that a person with infectious TB is non-compliant with recommended anti-tuberculous treatment or isolation requirements in such a way that is endangering, or likely to endanger the health of the public, as a first step the person's understanding of their public health responsibilities should be clarified, and the power of an authorised medical practitioner to make a Public Health Order explained. Intensive counselling and education to support behavioural change should be implemented. This is best undertaken by the treating clinicians and local TB service.

A suitable community organisation may be able to assist with supporting appropriate behaviour by the individual. Their involvement could include social support, and facilitating self-isolation until non-infectious.

Specific incentives and initiatives may include:

- Counselling.
- Provision of housing or supported accommodation.
- Independent living skills training (help with budgeting, life skills).
- Home care support (shopping, cooking, cleaning).
- Emotional support persons (such as a 'buddy' system or peer support group).
- A letter from the public health unit director to the effect that the attending doctor is concerned about compliance with treatment and emphasising the importance of following the doctor's treatment recommendations.

2.1.2 Psychosocial assessment

A person's ability and willingness to comply with TB treatment and isolation may be impacted by a range of factors, including:

- Homelessness, housing and financial concerns.
- Social isolation.
- Alcohol and illicit drug use.
- Mental illness.
- Psychiatric disturbances related to side effects of TB medications.
- Real or perceived stigma.
- Responsibilities and competing priorities, including work, childcare, education.

A full psychosocial assessment of the person is critical at this stage, if it has not already been undertaken. Expert support from a social worker, psychologist or psychiatrist may be required at this stage. The treating clinician and TB service should work with other healthcare teams involved in the person's management, such as drug and alcohol and mental health services, in order to overcome barriers to the person's non-compliance.

2.1.3 Case conference and consultation

A case conference between the treating clinician, local TB service, Public Health Unit, Aboriginal Health Unit or Multicultural Health Service (if applicable) and other local services involved in the care of the person with TB is often useful in addressing specific management issues, as well as developing a comprehensive care plan for that person.

The NSW TB Program Manager, Communicable Diseases Branch and Public Health Unit Director should also be consulted.

2.2 Level 2: Supported Management

In circumstances where counselling and support measures have failed to mitigate concerns that a person presents an imminent public health risk, more assertive management should be initiated. At this level, the NSW TB Program Manager should be consulted to consider the need to convene an expert panel, additional assessment should be undertaken, and other initiatives should be considered.

2.2.1 Seeking input from the NSW TB Program Expert Panel

Where the treating clinician and local TB service are concerned about the compliance of a person with infectious TB after local management has been attempted, they may seek advice from the NSW TB Program Manager regarding the potential to convene an Expert Panel to consider the case. The constitution of the Expert Panel is detailed in section 3 of this policy directive.

The Expert Panel is convened on a needs basis to review the management of challenging and complex cases. The Expert Panel will review the management of the case and provide advice on additional or alternative strategies.

In cases where the Expert Panel is consulted, care and management of the patient remains the responsibility of the treating clinicians and local TB service.

The TB service must provide a monthly report on treatment progress to the NSW TB Program until the person completes treatment or is transferred out of the TB service.

2.2.2 Letter of warning

A formal letter from the Local Health District Public Health Unit Director to the person should be considered at this stage. In some cases a formal letter of warning may be sufficient to improve behaviour.

This letter would act as an official warning to the person to discontinue any activity which may place other people at risk of infection with TB. The letter would include:

- The responsibilities of the client with respect to their diagnosis of TB.
- Expected behaviours of the client and the rationale for these.
- The services available to the person to support them to comply with their TB management .

- The steps that should be taken by the person to satisfactorily comply with their TB management.
- The legal powers available to take action against persons contravening the public health legislation, including the power to make a Public Health Order.

2.3 Level 3: Public Health Order

In extenuating circumstances where other strategies within management levels 1 and 2 have failed, a Public Health Order may be considered.

In the event that a Public Health Order under the *Public Health Act 2010* is considered the appropriate course of action by the Expert Panel, treating clinician, and local Public Health Unit Director, a recommendation is accordingly made to the Chief Health Officer by Health Protection NSW, in consultation with the NSW Ministry of Health Legal and Regulatory Services Branch.

A Public Health Order may require the person subject to the order to do any one or more of the following:

- To refrain from specified conduct.
- To undergo specified treatment.
- To undergo counselling by one or more specified persons or by one or more persons belonging to a specified class of persons.
- To submit to the supervision of one or more specified persons or of one or more persons belonging to a specified class of persons.
- To undergo specified treatment at a specified place.

2.3.1 Making the Public Health Order

The procedures associated with making a Public Health Order are:

- An authorised medical practitioner may make a written Public Health Order in respect of a person if satisfied on reasonable grounds that the person has TB and because of the way the person behaves, the person may, as a consequence of that condition, be a risk to public health. It would be expected that the authorised medical practitioner would be provided with advice from the Expert Panel to assist in this determination.
- In deciding whether to make a Public Health Order, the authorised medical practitioner must take into account:
    - The principle that any restriction on the liberty of a person should only be imposed if it is the most effective way to prevent any risk to public health.
- Unless it is an emergency or it is otherwise not reasonably practicable to do so, in deciding whether to make a Public Health Order in respect to TB, the authorised medical practitioner must also take into account:
    - Whether reasonable attempts have been made to provide the person with information about the effects of the condition the person has and the risks to public health of that condition.
    - The options other than a public health order that are available to deal with the risk to public health posed by the person.
    - If the proposed public health order will require the person to undergo treatment - the availability and effectiveness of the proposed treatment and the likely side effects of the proposed treatment on the person.
    - If the proposed public health order will require the person to be detained - the likely social, economic, physical and psychological effects of the detention on the person.
    - These guidelines.

- Section 66 of the Act allows a person who is subject to a Public Health Order for a category 4 condition to appeal to the Administrative Decisions Tribunal. A person to whom an Order is issued should be informed of their right of appeal and arrangements should be made to ensure that the person has appropriate legal representation in the Tribunal hearing.

2.3.2 Duration of the Public Health Order

A Public Health Order must state that it expires a specified number of days (not exceeding 28 days) after its service on the person, unless the order is earlier varied as to its duration or is earlier revoked. A Public Health Order ceases to have effect if:

- A copy of the application made to the Administrative Decisions Tribunal for confirmation of the order under Section 64 of the *Public Health Act 2010* is not served upon the client within three days of service of the order.
- The Tribunal revokes the order.
- The order expires before it is confirmed or revoked by the Tribunal or before or after an application to continue the order is made to the Tribunal.
- If the authorised medical practitioner considers that the person subject to the order is no longer a risk to public health, the authorised medical practitioner must revoke the order and immediately give notice in writing of the revocation to the person and the Civil and Administrative Tribunal.

2.3.3 Continuation of orders

Before the expiry of the Order, an authorised medical practitioner may apply to the Tribunal for continuation of the order for a period up to six months if the authorised medical practitioner is satisfied that the person subject to the order would continue to be a risk to public health as a consequence of having TB, if not subject to a Public Health Order.

The decision to seek continuation of a Public Health Order should be made in consultation with the NSW TB Program Expert Panel.

2.4 Level 4: Detention order

It must be emphasised that the use of public health detention is expected to be a rare occurrence, and should only ever be considered as a last resort.

All Local Health Districts should identify appropriate facilities and staff who are able to implement an order for secure detention under the *Public Health Act 2010*. See section 4.

Where the person to whom the Public Health Order applies is already detained under a custodial sentence, consideration should be given to the unique circumstances of implementing the Public Health Order, including:

- That client confidentiality, legal and safety issues be considered, and
- That isolation measures may require negotiation with Justice Health, Corrective Services NSW and Juvenile Justice.

3. NSW TB PROGRAM EXPERT PANEL

The role of the NSW TB Program Expert Panel is to provide expert advice to clinicians and to support local decision making in relation to complex and challenging cases of TB, including persons who knowingly risk infecting others. The Expert Panel is convened on an ad-hoc basis, at the request of the treating clinician or local TB Coordinator.

The treating clinician and local TB Coordinator are responsible for presenting the case to the Expert Panel. The Expert Panel reviews the clinical and public health management of the case and recommends additional or alternative management strategies.

The core constitution of the Expert Panel includes:
- Director, Health Protection NSW (Chairperson)
- Director, Communicable Diseases Branch
- Manager, NSW TB Program (Secretariat)
- At least one nominated expert TB physician
- Director, Public Health Unit (of the relevant local health district).

Additional Expert Panel members are selected based on specific needs of the case, and may include:
- Specialist TB nurses
- Additional expert TB physicians
- Aboriginal health worker
- Social worker
- Psychiatrist
- Representative of a refugee health service, or multicultural health worker
- Professional ethicist
- A member of the relevant community or key support group.

The Panel will advise the Chief Health Officer based on consideration of issues identified in section 2.3.1.

4. ACCOMMODATION

4.1 Hospital facilities

Persons with TB may require hospitalisation, either for the purposes of undertaking investigations, establishing a treatment regimen, or to ensure respiratory isolation. Local Health Districts should be prepared to effectively manage persons with TB who may be resistive to treatment and isolation orders.

Local Health Districts must:
- Develop a management plan addressing the needs of the case, other patients, staff and visitors.
- Provide adequate staff training.
- Assure the availability of appropriate secure facilities and processes, including the use of security personnel ('secure' in this context means the minimum additional security to ensure that the person does not injure themselves, or inconvenience staff or other patients).
- Identify a suitable location for accommodating a person with infectious TB who is detained under public health legislation.

People with TB may have concurrent mental illness, which can potentially be exacerbated by isolation and the effect of some TB medications. Local Health Districts should ensure that relevant expertise is available to safely and effectively manage such patients. The use of mental health legislation for detention of recalcitrant persons with TB will never be appropriate or lawful, except in circumstances where their mental health status is serious enough to warrant detention under the *Mental Health Act 2007*.

4.2 Alternative accommodation

When accommodation is required for the primary purpose of respiratory isolation or public health detention in patients who are medically stable, a non-hospital setting may offer the most appropriate environment. Local Health Districts must consider how best to accommodate people with TB in such situations and ensure suitable security arrangements to maintain them in detention.

MASS VACCINATION CLINICS DURING AN INFLUENZA PANDEMIC
(GL2018_008)

PURPOSE
This Guideline is a supporting document to the NSW Health Influenza Pandemic Plan (PD2016_016). It provides Local Health Districts with the framework to develop operational level plans for the establishment of clinics to deliver mass vaccination to the public.

KEY PRINCIPLES
Immunisation with a vaccine specific for the pandemic influenza strain, when available, is likely to be the most effective measure to control the spread of influenza in the community. The implementation of a mass immunisation program is identified as a key strategy of the Australian and NSW Health influenza pandemic plans.

This Guideline:
- provides guidance to NSW Local Health Districts (LHDs) on how to plan for and operate mass vaccination clinics during an influenza pandemic
- is a supporting guideline and should be read in conjunction with the policy directive NSW Health Influenza Pandemic Plan (PD2016_016), and other supporting guidelines including the Pandemic Guideline – Aboriginal Communities
- recognises that the delivery of mass vaccination of the population with pandemic vaccines will require models different to those currently used for routine immunisation programs in NSW
- outlines the scenarios and strategies that LHDs would be expected to plan for in order to establish and operate mass vaccination clinics
- describes the roles and responsibilities of key national, state and regional level stakeholders assisting in the development or distribution of vaccine and operation of vaccination clinics
- provides guidance on the minimum staff and resource requirements for LHDs to be able to operate vaccination clinics in their district
- may be able to be adapted for other infectious disease emergencies where large-scale vaccination clinics are required.

USE OF THE GUIDELINE
LHDs should use the attached Guideline to develop local plans for the establishment and operation of vaccination clinics should these be required during an influenza pandemic. Sections of particular relevance include:
- Vaccine Storage and Dispatch (Section 4)
- Mass Vaccination Clinic Requirements (Section 5)
- Mass Vaccination Clinic Operations (Section 6)

In planning for the establishment of clinics, LHDs need to:
- consider how to identify and deliver vaccine to likely priority groups in their population;
- in rural areas, consider alternative models where necessary for delivery of vaccination to population groups within their district
- monitor vaccine distribution, uptake and adverse events following immunisation;
- ensure that all staff working under the auspices of the LHD have completed the necessary education and training appropriate to their role in a vaccination clinic;
- work with their local primary healthcare organisations to determine if general practice clinics or community health centres could be used to conduct local mass vaccination clinics during the pandemic; and
- work with Aboriginal Community Controlled Health Services (ACCHS) in their district to determine if mass vaccination clinics could be established and operated within the ACCHSs.

The full guidelines can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_008

NSW CONTINGENCY PLAN FOR VIRAL HAEMORRHAGIC FEVERS (GL2016_002)

PURPOSE

The objectives of the *NSW Contingency Plan for Viral Haemorrhagic Fevers* are to provide guidance to support a coordinated response to the importation of suspected and confirmed cases of viral haemorrhagic fever (VHF), and to make recommendations on the appropriate management of cases and their contacts.

KEY PRINCIPLES

VHFs are severe and life-threatening viral diseases that are endemic to parts of Africa, the Middle East, Eastern Europe, and Asia. VHFs are of particular public health importance because they can spread via human-to-human contact in the community and particularly within hospital settings. They are often associated with a high case fatality rate as there are few if any effective treatments.

A single case of VHF constitutes a public health emergency. The management of a VHF patient requires considerable care to prevent further transmission in clinical settings and extensive public health action to identify and manage close contacts at risk of infection.

Contingency planning for VHFs aims to enable early diagnosis of VHF cases, to provide VHF patients with appropriate clinical care in a safe environment, and to prevent transmission to other people.

VHFs are notifiable infectious diseases and scheduled medical conditions under the NSW Public Health Act (2010). VHFs are also listed diseases under national biosecurity legislation and the International Health Regulations.

USE OF THE GUIDELINE

Chief Executives should ensure:

- Local protocols are developed based on the NSW Contingency Plan for Viral Haemorrhagic Fevers Practice Guideline
- Local protocols are in place in all hospitals and facilities which may be required to assess or manage patients with a VHF
- Ensure that all hospitals and facilities are appropriately resourced to safely assess, manage and, if indicated, transfer patients with a VHF
- Ensure that all staff treating patients are trained in the use of the NSW Contingency Plan for Viral Haemorrhagic Fevers Practice Guideline and locally developed protocols
- Ensure that clinical laboratory staff are educated in the use NSW protocols for the safe collection, transfer and testing of clinical specimens for VHF testing.

The full guidelines can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2016_002

PANDEMIC PREPAREDNESS AND RESPONSE – ABORIGINAL COMMUNITIES (GL2019_009)

PURPOSE

This Guideline is a supporting document to the *NSW Health Influenza Pandemic Plan* (PD2016_016). It is intended to support Local Health Districts (LHDs) in implementing pandemic preparedness and response activity specifically related to Aboriginal people.

KEY PRINCIPLES

Aboriginal people in NSW are at a greater risk from morbidity and mortality during an influenza pandemic. Without specific consideration and preparedness, a future pandemic may exacerbate existing health inequalities in Aboriginal communities.

Pandemic planning requires close and ongoing partnerships with Aboriginal people and communities to develop effective and culturally appropriate strategies for reducing the risk of a pandemic. This Guideline outlines key issues in pandemic preparedness and responses that are specific to Aboriginal communities and which need to be addressed for pandemic planning at state, regional and local levels, in conjunction with key stakeholders. This Guideline:

- Describes the roles and responsibilities of key NSW stakeholders in the implementation of this guidance;
- Outlines the strategies that LHDs would be expected to consider when working with Aboriginal communities in pandemic planning;
- Provides guidance for LHDs over activity that should be considered at each stage of a pandemic in NSW
- Is a supporting Guideline to the NSW Health Policy Directive *Influenza Pandemic Plan* (PD2016_016).

This Guideline is also intended to inform the Aboriginal Health and Medical Research Council of NSW (AH&MRC), Aboriginal Community Controlled Health Services (ACCHS) and other relevant stakeholders about ways of working with LHDs in pandemic preparedness and during the response.

USE OF THE GUIDELINE

LHDs should use the attached Guideline to lead the planning and response to the pandemic at a District level, and collaborate with ACCHSs to determine appropriate health service models for local Aboriginal people and communities during a pandemic. Key considerations are the need to:

- Work in collaboration with ACCHSs, Aboriginal Community Leaders and Elders' groups, Local Aboriginal Lands Councils (LALCs) and any Local Decision Making (LDM) regional alliances
- Take a family centred approach towards prevention
- Provide culturally appropriate information for families and means of communicating the information
- Seek input from AH&MRC and/or ACCHSs to develop and disseminate health messages effectively, including information about why Aboriginal people may be prioritised for antiviral treatment and or vaccination
- Show respect and acknowledgement of the Aboriginal land or Country being entered when undertaking pandemic planning and during a pandemic.

The full guidelines can be downloaded at

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2019_009

MANAGEMENT OF PEOPLE EXPOSED TO A CONTACT ORDER CONDITION (PD2019_037)

PURPOSE

This Policy Directive provides a process for the management of people who have been exposed to certain serious infectious diseases that pose a threat to public health because they can be either rapidly spread in the community, have a high mortality rate, or in the case of typhoid, can be transmitted by people without symptoms through food handling.

These conditions are known as 'contact order conditions'. Persons who have been exposed to a contact order condition can be subject to a public health order under The Public Health Act 2010 (the Act).

This Policy Directive explains the process through which the health system may encourage, facilitate and, only if required, enforce compliance with recommendations to avoid certain behaviours and/or other quarantine requirements for people following exposure to a contact order condition.

Public health orders are measures of last resort to prevent a public health risk and, in the case of exposure to contact order conditions, are only used when voluntary quarantine recommendations are refused.

MANDATORY REQUIREMENTS

All staff involved in the management of people who have been exposed to a contact order condition must adhere to these principles.

IMPLEMENTATION

Chief Executives must ensure that:

- The principles and requirements of this policy are applied, achieved and sustained
- Relevant staff are made aware of their obligations in relation to the Policy Directive
- Documented procedures are in place to support the Policy Directive.

Clinicians:

- Must comply with this Policy Directive.

Management of People Exposed to a Contact Order Condition Procedures

1 BACKGROUND

About this document

This Policy Directive provides a process for the management of people who have been exposed to certain serious infectious diseases that pose a threat to public health because they can be either rapidly spread in the community, have a high mortality rate, or in the case of typhoid, can be transmitted by people without symptoms through food handling. These conditions are known as "contact order conditions". Persons who have been exposed to a contact order condition can be subject to a public health order under the Public Health Act 2010 (the Act).

The management framework established by this Policy Directive is based on the following principles and assumptions:

- The general public have the right to appropriate protection against the risk of serious communicable infections.

- A person exposed to serious communicable infection has an important role in preventing the further transmission of the infection.
- Effective quarantine permits early detection and clinical management of serious infections where they arise, and helps to prevent further transmission.
- Counselling can affect the person's behaviour and lessen the risk of transmission.
- A person's willingness to comply with quarantine requirements is influenced by a range of factors, including the degree and duration of the restrictions, their physical and mental health, and their social, housing, work and family circumstances and responsibilities.
- Any public health measure implemented should be proportional to the public health risk posed.
- Any restriction on the liberty of a person should be imposed only if it is the most effective way to prevent a risk to public health.

This Policy Directive explains the process through which the health system may encourage, facilitate and, only if required, enforce compliance with recommendations to avoid certain behaviours and/or enter quarantine requirements for people following exposure to a contact order condition.

Public health orders are measures of last resort to prevent a public health risk and, in the case of exposure to contact order conditions, are only used when voluntary quarantine recommendations are refused.

Key definitions

Authorised medical practitioner: means the NSW Chief Health Officer or a registered medical practitioner authorised by the Secretary to exercise the functions of an *authorised medical practitioner* under Division 4 of the Act.

Contact order condition: means one of the conditions listed in Schedule 1A of the Act as contact order conditions. These are reproduced in Table 1 below. More information about each condition and the related public health concerns are included in the Appendices.

Expiry period: means the maximum period which a person who has been exposed to a contact order condition can be subject to a public health order. The expiry period for each contact order condition correlates to the expected incubation periods for each condition.

Exposed
The term 'exposed' is used when a person has encountered a disease causing pathogen in a way that is judged to be sufficient for infection to take place. However, it is not necessarily the case that infection occurs. The criteria for a person to be judged to have been 'exposed' vary by the disease and are described in published public health control guidelines for each disease as 'contact definitions'. Public health authorities apply these criteria to contacts identified during investigations of people with the disease.

Incubation period: means the time period between when a person is exposed to a pathogen and the appearance of the first symptoms or signs of the condition caused by infection with the pathogen. It is assumed that if an exposed person has not developed the signs or symptoms of the condition by the end of the incubation period then they are no longer at risk of developing the infection from that exposure.

Table 1: The five contact order conditions listed in Schedule 1A with their expiry periods:

Condition	Expiry period
Avian influenza in humans	10 days
Middle East respiratory syndrome coronavirus	10 days
Severe Acute Respiratory Syndrome	10 days
Typhoid	14 days
Viral haemorrhagic fevers	21 days

Isolation: refers to the public health practice of separating ill people who have a serious communicable disease from those who are healthy. This enables treatment of the person to be provided while preventing exposure of well people.

Quarantine: means the limitation of freedom of movement of a person who may be infected with a disease, but who has not yet developed symptoms or signs. Quarantine continues until the incubation period for the disease expires. If a person in quarantine develops symptoms or signs of the disease then clinical management in isolation is arranged. Quarantine (and isolation) may be voluntary or enforced.

Legal and legislative framework

The amendments to the Act relating to contact order conditions came into force on 1 April 2018.

Division 4 of Part 4 of the Act details the powers and provisions related to public health orders for Category 4 and 5 conditions and public health orders made in respect to a person exposed to a contact order condition.

Under section 62(1)(b) of the Act, an *authorised medical practitioner* may make a public health order in respect of a person if satisfied, on reasonable grounds, that the person:

- has been exposed to a contact order condition, and
- is at risk of developing the contact order condition, and
- because of the way the person behaves, may be a risk to public health.

THE MANAGEMENT STAGES

The management of people exposed to a contact order condition begins with a voluntary stage that seeks to support the person to comply with recommendations to avoid certain behaviours and/or enter into voluntary quarantine. It only proceeds to consideration of a public health order if the person refuses to comply with some or all of these recommendations.

Management of typhoid contacts

For contacts of a person with a typhoid infection, the focus of public health measures is to restrict specific activities that have a higher likelihood of disease transmission, such as preparing food for others or caring for vulnerable contacts (e.g. child care work).

Contacts who are assessed to be at higher risk of transmitting infection because of occupational or personal characteristics are recommended to be excluded from work, school, and child care until they can be excluded as a typhoid case. Usually this is achieved after they provide two negative stool samples at least 24 hours apart. If feasible, they may undertake other duties (not high risk) while awaiting specimen results.

Other quarantine measures are unlikely to be recommended for typhoid contacts.

Voluntary quarantine

For contacts exposed to one of the listed contact order conditions (other than typhoid), it is important to stress the importance of quickly achieving appropriate[1] quarantine arrangements. This ensures that other people are not exposed to these serious conditions if a contact is already infectious or becomes infectious during the incubation period.

Counselling and support is an integral part of the management of all persons exposed to a contact order condition but it needs to be balanced with the public health imperative to rapidly implement disease control measures.

People exposed to a contact order condition should receive culturally and linguistically appropriate counselling to ensure that they understand the public health significance of their exposure and the importance of their compliance with quarantine. A professional interpreter should be used whenever relevant.

The person is to be managed in voluntary quarantine by the public health unit (PHU) of the relevant local health district (LHD), with additional support through the LHD. PHU staff must counsel the person and seek agreement for voluntary quarantine for the person. The LHD should identify and seek to overcome any barriers to quarantine (e.g. family, accommodation, employer, pet care). The PHU should identify whether other agencies may be able to assist, such as Aboriginal medical services when an Aboriginal person is identified as a contact.

The PHU must also provide documentation and information to the person explaining why voluntary quarantine is necessary, for how long it will last, how the person in quarantine can get support, and the possible consequences if voluntary quarantine is refused. This may include organising supporting letters from the PHU director for employers where required.

Daily contact is to be made by the PHU with the person in quarantine to monitor for signs or symptoms of infection, typically by phone. If concerns arise, the PHU must take action to organise appropriate investigation and isolation for the patient.

Health Protection NSW will provide expert advice to support the PHU.

Case conference and consultation

A case conference between the PHU and other local services involved in the care of the person is essential in addressing specific management issues, as well as developing a comprehensive quarantine and monitoring plan for that person. The Director, Communicable Diseases (HPNSW) should also be invited to attend.

Psychosocial assessment

A person's ability and willingness to comply with quarantine restrictions may be impacted by a range of factors, including housing and financial concerns, mental illness, real or perceived stigma, and competing responsibilities, including work, childcare, and education.

The LHD should support the PHU and work with appropriate agencies in order to overcome barriers to the person's non-compliance.

If voluntary quarantine is refused

In the event that a contact is not compliant with recommended quarantine and monitoring requirements in such a way that is endangering, or likely to endanger the health of the public, as a first step the PHU should counsel the person to ensure that he or she understands the public health consequences of refusal, and the power of an *authorised medical practitioner* to make a public health order.

[1] As assessed by the Public Health Unit Director.

The PHU should identify barriers and provide specific incentives (e.g. books, movies, games to overcome boredom) and other initiatives, such as further specialised counselling, or providing appropriate accommodation for quarantine.

The PHU may also deliver a formal letter from the PHU director that emphasises the importance of following the PHU quarantine recommendations and possible implications of refusing recommendations, such as a public health order. Before any formal warning letter is sent, Legal and Regulatory Services should be consulted.

In circumstances where counselling and support measures have failed to mitigate concerns that a person will not comply with quarantine requirements, more assertive management should rapidly be initiated.

A consultation by a public health physician and or infectious diseases physician should be organised to ensure that the person understands the public health significance of their exposure and the importance of their compliance with quarantine.

Additional support from HPNSW

The Director, Communicable Diseases Branch should also be consulted to consider the need to convene an expert panel, and other initiatives should be considered.

Where the PHU director is concerned about the compliance of a person exposed to a contact order condition they may seek advice from the Director, Communicable Diseases Branch regarding the potential to consult with the Executive Director, Health Protection and the Chief Health Officer.

The Chief Health Officer may choose to rapidly convene an expert panel to consider the circumstances, review the management of the contact and provide advice on additional or alternative strategies. In these circumstances, the management of the person remains the responsibility of the LHD.

Involuntary quarantine and public health orders

If a person refuses to comply with a recommendation to undertake voluntary quarantine according to the PHU's directions, then a public health order should be urgently considered.

Note that in the case of people considered contacts of a confirmed typhoid case, a public health order would usually only be considered for those contacts who are in a high risk occupational group, such as a food handler, and who have refused the recommendation to cease work until they have been confirmed to be non-infectious through stool screening. This includes where a high risk typhoid contact is refusing to submit a stool sample for testing.

The process for issuing a public health order would generally commence with a recommendation made by the PHU director to the Chief Health Officer, in consultation with the Executive Director, HPNSW. The Chief Health Officer may also convene an expert panel to advise on the need for a public health order and the specific provisions that would be included in the public health order, if supported.

A public health order is made by the Chief Health Officer (or other authorised medical officer). This would generally occur in consultation with the Executive Director, Health Protection and the Executive Director, NSW Ministry of Health Legal and Regulatory Services Branch.

Expert panel composition

The Chief Health Officer may convene an expert panel to provide expert advice on issues related to persons exposed to contact order conditions, including the need, if any, for a public health order to be issued.

The PHU director is responsible for presenting information about the source case and the contact to the expert panel. The expert panel reviews the public health management of the contact and recommends additional or alternative management strategies.

The core constitution of the expert panel includes:

- Chief Health Officer (Chairperson), who may delegate to Executive Director, Health Protection NSW
- Executive Director, Health Protection NSW
- Director, Communicable Diseases
- One or more infectious diseases physicians
- PHU director of another LHD.

Additional expert panel members are selected based on specific needs of the case, such as a social worker, a professional ethicist or a member of a relevant community or key support group. Clinicians managing the source case may also be consulted.

An expert panel may also be convened by Health Protection NSW on behalf of an LHD to provide advice on the local management of persons exposed to contact order conditions.

Conditions of a public health order

A public health order relating to exposure to a contact order condition may require the person subject to the order to do any one or more of the following:

- to refrain from specified conduct, e.g. to not make physical contact with other people or maintain a specified distance from others,
- to undergo specified treatment (whether at a specified place or otherwise),
- to undergo counselling by one or more specified persons or by one or more persons belonging to a specified class of persons,
- to submit to the supervision of one or more specified persons or of one or more persons belonging to a specified class of persons, (e.g. an infectious diseases physician or infectious diseases unit staff)
- to notify the Secretary of other persons with whom the person has been in contact within a specified period,
- to notify the Secretary if the person displays any specified signs or symptoms, to undergo specified testing for the relevant condition.

A public health order may authorise the person subject to the order:

- to be detained at a specified place for the duration of the order, or
- in relation to an order that requires the person to undergo specified treatment at a specified place—to be detained at that place while undergoing the treatment.

A public health order should specify who is responsible for managing the person subject to the order. This will generally be the Director of the PHU of the LHD where the person resides or an infectious diseases physician.

Making the public health order

An *authorised medical practitioner* may make a written public health order in respect of a contact order condition if satisfied on reasonable grounds that the person:

- has been exposed to a contact order condition, and
- is a risk of developing that contact order condition, and
- because of the way the person behaves, the person may be a risk to public health.

It would generally, time permitting, be expected that the *authorised medical practitioner* would be provided with advice from an Expert Panel to assist in this determination.

In deciding whether to make a public health order, the *authorised medical practitioner* must take into account:

- the principle that any restriction on the liberty of a person should only be imposed if it is the most effective way to prevent any risk to public health, and
- the matters set out in the Public Health Regulation 2012 (clause 39) being:
    - the options other than a public health order that are available to deal with the risk to public health posed by the person,
    - if the proposed public health order will require the person to undergo treatment—the availability and effectiveness of the proposed treatment and the likely side effects of the proposed treatment on the person,
    - if the proposed public health order will require the person to be detained— the likely social, economic, physical and psychological effects of the detention on the person.

The matters set out in the Public Health Regulation do not need to be taken into account in the case of an emergency or if it is otherwise not reasonably practicable.

Duration of the public health order

A public health order does not take effect until it is served personally on the person subject to the order.

A public health order must state that it expires at the end of the expiry period for the particular contact order condition, unless earlier revoked.

However, a public health order based on a contact order condition will expire at the end of 3 business days after the person subject to the order is served with the order unless, before it expires, the person is served with a copy of an application for its confirmation under section 64. If an application for confirmation is not served on the person within 3 business days, the order will lapse and the person should be notified that they are no longer the subject of a public health order and no action can be taken under the order (e.g. if the person is detained, the person must be released from detention). As soon as practicable after such an application is made, the Civil and Administrative Tribunal is to inquire into the circumstances surrounding the making of the public health order.

Following its inquiry, the Civil and Administrative Tribunal:

 may confirm the public health order, or may

vary the order and confirm it as varied, or may

revoke the order.

If the *authorised medical practitioner* considers that the person subject to the order is no longer a risk to public health, the *authorised medical practitioner* must revoke the order and immediately give notice in writing of the revocation to the person and the Civil and Administrative Tribunal.

Detention order

While any condition of a public health order will restrict a person's liberty and should only be used if it is the most effective way to prevent any risk to public, detention of a person seriously restricts a person's liberty. It would be expected to be a rare occurrence, and should only ever be considered as a last resort. Consideration should be given to using other conditions in a public health order, such as refraining from certain conduct, before detention is considered.

All LHDs should identify appropriate facilities and staff who are able to implement an order for secure detention under the *Public Health Act 2010*. See section 3 below.

Where the person to whom the public health order applies is already detained under a custodial sentence, consideration should be given to the unique circumstances of implementing the public health order, including:

- that client confidentiality, legal and safety issues be considered, and
- that quarantine/isolation measures may require negotiation with Justice Health, Corrective Services NSW and Juvenile Justice.

ACCOMMODATION

Voluntary quarantine

When accommodation is required for the purpose of voluntary quarantine of a contact who is medically stable, quarantine at the person's home or at a commercial residential environment is preferred.

LHDs must consider how best to accommodate contacts in such situations and ensure arrangements to monitor them in quarantine.
The NSW Ministry of Health may be able to assist LHDs with identifying suitable accommodation for contacts through its links with other government agencies.

Involuntary quarantine with a public health order

When accommodation is required for the purpose of involuntary quarantine, i.e. subject to a public health order, for a contact who is medically stable, quarantine at a person's home may not be appropriate. If a public health order includes an order for detention, the order will specify where the person is to be detained. If the place of detention is on LHD property, LHDs must consider how best to accommodate contacts in such situations so that quarantine can be enforced in accordance with the conditions of the public health order.
LHDs must:

- Identify a suitable location for accommodating a contact who is detained under a public health order. This location would be specifically named in the public health order.
- Develop a management plan addressing the needs of the contact.
- Provide adequate staff training.
- Assure the availability of appropriate secure facilities and processes, including the use of security personnel
  ('secure' in this context means the minimum additional security needed to ensure that the person does not injure themselves and does not attempt to leave the premises without authority).

People exposed to a contact order condition may have concurrent medical conditions or mental health concerns which can potentially be exacerbated by quarantine. LHDs should ensure that relevant expertise and services are available to safely and effectively manage such contacts.

The use of public hospitals as locations for the involuntary quarantine of medically stable contacts is not recommended but remains an option if no other suitable alternative can be found.

APPENDICES

The five contact order conditions are summarised below. For further information consult the NSW Health infectious disease website: http://www.health.nsw.gov.au/infectious .

Avian influenza in humans

Humans are at risk of infection with influenza viruses that are circulating in animals, particularly avian influenza viruses. If such a virus acquired the capacity to spread easily among people it could start an epidemic or pandemic.

Avian influenza viruses are the most diverse group of influenza viruses and are considered to be the most likely source of novel pandemic influenza viruses affecting human populations.

Humans with influenza infections typically have the virus appear in the respiratory tract in the 24 hours prior to the onset of illness. This means infected persons can be infectious to others through the respiratory route prior to feeling unwell.

A single case of human influenza caused by an avian influenza virus or other new subtype may constitute a public health emergency of international concern under the International Health Regulations (2005), and is required to be reported to the World Health Organization (WHO). Infection with avian influenza also meets the criteria for a listed human disease under the Australian Biosecurity Act, in the category *human influenza with pandemic potential*.

Middle East respiratory syndrome coronavirus

Middle East respiratory syndrome (MERS) is a serious infection caused by the MERScoronavirus (MERS-CoV). In humans, MERS-CoV infection is mainly associated with respiratory infections and can lead to severe disease, particularly in older people and in people with underlying medical conditions. Since it was first identified in 2012, case fatality rates have been approximately 35%.

Camels are the major animal source of MERS-CoV infection in humans but the majority of human cases of MERS have been attributed to person to person spread of the infection in health care settings.

While the MERS-CoV virus does not currently pass easily from person to person, transmission has been well documented following close contact, such as occurs when providing unprotected care to a patient. Hospital-associated outbreaks have occurred in several countries, with the largest outbreaks seen in Saudi Arabia, United Arab Emirates, and the Republic of Korea.

While most cases transmit the infection to few other people, there have been a number of well documented incidents where a single infected person has been linked to a large cluster of new infections. Rapid implementation of droplet and contact precautions has been effective in preventing further spread and controlling outbreaks.

A single human case of MERS-CoV infection may constitute a public health emergency of international concern under the International Health Regulations (2005), and would usually be reported to the World Health Organization. This would also be considered a listed human disease under the Australian Biosecurity Act, in the category *Middle East respiratory syndrome*.

Severe Acute Respiratory Syndrome

Severe acute respiratory syndrome (SARS) is a serious infection caused by the SARScoronavirus (SARS-CoV). In humans, SARS infection is mainly associated with respiratory infections and can lead to severe disease.

Case fatality rates during the 2002-2003 global outbreak of SARS ranged from 7% to 17% but were as high as 50% in older people and in people with underlying medical conditions.

The spread of SARS between humans is thought to have occurred mainly through the respiratory route but also by direct contact and fomite transmission. While most cases transmitted the infection to few other people, there were a number of well documented ‘superspreading events’ where a single infected person was linked to many new infections. Rapid implementation of droplet and contact precautions was effective in preventing further spread and controlling outbreaks.

There has been no or very limited person to person spread of SARS since 2002-2003, but there remains a risk that the virus could be re-introduced to human populations from an animal reservoir, most likely certain bats species in Asia.

A single human case of SARS infection may constitute a public health emergency of international concern under the International Health Regulations (2005), and is required to be reported to the World Health Organization. This would also be considered a listed human disease under the Australian Biosecurity Act, in the category *severe acute respiratory syndrome*.

Typhoid

Typhoid is a febrile illness caused by infection with *Salmonella* Typhi bacteria which can cause severe disease. Without treatment the case fatality rate is approximately 15%. Asymptomatic and mild infections also occur.

The time from contact with the typhoid bacteria to the start of symptoms (incubation period) is usually from 8 to 14 days but can rarely be as long as 60 days. The bacteria that cause typhoid are found in the faeces of infected people.

If left untreated, about 10% of typhoid fever patients will excrete the bacteria in their faeces for three months after the onset of symptoms and 3-5% become chronic carriers.

Transmission occurs via the faecal-oral route, usually when faecally-contaminated food or water is ingested. Transmission from infected persons prior to the onset of illness has been documented and is a particular risk for infected food handlers who may put large numbers of people at risk.

Close contacts of typhoid cases are considered at higher public health risk if their work involves food handling or caring for children, hospital patients or the elderly. Public health guidelines state that contacts in these high risk groups must not work until they have had two stool samples, taken at least 24 hours apart, test negative for typhoid, showing that they are not infectious.

Viral haemorrhagic fevers

Viral haemorrhagic fevers of serious public health concern include infections caused by Ebola viruses, Marburg virus, Lassa fever virus and Crimean-Congo haemorrhagic fever virus. Infections tend to be severe and often fatal. For example, outbreaks of Ebola virus disease in African countries have had case fatality rates of 50% or higher.

The mode of transmission depends on the particular virus and in the particular country in which it is endemic. In Australia, infections would most likely be brought in through an infected traveller and be spread through direct contact with infected blood or body fluids.

A single human case of a VHF infection may constitute a public health emergency of international concern under the International Health Regulations (2005), and would usually be required to be reported to the World Health Organization. This would also be considered a listed human disease under the Australian Biosecurity Act, in the category *viral haemorrhagic fevers*.

SURVEILLANCE AND MANAGEMENT OF CARBAPENEMASE-PRODUCING ENTEROBACTERALES (CPE) IN NSW HEALTH FACILITIES (GL2019_012)

PURPOSE

This guideline is designed to assist public health care facilities in NSW to:

1. Identify suspected cases of Carbapenemase producing *Enterobacterales* (CPE)1
2. Implement control measures to prevent transmission of CPE
3. Understand the local epidemiology of CPE.

While this Guideline has been written specifically for CPE, recommended measures may also be applicable to any species of multidrug-resistant *Enterobacterales* (MDR-E) and other carbapenemase producing organisms (CPO). The local decision whether to apply to other MDR-E and CPO is to be made in consultation with content experts.

As evidence for recommendations continues to emerge, recommendations will be reviewed and revised when significant new findings are available.

KEY PRINCIPLES AND USE OF THE GUIDELINE

Identify CPE cases

- Conduct a risk assessment to identify people who should be screened for CPE at admission
- Screen patients for CPE at admission if a case contact, if flagged or if admitted to a healthcare facility or aged care facility overseas in the last 12 months
- The minimum requirement for admission screening is one rectal swab or faecal sample
- Screening during hospital admission may also be indicated in additional clinical scenarios, based on local risk assessment

Manage CPE cases

- Implement contact precautions for patients with suspected or confirmed CPE
- Inform health care providers of patients with suspected or confirmed CPE
- Educate the patient and their family on CPE and how to prevent transmission
- Place alerts in patient medical records for patients with suspected or confirmed CPE
- Routinely manage all CPE cases under contact precautions for subsequent admissions

Manage contacts of CPE cases

- Identify contacts of all suspected and confirmed CPE cases
- Screen contacts of all confirmed CPE cases
- For contacts that have already left the health care facility, place alerts in patient medical records to prompt screening when the patient is readmitted

Manage local transmission of CPE

- When local transmission of CPE is identified, convene a CPE outbreak management team
- Investigate the cause of the local transmission
- Implement strategies to limit further transmission
- Report local transmission to the Clinical Excellence Commission (CEC)

The complete Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_012

316(16/08/19)

1 This document uses the collective term *Enterobacterales*, rather than *Enterobacteriaceae*. Recent taxonomic studies have narrowed the definition of the family *Enterobacteriaceae*. *Enterobacteriaceae* are one of seven families in the *Enterobacterales* order. When the abbreviation CPE is used in this document, it refers to carbapenemase producing *Enterobacterales*.

TRIGGERS FOR ESCALATION FOLLOWING DETECTION OF INFECTION OUTBREAKS OR CLUSTERS (GL2019_013)

PURPOSE

This Guideline has been developed to support NSW public healthcare facilities with effective and timely escalation of information on outbreaks or clusters of healthcare associated infections, multidrug-resistant organisms (MROs) and/or non-MROs.

KEY PRINCIPLES

NSW public healthcare facilities must have written procedures that address the outbreak management requirements for common communicable diseases and MROs (e.g. gastroenteritis, influenza, Carbapenemase-producing *Enterobacterales*) and identify delegations of responsibility during the outbreak (Infection Prevention and Control Policy).

A framework for escalating outbreaks and clusters with effective and timely management will ensure minimal impact and when adhered to guide future assistance.

This Guideline provides a tool to assist NSW public healthcare facilities with developing local escalation frameworks or protocols that are tailored to their needs and available resources.

USE OF THE GUIDELINE

Chief Executives should ensure that

- This Guideline is implemented in healthcare facilities where there is or may be a risk of an outbreak or cluster of infection
- Health workers are made aware of the escalation process for outbreaks and clusters of infection
- There is adequate resourcing for the response to an outbreak or cluster of infection.

Health workers should escalate outbreaks or clusters of infection as per the local escalation framework or protocol.

The complete Guideline is available at:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_013

EARLY RESPONSE TO HIGH CONSEQUENCE INFECTIOUS DISEASES
(PD2023_008)

POLICY STATEMENT

NSW Health coordinates a central, specialised response during the initial stage of high consequence infectious disease management, in order to mitigate the risk of public health emergency and associated healthcare system impacts.

SUMMARY OF POLICY REQUIREMENTS

High consequence infectious diseases have the potential to significantly impact individual and population health, and can in turn pose a risk to the delivery of healthcare services. A specialised, centrally coordinated response is required to ensure effective clinical management and containment of such diseases.

This Policy Directive details the NSW Health operational response to the early phase when there is limited or no transmission in the community including the function of: the Statewide High Consequence Infectious Disease service, the Physical Containment Level 4 (PC4) High-Security Laboratory at NSW Health Pathology Institute of Clinical Pathology and Medical Research, and a summary of strategic and planning activities that need to occur in the initial phase should case numbers be expected to rise.
inf
The roles and responsibilities of all parties involved in a centrally coordinated response are outlined in this Policy Directive.

Local Health Districts, Specialty Health Networks and pillars of NSW Health are required to ensure relevant planning and clinical staff are familiar with the Policy Directive and make any local preparations necessary to guarantee adherence to the roles and responsibilities described, in the event of a high consequence infectious disease case presentation.

The Policy Directive includes direction on key response actions such as communication, enhanced surveillance, laboratory diagnostic testing, clinical management, infection prevention and control processes, and acquisition and distribution of key treatments and equipment.

Different immediate patient flow and referral actions are detailed for identification of potential high consequence infectious disease patients at international borders, general practitioner or specialist rooms, and hospital facilities.

This Policy Directive will remain in effect until disease-specific operational response plans are developed and ready for implementation, or until the High Consequence Infectious Diseases Advisory Group considers there is no further risk of transmission or significant health impacts within NSW.

The Early Response to High Consequence Infectious Diseases policy directive is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_008

NSW INFECTION PREVENTION AND CONTROL RESPONSE AND ESCALATION FRAMEWORK (IB2023_019)

PURPOSE

The NSW IPAC Response and escalation framework (Framework) in NSW has been revised to include other acute respiratory infections while continuing to provide guidelines for COVID-19.

The Framework supports NSW Health to respond to both outbreaks and pandemics or infections of state or national significance. The Framework outlines a foundational level for when the NSW Health system remains prepared for infection risks, with structured infection prevention and control escalation strategies for yellow, amber and red transmission risks.

The NSW Health Secretary will direct the minimum state alert level, and NSW Health organisations must undertake local risk assessments to determine if further infection prevention and control measures are required in their facilities.

This Information Bulletin must be read in conjunction with the *Infection Prevention and Control Manual: COVID-19 and other Acute Respiratory Infections*.

KEY INFORMATION

Chapter 3 of the *Infection Prevention and Control Manual: COVID-19 and other Acute Respiratory Infections* - Infection Prevention and Control (IPAC) Response and Escalation Framework was developed to provide guidance to NSW Health facilities to manage changing levels of COVID-19 transmission risk. This has transitioned to include other acute respiratory infections and potential communicable diseases of state or national significance.

Situation

The revised Framework adopts a foundational level approach to ensure the application of robust infection prevention and control practices as a minimum on which escalation strategies are added to enhance IPAC. The Framework also provides guiding controls for transmissible infections with a clear response to changing transmission risk and burden to the health care system.

Clinical Recommendations

All state-wide changes to risk level will continue to be informed by consultation closely monitored through health system metrics and guided by the Risk Escalation Review Panel (RERP) with the state alert level being directed by the NSW Health Secretary.
NSW Health organisations:

- May apply local IPAC enhancements based on internal monitoring and risk assessment (refer to the NSW IPAC Response and escalation framework – Principles for IPAC monitoring and management for local implementation on page 54 of the *Infection Prevention and Control Manual: COVID-19 and other Acute Respiratory Infections*).
- Are to refer for review any planned escalation or de-escalation to a different risk level to the Risk Escalation Review Panel.

Additional supporting policies and guidelines:

- Infection Prevention and Control Practice Handbook
- NSW Health Guideline *Triggers for Escalation Following Detection of Infection Outbreaks or Clusters* (GL2019_013)
- NSW Health Policy Directive *Infection Prevention and Control Policy* (PD2017_013).

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

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INCIDENT MANAGEMENT (PD2020_047)

PD2020_047 rescinds PD2020_020

PURPOSE

NSW Health Services must have incident management processes in place that are consistent with the requirements of this Policy and the Health Administration Act 1982, to effectively respond to clinical and corporate incidents and act on lessons learned.

SUMMARY OF POLICY REQUIREMENTS

All staff are responsible for identifying incidents and for taking immediate action to ensure the safety of patients, visitors and other staff.

Notify incidents and escalate

Clinical and corporate incidents, near misses and complaints are to be recorded in the incident management system, ims+.

For all clinical incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues; the Chief Executive must immediately contact the Ministry of Health and the Clinical Excellence Commission Chief Executive.

For all corporate incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues, the Chief Executive must immediately contact the Ministry of Health.

Serious incidents must be notified and escalated within the Health Service and to the Ministry of Health via a reportable incident brief (RIB). The RIB is to be submitted in ims+ within 24 hours of notification for RIB Part A, and within 72 hours (or earlier, as directed by the Chief Executive or Ministry of Health) for RIB Part B.

Open disclosure

Open disclosure must occur whenever a patient has been harmed, whether that harm is a result of an unplanned or unintended event or circumstance, or is an outcome of an illness or its treatment that has not met the patient's or the clinician's expectation for improvement or cure, as per the NSW Health *Open Disclosure Policy* (PD2014_028).

Clinical incident review

Health Services must undertake a preliminary risk assessment within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for reportable incidents (clinical Harm Score 1 incidents). The Chief Executive may also direct that a preliminary risk assessment be completed for other clinical incidents (Harm Score 2 – 4) that may be due to a serious systemic problem.

Any person appointed to undertake a preliminary risk assessment must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff.

A serious adverse event review must be undertaken using an approved review method, following a clinical Harm Score 1 incident. The review is to identify any factors that caused or contributed to the incident, and any practices, processes or systems that could be reviewed for the purposes of a recommendations report. The Chief Executive may also direct a serious adverse event review be undertaken for other clinical incidents (Harm Score 2 – 4) which may be due to serious systemic problems.

Preliminary risk assessment assessors and serious adverse event review team members are bound by strict confidentiality requirements and must not disclose information obtained during the preliminary risk assessment or serious adverse event review, unless it is for the purpose of the preliminary risk assessment or serious adverse event review.

The serious adverse event review findings report, and recommendations report (if there is one), must be submitted to the Ministry of Health within 60 calendar days of the incident notification in ims+.

At the completion of a serious adverse event review, the family is to be invited to meet to discuss the findings and recommendations and to be given copies of the findings report and recommendations report.

Corporate incident review

Health Services must undertake a safety check within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for corporate Harm Score 1 incidents.

Any person appointed to undertake a safety check must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff, or continuing critical risk due to loss of service.

A corporate Harm Score 1 review must be undertaken following a corporate Harm Score 1 incident, using a review method determined by the type of corporate incident.

The review is to identify any underlying factors as to why the incident occurred and make recommendations to prevent and minimise risk of recurrence.

A corporate Harm Score 1 review report is due to the Ministry of Health within 60 calendar days of incident notification in ims+.

Implementation and feedback

Health Services are to monitor the implementation of recommendations arising from incident reviews and have escalation processes in place for recommendations that cannot be progressed.

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and recommendations. Health Services are also to share feedback on the lessons learned and proposed changes more broadly with clinicians, managers and staff.

The complete Incident Management Policy and Procedures is available from
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_047

333(14/12/20)

OPEN DISCLOSURE (PD2023_034)

PD2023_034 replaced PD2014_024

The Open Disclosure Policy Directive sets out the minimum requirements for implementing open disclosure within NSW Health facilities and services.

The complete Open Disclosure policy is available from:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_034

347(18/10/23)

SAFETY ALERT BROADCAST SYSTEM (PD2013_009)

PURPOSE

The NSW Ministry of Health Safety Alert Broadcast System (SABS) is the mechanism to provide a systematic approach to the distribution of patient safety information to the NSW health system and includes a mechanism to ensure the required action and management of patient safety issues by health services.

The SABS includes three tiers of notifications to provide NSW health services with early warnings of issues, namely:

- Safety Alert
- Safety Notice
- Safety Information

MANDATORY REQUIREMENTS

Safety Alerts

Local Health Districts/Specialty Health Networks must:

- Distribute the SAB to staff identified in the Alert (and other staff as relevant).
- Acknowledge receipt of the SAB within the defined timeframe.
- Ensure completion of required actions within the designated timeframe.
- Submit required responses to the CEC within the designated timeframe.

Safety Notices

Local Health Districts/Specialty Health Networks must:

- Distribute the SAB to staff identified in the Alert (and other staff as relevant).
- Consider the relevance of the information to the Local Health District.
- Review relevant policies and procedures to address the issues.
- Identify any actions required and implement those actions.
- Submit required responses to the CEC within the designated timeframe.

Safety Information

Local Health Districts/Specialty Health Networks must:

- Distribute the SAB to all staff.
- Consider the relevance of the information to the Local Health District.
- Identify any actions required and implement those actions (if appropriate).
- Submit required responses to the CEC within the designated timeframe.

IMPLEMENTATION

NSW Clinical Excellence Commission is responsible for

- assessment of information received and production of SABS document
- distribution of SABS notifications to NSW health services in a timely manner
- monitoring State-wide implementation of requested actions
- providing reports to the Clinical Risk Action Group (CRAG) on compliance of mandatory actions with SABS
- reviewing the SABS Policy Document in accordance with PD2014_043, NSW Health Policy Directives and Other Policy Documents.

Chief Executives are responsible for establishing an efficient and effective process for

- receipt, distribution, implementation and effectiveness for SABS notifications,
- ensuring distribution of SABS notifications to the appropriate people within the health service,
- acknowledging receipt of SABS Safety Alerts within a time frame defined at the time of release, ideally within 2 days.

Directors of Clinical Governance are responsible for

- ensuring implementation of nominated action/s, where relevant,
- monitoring the effectiveness of the SABS within the health service.

1. BACKGROUND

1.1 About this document

The NSW Ministry of Health and the Clinical Excellence Commission are made aware of issues affecting patient safety from a variety of sources. These include but are not limited to:

a. Incident Information Management System (IIMS) incident notifications.

b. Reportable Incident Brief (RIB) information and Root Cause Analysis (RCA) reports.

c. Health Care Complaints Commission (HCCC) and Coroners reports.

d. Information from Health Services, the Clinical Excellence Commission (CEC), the Australian Commission on Safety and Quality in Healthcare, and other jurisdictions.

e. Safety alerts, product recalls and notices issued by organisations including the Therapeutic Goods Administration (TGA), international authorities such as the US Food and Drugs Administration (FDA) and the UK Medicines and Healthcare Products Regulatory Agency (MHRA).

This Policy Directive outlines the NSW Ministry of Health's approach to the communication and management of statewide patient safety issues raised through these sources.

The Safety Alert Broadcast System (SABS) aims to:

a. Provide a coordinated approach to the management and distribution of patient safety information within NSW Health Services.

b. Ensure that SABs notifications have been received by the Chief Executive of each Local Health District/Specialty Health Network or service and that appropriate distribution of the information occurs.

c. Monitor NSW Health service implementation of risk management strategies.

SABs policy does not apply to:

a. Public Health alerts issued by the Chief Health Officer (CHO) about environmental health issues, food safety, or consumer products or public health events related to communicable diseases such as SARs or pandemic influenza.

b. Corporate alerts relating to areas such as equipment (other than medical devices), power supply and information technology.

c. WorkCover alerts and notices.

Compliance with this policy is mandatory for all health service staff.

Private health facilities should review the information provided in SABS and implement any action as appropriate to ensure patient safety.

Key definitions

CEC	A board governed statutory health corporation established under the Health Services Act as part of the NSW Patient Safety and Clinical Quality Program (PSCQP). It builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001.
Clinical Governance	Clinical governance can be considered as the responsibility of governing bodies to demonstrate sound strategic and policy leadership in clinical safety and quality, to ensure appropriate safety and quality systems are in place and to ensure organisational accountability for safety and quality.
The Ministry	NSW Ministry of Health.
DCG	Director, Clinical Governance.
Health Services	For the purposes of this policy, the term "health services" refers to Public Health Organisations, Justice and Forensic Mental Health Network and the Ambulance Service of NSW
HCCC	Health Care Complaints Commission.
IIMS	Incident Information Management System
IRR	Information Risk Rating
Local Health Districts, Specialty Health Networks and Services	Organisations constituted under the *Health Services Act 1997* that are principally concerned with the provision of health services to residents within a designated geographic area and/ or service type.
Private Health Facilities	Private health facilities licensed under the *Private Health Facilities Act 2007.*
Public Health Organisations (PHO)	This term refers to Local Health District, statutory health corporations or an affiliated health organisation in response of its recognised establishments and recognised services as defined in the *Health Services Act 1997*.
PSCQP	Patient Safety and Clinical Quality Program (PD2005_608)
RIB	Reportable Incident Brief
RCA	Root Cause Analysis
SABS	Safety Alert Broadcast System
TGA	Therapeutic Goods Administration

2. SABS NOTIFICATIONS

The SABS notifications provide a systematic three-tiered approach to the distribution, prioritisation and management of patient safety information. This includes a standardised system for monitoring the implementation of required actions by health services.

The three notifications issued under the SABS use the following colour coding to indicate the level of urgency.

1. **Safety Alert** (Red)
2. **Safety Notice** (Amber)
3. **Safety Information** (Green)

2.1 Safety Alert (Red)

The aim of the **Safety Alert** is to quickly disseminate information to Local Health Districts (LHDs)/Specialty Health Networks about a safety matter needing **immediate attention and action.** The Safety Alert will specify **mandatory** action/s to be taken by health services and the timeframes in which such actions should occur and assign responsibility for action. The colour coding for Safety Alerts is **RED**. This Alert takes precedence over any contrary policy/procedure/ guideline contained in a Policy Directive or Guideline. On receipt of a Safety Alert, LHDs/ Specialty Health Networks are to ensure local policies/procedures/guidelines comply with the information contained therein.

2.2 Safety Notice (Amber)

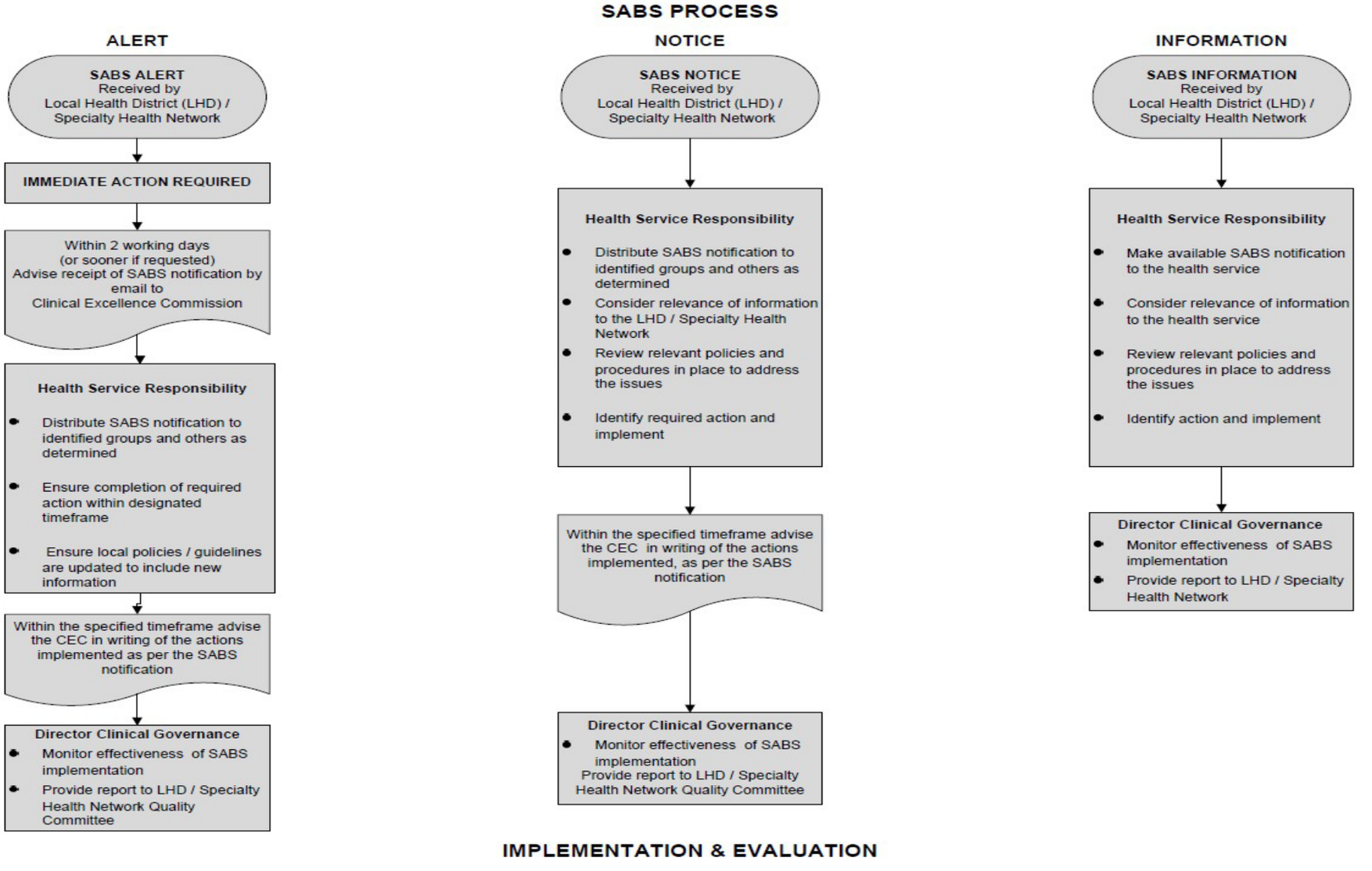
The aim of the **Safety Notice** is to inform Local Health Districts/Specialty Health Networks about potential quality and safety issues requiring **risk assessment at the local level** to determine appropriate action/s regarding any identified problems. The colour coding for Safety Notices is **AMBER**.

2.3 Safety Information (Green)

The aim of the Safety Information is to disseminate quality and safety information to health services to ensure lessons learned from State-wide, national and international sources are shared across the NSW Health System in an active manner. The Safety Information may include items such as updates on State-wide initiatives implemented under the NSW Patient Safety and Clinical Quality Program, information about Policy Directives and Guidelines and access to the most current information focusing on clinical quality and patient safety issues and research. The colour coding for Safety Information is GREEN

Table 1 Easy Guide to health service responsibilities for receipt and management of a SABS notification

SABS document	Aim	Distribution strategy*	Health service response on receipt of SABS document
Safety Alert	Alert LHDs/Specialty Health Networks to a safety matter needing **immediate attention and mandatory action.** The colour coding for Safety Alerts is **RED**.	The CEC distributes SABS to: • The Chief Executive; and • The officer responsible for designated action/s (indicated on the SABS). The LHD/Specialty Health Network distributes SABS to: • staff identified in the Alert; and • other relevant staff.	• Acknowledge receipt within a defined time frame, usually 2 working days. • Ensure completion of required action/s within designated timeframe. • Ensure local policies and guidelines are updated to include new information if required. • Submit required responses to the CEC within the designated timeframe at quality@cec.health.nsw.gov.au.
Safety Notice	Informs LHDs/Specialty Health Networks or services about potential quality and safety issues requiring **risk assessment at the local** level to determine appropriate action regarding any identified problems. The colour coding for Safety Notices is **AMBER**.	The CEC distributes to: • The Chief Executive; and The officer responsible for suggested action/s. The LHD/Specialty Health Network distributes SABS to: • staff identified in the Notice; and • other relevant staff.	• Consider relevance of information to the LHD/Specialty Health Network or service. • Review relevant policies and procedures in place to address the issues. • Identify required action/s and implement. • Submit required responses to CEC within the designated timeframe at quality@cec.health.nsw.gov.au.
Safety Information	Disseminates quality and safety news to LHDs/ Specialty Health Networks or services to ensure lessons learned are shared across health services. May include updates on initiatives implemented under the NSW Patient Safety and Clinical Quality Program, information about policy directives and guidelines and provide access to the latest information and research focusing on clinical quality and patient safety. The colour coding for Safety Information is **GREEN**.	The CEC distributes to: • The Chief Executive and the Director of Clinical Governance. The LHD/Specialty Health Network ensures: • the availability of Safety Information to all staff.	• Consider relevance of the information to LHD/Specialty Health Network. • Identify any action/s and implement (if any).


SABS PROCESS
ALERT
SABS ALERT
Received by
Local Health District (LHD) /
Specialty Health Network
IMMEDIATE ACTION REQUIRED
Within 2 working days
(or sooner if requested)
Advise receipt of SABS notification by
email to
Clinical Excellence Commission
Health Service Responsibility
Distribute SABS notification to identified groups and others as determined
Ensure completion of required action within designated timeframe
Ensure local policies / guidelines are updated to include new information
Within the specified timeframe advise the CEC in writing of the actions implemented as per the SABS notification
Director Clinical Governance
Monitor effectiveness of SABS implementation
Provide report to LHD / Specialty Health Network Quality Committee
NOTICE
SABS NOTICE
Received by
Local Health District (LHD) /
Specialty Health Network
Health Service Responsibility
Distribute SABS notification to identified groups and others as determined
Consider relevance of information to the LHD / Specialty Health Network
Review relevant policies and procedures in place to address the issues
Identify required action and implement
Within the specified timeframe advise the CEC in writing of the actions implemented, as per the SABS notification
Director Clinical Governance
Monitor effectiveness of SABS implementation
Provide report to LHD / Specialty Health Network Quality Committee
INFORMATION
SABS INFORMATION
Received by
Local Health District (LHD) /
Specialty Health Network
Health Service Responsibility
Make available SABS notification to the health service
Consider relevance of information to the health service
Review relevant policies and procedures in place to address the issues
Identify action and implement
Director Clinical Governance
Monitor effectiveness of SABS implementation
Provide report to LHD / Specialty Health Network
IMPLEMENTATION & EVALUATION

3. DISTRIBUTION OF SABS NOTIFICATIONS TO LOCAL HEALTH DISTRICTS/SPECIALTY HEALTH NETWORKS

The Clinical Excellence Commission will ensure that the SABS notification is distributed by the following process:

1. Email to all Chief Executives.
2. Copy of the email to each Chief Executive nominated person.
3. Copy of email to all Directors of Clinical Governance.
4. Copy of email to position assigned responsibility for action in the SABS document.
5. Copy of email to Director, Private Health Care for distribution to licensed private health facilities.
6. Copy of email internally to Clinical Excellence Commission staff.
7. Copy of email to Corporate Governance and Risk Management Branch.
8. Copy of email to Strategic Relations and Communications Branch.

Available on the Department's website http://www.health.nsw.gov.au/quality/sabs

3.1 Distribution of Safety Alerts out of normal business hours

The CEC will contact the Chief Executive by telephone should there be need to disseminate a Safety Alert or an emergency drug recall out of business hours. The distribution of the formal Safety Alert will be on the first day of the CEC's normal business hours.

3.2 Local Health District/Specialty Health Network Distribution of SABS notifications

Each SABS notification will include a recommended distribution list for use by the CEC. Local Health Districts/Specialty Health Networks are responsible for ensuring an effective internal distribution strategy is in operation.

3.3 Local Health District/Specialty Health Network or Services request for response from SABS notification

When Local Health Districts/Specialty Health Networks are required to respond back to the CEC, then it is the **responsibility of the Chief Executive** or equivalent of that entity to ensure that:

a. Responses back (where requested) are received within the stipulated timeframe.
b. A system is developed so that only one response from each Local Health District/Specialty Health Network is returned back to the CEC.

The response should be emailed to the CEC at quality@cec.health.nsw.gov.au

3.4 Local Health District/Specialty Health Network responsibility for actions arising from SABS notification

When LHDs/Specialty Health Networks are required to take action resulting from a SABS notification then it is the **responsibility of the Director of Clinical Governance** to ensure that:

a. the nominated actions have been implement in the stated timeframe;
b. a written response has been returned to the CEC (where requested) of the actions taken arising from the SABS notification;
c. the response should be emailed to the CEC at quality@cec.health.nsw.gov.au
d. the Directors of Clinical Governance are to report the implementation status of actions arising from SABS notifications to the local peak Quality Committee.

3.5 Review of SABS Notifications

All Safety Alerts will have a mandatory review date consistent with other Policy Directives. This review establishes if the document remains active, requires updating or is obsolete.

The Clinical Excellence Commission will review and update all Safety Alerts and Notices as new information becomes available.

4. EVALUATION OF SABS

The Director of Clinical Governance is responsible for monitoring the effectiveness of the SABS at the local level to ensure compliance with the CEC Quality Systems Assessment Program.

5. RELEVANT NSW HEALTH POLICY DIRECTIVES AND REFERENCES

5.1 Relevant NSW Health Policy Directives

NSW Health Policy Directive, Guidelines and Information Bulletin can be accessed at:
http://www.health.nsw.gov.au/policies/pages/default.aspx

NSW Policies Directives	Document No.
Lookback Policy	PD2007_075
Open Disclosure Policy	PD2014_028
Patient Safety and Clinical Quality Program	PD2005_608
NSW Health Policy Directives and Other Policy Documents	PD2014_043
Complaint Management Policy	PD2006_073

5.2 References

Department of Health Safety Alert Broadcasting System (UK) available at
http://webarchive.nationalarchives.gov.uk/20060904193721/info.doh.gov.uk/sar/cmopatie.nsf/

Medicines and Healthcare products Regulatory Agency (MHRA) available at
http://www.mhra.gov.uk

US Food and Drug Administration FDA available at http://www.fda.gov/

6. ATTACHMENTS

6.1 Safety Alert Template

NSW GOVERNMENT Health

Safety Alert 00#/YY

Title

(dd month year)

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Xxxxx
- xxxxx

Action required by:

- Chief Executives
- Directors of Clinical Governance
- Xxxxx

We recommend you also inform:

- Xxxxxxxxxxx
- Xxxxxxxxx
- Xxxxxx
- Xxxxxx

Deadline for completion of action

(dd month year)

Expert Reference Group

Content reviewed by:

- Xxxxxxxxxxx
- Xxxxxxxxx
- Xxxxx
- Xxxxxx

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email:
quality@cec.health.nsw.gov.au

Internet Website:
http://www.health.nsw.gov.au/quality/sabs

Intranet Website
http://internal.health.nsw.gov.au/quality/sabs/

Review date

month year

Heading

Para text text

1. step

Heading

Para text text....

- bullet

Actions required by Local Health Districts / Specialty Health Networks

1. text text style step2
2. text text

6.2 Safety Notice Template

NSW GOVERNMENT Health

Safety Notice 00#/YY

Title

(dd month year)

Distributed to:
- Chief Executives
- Directors of Clinical Governance
- Xxxxx
- xxxxx

Action required by:
- Chief Executives
- Directors of Clinical Governance
- Xxxxx

We recommend you also inform:
- Xxxxxxxxxxx
- Xxxxxxxxxx
- Xxxxxx
- Xxxxxx

Expert Reference Group

Content reviewed by:
- xxxxxxxxxx
- xxxxxxxx
- Xxxxx
- xxxxx

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email: quality@cec.health.nsw.gov.au

Internet Website: http://www.health.nsw.gov.au/quality/sabs

Intranet Website http://internal.health.nsw.gov.au/quality/sabs/

Review date

month year

Heading

Para text text

1. step

Heading

Para text text....

- bullet

Suggested actions by Local Health Districts / Specialty Health Networks

1. Forward information to appropriate area for action.
2. Ensure a system is in place to document actions taken.

6.3 Safety Information Template

NSW GOVERNMENT Health

Safety Information 00#/YY

Title

(dd month year)

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Xxxxx
- Xxxxxx

Expert Reference Group

Content reviewed by:

- Xxxxxxxxxxx
- Xxxxxxxxx
- Xxxxx
- Xxxxxx

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email:
quality@cec.health.nsw.gov.au

Internet Website:
http://www.health.nsw.gov.au/quality/sabs

Intranet Website
http://internal.health.nsw.gov.au/quality/sabs/

Review date

month year

Heading

Paragraph

Paragraph

Suggested actions by Local Health Districts / Specialty Health Networks

1. Forward information to appropriate area for action.
2. Ensure a system is in place to document actions taken.

ADULT AND PAEDIATRIC HOSPITAL IN THE HOME GUIDELINE (GL2018_020)

GL2018_020 rescinds GL2013_006

PURPOSE

The purpose of this Guideline is to support the implementation and expansion of the Hospital in the Home (HITH) program within NSW Health by providing standardised guidance for local health districts and networks. It will assist districts and networks develop, monitor and evaluate HITH services while meeting local needs and state-wide standards.

KEY PRINCIPLES

HITH is a hospital substitution program which means that the patient admitted to HITH would otherwise be accommodated in a hospital. Access is needs based and available regardless of age, diagnosis, disability, geography, culture or gender. The objective being to provide patient centred care as close to home as possible.

Admission to a HITH service is voluntary and should not result in the patient incurring costs additional to what they might have had they been admitted to hospital.

HITH services provide integrated clinical care that meets National Safety and Quality Health Service Standards.

USE OF THE GUIDELINE

Districts and networks should use this Guideline to:

- develop district/network level governance for HITH
- integrate HITH as part of an overall acute demand strategy
- establish appropriate systems for clinical engagement

To download the Guideline please go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2018_020

GUIDELINES FOR ANIMAL VISITS AND INTERVENTIONS IN PUBLIC AND PRIVATE HEALTH FACILITIES IN NSW (GL2012_007)

GL2012_007 rescinds GL2006_012.

PURPOSE

The purpose of the guideline is to outline protocols for implementing and supporting assisted animal visits and interventions for patients in NSW public and private health facilities in NSW.

KEY PRINCIPLES

Animal visits and interventions are patient-driven and implemented to create a better health experience.

All types of animal visitation programs are to be conducted in accordance with relevant NSW Health policies and legislation relating to best practice in healthcare, infection control, patients rights and animal welfare.

Health facilities and health organisations are responsible for informing all staff about the roles and responsibilities associated with managing and coordinating animal visits/intervention activities.

Health services and animal agencies have responsibilities for hosting animal visitation programs and maintaining an animal's health and well-being.

USE OF THE GUIDELINE

In support of the principles outlined above, Chief Executives and delegated officers are expected to ensure compliance with relevant legislation and government and health policies by communicating and implementing the guideline to all health service personnel and relevant non-government organisations with direct or indirect responsibilities associated with animals visiting patients in public and private health facilities in NSW.

The Guideline includes the following sections:

- Animal Visitations Programs (Which type of program/animal visitation)
- Implementing Effective Animal Visitation Programs (Identifying animals for patient interaction Consultation, Communications and Planning)
- Key Elements of Animal Visitation Programs
- Personal Pet Visitations
- Resident Animals
- Therapy Animal Organisations
- NSW Health Policies and Legislation

To access the attachment to this Policy Directive please go to
http://www.health.nsw.gov.au/policies/gl/2012/GL2012_007.html

ELECTIVE SURGERY ACCESS (PD2022_001)

PD2022_001 rescinds PD2012_011.

POLICY STATEMENT

NSW Health organisations that manage elective surgery services must ensure clinically appropriate, consistent and equitable management of access for patients across the state**.**
Arrangements must be in place to provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

SUMMARY OF POLICY REQUIREMENTS

All local health districts and specialty health networks with surgical services must have local procedures in place that are consistent with the principles and requirements identified in this Policy. Referring patients to the elective surgery list occurs with receipt of the Recommendation for Admission (RFA) form in a timely manner by the treating doctor.

Clinical urgency categories (CUCs) are to be assigned in accordance to this policy, and any variance or reclassification validated by the surgeon with documented evidence. The procedures part of this policy also provides the management process for colonoscopy, cosmetic and discretionary procedures and new procedures and interventions.

The acceptance of a Recommendation for Admission (RFA) form and variations to normal bookings, including bilateral procedures and duplicate bookings are also included together with the importance of ensuring that the minimum data is set and legible. When the information on the RFA is not legible there is instruction on how to proceed and an example letter that is to be sent to the surgeon requesting clarity.

Once the RFA has been reviewed for completion and appropriate category allocation, timely registration on the elective surgery list is required. Patients and their General Practitioners should also be aware of the patient's addition to the elective surgery list, clinical urgency category and estimated timeframe for their surgery. It is also important that both patients and their general practitioners are aware and how to contact the hospital in the event of a change in the patients' clinical condition or circumstances.

In the event that a patient's clinical condition changes and a clinical review is required, the procedures part of this policy explains the process to instigate a clinical review. It also explains how the patient's booking is to be managed, when changes are made to the original listing procedure and when there are hospital-initiated delays. This includes if a patient is to be removed from the elective surgery list for reasons other than surgery including who is required to be informed and consulted when this occurs.

All patients on the elective surgery list are to be managed according to their clinical urgency category and treated in turn. Surgical services must keep accurate records of hospital delays and patient deferrals. The clinical staging of procedures and the importance of accurate recording of these events when a patient is 'not ready for care' should also be recorded and monitored.

Finally, it is essential that the elective surgery list is regularly audited to ensure accurate information is available for patients, clinicians and administrators. Succession planning of key auditing processes should be in place to ensure this practice continues in the event of annual leave or a staff member resigns.

ELECTIVE SURGERY ACCESS: PROCEDURES

1. BACKGROUND

Each year more than 220,000 patients have elective surgery or procedures in NSW public hospitals. People who need surgery are placed on an elective surgery list according to the urgency of their clinical need.
Managing patients on elective surgery lists is a key priority for the NSW Government and NSW Health so that the community has timely access to high-quality and patient-centred surgical services.
Elective surgery management is a challenging, dynamic and complex process requiring input from and coordination by a multidisciplinary team.
Public hospitals across NSW must actively manage all aspects of elective surgery lists with transparent and patient-focused processes for:

- Referring patients for surgery
- Assigning to patients the appropriate clinical urgency category (CUC)
- Accepting referrals for surgery
- Registering patients onto the elective surgery list
- Compiling and maintaining the elective surgery list
- Booking patients for surgery under the principals of treating patients in turn and treating patients within clinically appropriate timeframes
- Ensuring patients have timely and effective communication about their elective surgery
- Removal of patients from the elective surgery list
- Accurate data collection documentation, auditing and reporting
- Regular system evaluation, monitoring and improvement
- Well-informed patients and staff (clinical and non-clinical) who understand the process and their roles and responsibilities

1.1 About this document

The elective surgery access Policy Directive is the reference guide for facilities to manage elective surgery lists. The Policy covers the procedures that facilities are required to follow and adequately manage surgery lists.
All medical and surgical procedures that are performed within operating theatres, procedure rooms and endoscopy suites, must be added to the elective surgery list.

1.2 Key definitions

Admission
The process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same day or overnight care and treatment.

Admission date
Date on which an admitted patient commences an episode of care.

Clinical review
A review of a patient on the elective surgery list to ensure that their waiting time remains appropriate for their clinical condition.

Clinical urgency category
A clinical assessment of the timeframe in which a patient requires elective admission. Urgency categories 1, 2 and 3 referred to in this document align with clinical urgency categories.

Cosmetic surgery
Procedure performed to reshape normal structures of the body, or to adorn parts of the body with the aim of improving the consumer's appearance and self-esteem. These procedures do not attract a Medicare rebate.

Decline
A Planned Admission/Planned Procedure Date outcome where the offer is not accepted by the patient due to non-clinical personal reasons.

Deferred patient
Patients that are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Discharge Intention
Recorded when the person is added to the elective surgery list. It identifies whether the treating doctor expects that the person will be admitted and discharged on the same day (i.e. day patient) or will stay overnight.

Discretionary surgery
Surgical procedures that must not be undertaken in public hospitals in NSW unless essential. They must meet an identified clinical need to improve the physical health of the patient.

Elective surgery list
A list that contains the names and details of all patients who have submitted a Recommendation for Admission (RFA) and have been added to the elective surgery list contained in the Patient Administration System (PAS) at a hospital. The term elective surgery list in this policy will include both surgical and medical lists.

Indicator Procedure Code (IPC)
This is an administrative coding used for the procedure or treatment the patient is to undergo when admitted.

Listing date
The date the Recommendation for Admission Form was received. Calculation of waiting time starts from this date.

Listing status
Indicates the status of the person on the elective surgery list that is the extent to which a patient is ready and available for admission. This may change while the patient is on the elective surgery list for example, after a clinical review.

Non-admitted patient
A patient who does not undergo a hospital's formal admission process.

Not ready for care
Patients who are not able to be admitted to hospital. These patients are either staged patients or deferred patients.

Planned Admission Date (PAD)
The date on which it is proposed that a patient on the elective surgery list will be admitted for an episode of care.

Planned procedure
The procedure or treatment the patient is to undergo when admitted.

Planned procedure date
The date on which it is proposed that a patient on the elective surgery list will have their procedure completed.

Pre-admission
Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans.

Ready for care
A patient who is prepared to be admitted to hospital or to begin the process leading directly to admission and surgery. The process leading to surgery could include investigations/procedures or other preoperative preparation.

Specialty
Treating doctor's area of clinical expertise. Where the doctor undertakes surgical procedures, which can be classified into different specialities. The doctor will have a different list for each specialty (for example, Obstetrics/Gynaecology).

Hospitals may have many more specific clinical areas identified, but these must be categorised under the main specialty headings for central reporting.

Staged
A suspension period applied where the patient is clinically not ready for care. This may be indicated by either the doctor or the patient.

Status Review Date
This is the date determined for an assessment (clinical or administrative) as to whether a deferred or staged person (i.e. Not Ready for Care) has become ready for admission to the hospital at the first available opportunity (i.e. Ready for Care).

Surgery
Procedures listed in the surgical operations section of the Commonwealth Medical Benefits Schedule. Surgery is classified as either emergency surgery, elective surgery or other surgery based on a patient's presentation and subsequent care, not by time periods to surgery.

Emergency surgery
Surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery later following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission.
Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).

Elective surgery
Planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery list.

Other surgery
The procedure cannot be defined as either emergency surgery or elective surgery, for example, transplant surgery and planned obstetrics procedures.

Waiting Time
The total time a patient spends on the elective surgery list.

2. SUMMARY OF KEY RESPONSIBILITIES

2.1 Admissions / booking staff

Admissions / Booking Clerks are expected to enter required data on the elective surgery list 'system' within three working days of receipt of the completed RFA. They need to check allocated clinical urgency categories against the list of recommended clinical urgency categories and ensure all documentation and electronic data input is accurate, legible and complete.

2.2 Elective surgery list coordinators

Elective surgery list coordinators have efficient oversight and management of patients requiring elective surgery to ensure that all relevant audits are completed and provide operational advice on the achievement of elective surgery performance.

2.3 Senior manager

Senior managers who are involved with coordination of surgical services and have decision-making responsibility in ensuring the appropriate application of this policy and ensuring that patients have timely access to care. Surgical services are administered according to local need at Local Health Districts and Specialty Health Networks across NSW.

Not all positions will be the same across NSW, individual facilities need to establish processes and points of escalation to ensure safe, clinically appropriate and equitable access of elective surgery programs.

2.4 Treating doctors

Treating doctors will provide clinical care in the best interests of patients informed by current evidence and best practice. They will have a clear understanding of the clinical capability of the service where the procedure is to be undertaken to ensure the right care is available and occurs in a setting with access to the necessary supportive care for example; imaging, pathology or access to intensive care.

They will only conduct procedures in keeping with the role delineation of the service and the credentials the doctor holds for surgical or other invasive procedures. They must be contracted and appropriately credentialed with the district, network or facility and have a clear understanding of the clinical networks available should the patient require transfer to a higher level of care.

Written informed consent from the patient must be obtained after fully informing the patient of the proposed surgery, procedure or treatment, any potential complications and expected length of hospital stay. The treating doctor must also inform the patient that under Medicare principles, public patients are allocated to a doctor by the hospital and that if the patient elects to be a public patient, their surgery may be performed by another surgeon or hospital. The treating doctor must also inform the patient that they are prioritised for surgery based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.

A fully completed and legible RFA must be submitted to the hospital within five working days of the patient agreeing to the proposed procedure/treatment. If the treating doctor is unable to perform the procedure within the clinical urgency category timeframe, they must in conjunction with the hospital, make arrangements for another clinician to perform the procedure within the patient's clinical urgency category.

The treating doctor must also review their elective surgery list provided by the hospital at least monthly and maintain timely clinical record keeping and record sharing and comply with mandatory reporting requirements. They must also participate in quality improvement initiatives including morbidity and mortality reviews and organise ongoing clinical care for patients in their absence.

2.5 Hospital clinical directors of surgical services or equivalent
This position must promote efficient and effective elective surgery list management by clinicians within their hospital and liaise with the district/network program director of surgical services or equivalent, for escalation of any issues. Specific responsibilities include the management of assigned clinical urgency categories not in accordance with the list of recommended clinical urgency categories and where insufficient evidence has been provided by the treating doctor and in the review and management of applications to perform cosmetic and discretionary procedures or exceptions to the policy.
For smaller sites that may not have a hospital clinical director of surgical services or equivalent, these responsibilities should be undertaken by the district/network Program Directors of Surgical Services or equivalent.

2.6 District / Network program directors of surgical services or equivalent
This position must ensure that clear administrative and clinical procedures/protocols, are in place to implement this policy and promote efficient, equitable and effective list management within all levels of hospital management. This includes the provision of adequate facilities/staff/work environment to facilitate the surgical management of patients referred to the hospital. They are also required to address issues arising with the management of the patient with the treating doctor and General Practitioner as required.

2.7 Chief executives
The chief executive is required to regularly review elective surgery performance across individual hospitals and engage relevant clinicians to ensure consistent application of policy requirements across the organisation. They would also ensure that there is provision for training and education programs for staff involved in managing elective patients and lists

3. ELECTIVE SURGERY LIST

To place a patient on an elective surgery list, the treating doctor must have fully informed the patient about the planned surgery or procedure/treatment and obtained their written consent in line with NSW Health Consent to Medical and Healthcare Treatment Manual.

The treating doctor must complete a Recommendation for Admission form (RFA) legibly and accurately and forward the completed RFA form to the facility within five working days of the patient agreeing to the proposed procedure or treatment.

To ensure that patient information is protected and secure, the RFA must be submitted to the facility in the most appropriate way for example, mail, hand delivery by the treating doctor, patient or carer or electronically if there is an approved system in place. Unsecure or unencrypted transfer of RFA forms through email is not permitted.

Facsimiles (fax) of an RFA form must not routinely be used and must only be accepted for urgent admissions for example, patients in clinical urgency category 1 where there is limited time to send a hard copy. A hard copy or an electronic version (if approved eRFA system is used) must follow as soon as possible.

At the time of lodgement of the RFA form, a patient must be ready for care and be able to accept an assigned planned admission or planned procedure date (excluding staged procedures).

3.1 Completion of the Recommendation for Admission (RFA) form

The following minimum data set on the RFA must be completed.

Treating Doctor must provide:	
• Patient's full name • Patient's address • Patient's email address where provided • Patient's contact information (home, mobile and/or work telephone) • Patient's gender • Patient's date of birth • Patient's Medicare number • Clinical urgency category • If classified as staged, the time interval when the patient will be ready for care must be indicated • Discharge intention (i.e. day only, or indication of number of nights in hospital) • Presenting problem/diagnosis	• Significant medical history (including allergies, infection risk and disability) • Treating doctor (if different) • Date the RFA is completed • General Practitioner's name and address • Interpreter requirements • Estimated operating time, including anaesthetic • Specific preadmission requirements. • Special operating theatre equipment. • Requirement for an intensive care or high dependency bed post-procedure • Planned procedure/treatment
Admission/booking staff must provide:	
• Planned Admission Date / Planned Procedure Date (if allocated) • Short notice / Standby offers	• Aboriginal and Torres Strait Islander Origin • Status Review Date (for staged patients) • Anticipated election status e.g. Medicare/public or private

3.2 Clinical urgency categories

Categorisation of elective patients by clinical urgency category is required to ensure they receive care in a timely, equitable and clinically appropriate manner.

A clinical urgency category must be assigned by the treating doctor and be based on the patient's clinical need, regardless of their health insurance status. It must be appropriate to the patient and their clinical condition and not influenced by the availability of hospital or surgeon resources.

When allocating a clinical urgency category, reference must be made to the *NSW Recommended Clinical Urgency Categories*.

	Procedures that are clinically indicated within
Category 1 - Urgent	30 days
Category 2 - Semi-urgent	90 days
Category 3 - Non-urgent	365 days
Category 4 - Not ready for care or patient suspension	Patient not currently available for surgery • Staged – section 6.4.1 • Deferred – section 6.4.2

A departure from the recommended clinical urgency category may be warranted for sound clinical reasons, including in circumstances where the procedure is for diagnosis or treatment of a proven or suspected malignancy.

For individual patient exceptions to the recommended clinical urgency category, the treating doctor must supply supporting documentation and discuss this with the district/network program director of surgical services or the equivalent.

If there is no supporting clinical information supplied, the admissions/booking staff must contact the treating doctor to provide the required information to support the selected change in clinical urgency category and ensure that the patient is added to the elective surgery list within three working days from receipt of the RFA.

The NSW Recommended Clinical Urgency Categories must be used until clarification is sought from the treating doctor.

Where the procedure is not within the NSW Recommended Clinical Urgency Categories treating doctors must follow the principles outlined in this policy when assigning the clinical urgency category.
There must be a review and escalation process at each facility for hospital clinical directors of surgical services or equivalent to review all variations from the recommended clinical urgency category to ensure appropriate prioritisation of patients

3.2.1 Inclusions and exclusion criteria for category 1 – urgent surgery

The allocation of clinical urgency category 1 is specifically reserved for those patients whose clinical condition has been assessed as requiring the procedure or treatment within 30 days.

This category is not to be used to advance the date for elective surgery patients whose clinical condition does not require the procedure or treatment to be completed within 30 days for example, vasectomy, joint replacement surgery, routine cataract surgery, routine tonsillectomy.

3.2.2 Reclassification of clinical urgency category

Only the treating doctor or their delegate may undertake reclassification of patients between categories. To reclassify a patient, the treating doctor must ensure documented evidence is readily available to validate any changes to a patient's clinical urgency category.

Documentation is to include the name and signature of the relevant staff member documenting the change, the date and time of notification of the category change, the person notifying the category change and the reason for the category urgency category change. The documentation is to be attached to or form part of the RFA and will become part of the patient's medical record.

If a patient is reclassified to a higher clinical urgency category, for example from a category 3 to a category 2, the count of days waiting will restart from the date the change was made.

If a patient is reclassified to a lower clinical urgency category, the waiting days will continue from the listing date, for example from a category 2 to a category 3.

The elective surgery list is to be updated with any changes and the treating doctor advised of the changes in writing to confirm completion of the change in patient category.

3.2.3 NSW colonoscopy categorisation

High quality, timely colonoscopy is critical to the early detection and treatment of bowel cancer and other gastrointestinal conditions.

For detailed information on criteria for the categorisation and prioritisation of patients presenting to NSW public hospital colonoscopy services please refer to the Agency for Clinical Innovation's *NSW Colonoscopy Categorisation Clinical Practice Guide*.

3.2.4 Cosmetic and discretionary surgery

The following list of surgical procedures must not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient's physical health and the procedure has been approved by the district/network program director of surgical services or equivalent.

Cosmetic/Discretionary Procedure	Exception
Bilateral breast reduction	Severe disability due to breast size Gross breast asymmetry in patients under 21 years old Virginal Hyperplasia/Hypertrophy
Bilateral breast augmentation	Nil
Replacement breast prosthesis	Replacement for post-cancer patients only
Bilateral mastectomy	Genetic risk such as BRCA1, BRCA2, TP53 or PTEN Cancer in the other breast
Breast reconstruction	Post cancer and genetic risk patients
Hair transplant	Disfiguring hair loss due to severe burns
Blepharoplasty/reduction of upper or lower eyelid	Documented severe visual impairment/obstruction
Total rhinoplasty	Nasal fracture/major facial trauma Congenital abnormality due to a documented syndrome as referred from a Consultant Paediatrician (paediatrics only)
Liposuction	Nil
Abdominal lipectomy (abdominoplasty)	Nil
Meloplasty/facelifts	Nil
Correction of bat ear (>16 years old)	Nil
Tattoo removal procedure	Nil
Removal of benign moles	Nil
Candela laser	Congenital abnormality – paediatrics < 17 years old
Varicose veins	CEAP Grade > C3 CEAP Classification System
Laser photocoagulation	Nil
Gender affirming surgery	Congenital abnormalities in children
Lengthening of penis procedure	Congenital abnormalities in children
Insertion of artificial penile prosthetic devices	Post cancer, major trauma and severe burns Patients with neurological erectile dysfunction
Reversal of sterilization	Nil
Circumcision	Phimosis, paraphimosis, balanitis
Temporomandibular joint arthrocentesis	Nil
Labiaplasty	Congenital abnormality in paediatrics < 17 years
Knee arthroscopy when the main indication is osteoarthritis and the patient is 50 years or older.	Only after approval by district/network program director of surgical services (or equivalent) and local selection criteria has been met

The treating doctor must obtain approval from the program director of surgical services or equivalent, in consultation with senior management before submitting the RFA.

They must document on the RFA form at the time a patient is referred objective medical criteria supporting the decision for surgery for all procedures that may be considered cosmetic or discretionary. This requirement supports appropriate documentation of clinical decision making and the review process. For procedures not appearing in section 3.3, or where there is doubt about the nature of the proposed surgery, the request must be referred to the program director of surgical services or equivalent for review prior to the patient being added to the elective surgery list.

The patient must be advised by the treating doctor when the RFA form is going through the approval process together with an estimated time for review.

Clinical directors of surgical services or equivalent, must review the addition of cosmetic and discretionary procedures to the elective surgery list to ensure their addition was in accordance with this Policy.

3.4 Dental surgery

For operating lists that are dedicated to the Priority Oral Health Program – patients must be eligible for treatment as identified in the NSW Health Policy Directive *Priority Oral Health Program and Elective Surgery List Management* (PD2017_023).

3.5 Introduction of new procedures and technologies

Each district or network must have a process in place to formally approve new procedures not previously undertaken at the hospital. The clinician must be appropriately credentialed by a relevant committee and have privileges to undertake the procedure before the patient is added to the elective surgery list.
For additional information, refer to:

- NSW Health Guideline *NSW Framework for New Health Technologies and Specialised Services* (GL2018_023)
- Australian Safety and Efficacy Register of New Interventional Procedures – Surgical – RACS/ASERNIP-S
- RACS General Guidelines for Assessing, Approving & Introducing New Surgical Procedures into a Hospital or Health Service.

3.6 Planned procedure / treatment not available at the hospital

An RFA form must not be accepted and must be returned to the treating doctor if the procedure or treatment is not provided at the nominated hospital.
The treating doctor must be informed that the RFA is not accepted and make alternative arrangements for the patient.

3.7 Patient consent and communication

Patients must be fully informed about the risks and benefits of the proposed surgery by the treating doctor, procedure/treatment and have consented to the treatment offered.
Consent must be obtained in accordance with the requirements outlined in the NSW Health *Consent to Medical and Healthcare Treatment Manual*.

3.7.1 Information to be provided to the patient

Treating doctors must explain the elective surgery list, including:

- Reason for referral to the elective surgery list
- Elective surgery list process, including clinical urgency categories
- That prioritisation for surgery is based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.

Treating doctors must also explain the difference between admission as a public or private patient and provide the patient with information to enable them to elect to be treated as a private or public patient. When a patient chooses to be treated as a public patient, treating doctors must explain the circumstances in which care might be provided by another doctor or health service.

Under the Medicare principles, public patients are allocated to a doctor by the hospital. While in most instances public patients will be admitted under the care of the original treating doctor, this is not always guaranteed.

In keeping with the principle of providing the earliest access and optimal care, surgery may be performed by another treating doctor if this would result in the patient receiving an earlier date for surgery.

When a patient chooses to be treated as a private patient, the treating doctor must also ensure the patient is advised of the associated costs of treatment and that priority of treatment will be based on clinical need regardless of insurance status.

4. ACCEPTANCE OF RECOMMENDATION FOR ADMISSION FORM

4.1 Standard bookings

When RFA forms are received from the treating doctor, elective surgery admissions/ booking office staff must date stamp the hard copy form or document on electronic RFA.
They must ensure that the form is legible and the minimum data set (see section 3.1) is included before acceptance of the RFA form. For further information, refer to the NSW Policy Directive *Health Client Registration* (PD2007_094).

A locally agreed process must be in place to manage incomplete forms. Where information is missing on the RFA or the form is not legible, the treating doctor must be contacted by telephone or in writing as soon as possible to provide the required information. If the RFA is to be returned to the doctor, then the original RFA must remain in the booking office after acceptance and a copy of the RFA must be used to return to the treating doctor for missing information.

RFA forms are to be returned to the treating doctor if the RFA states the patient's surgery is required beyond 12 months.

If an RFA is not presented to the elective surgery booking office within three months of the date the RFA was signed, acceptance of the form must be discussed with the treating doctor to ensure the patient's clinical condition has not changed. A review of the patient's clinical condition may be required before the form is accepted.

An example of a letter regarding an incomplete RFA is available on the Elective Surgery Program Resources webpage.

4.2 Variations from standard bookings

4.2.1 Bilateral procedures

An RFA must only be accepted for one procedure unless the bilateral procedure is occurring in the same admission. This is to ensure that the patient has been reviewed and that they are clinically ready to undergo the subsequent procedure.

Bilateral procedures include, right and left cataract extractions, right and left hip replacements.

4.2.2 Multiple admission forms received for one patient

Multiple RFAs can be accepted if the treatments/procedures are independent of each other for example, cholecystectomy and tonsillectomy.

The treating doctor must assign a clinical urgency category for each procedure. Where categories differ, the procedure with the more urgent category takes precedence. Where categories are the same, the treating doctor/s must specify the priority.

4.2.3 Duplicate bookings

An RFA for the same procedure with different treating doctors at the same hospital; or for the same procedure at a different hospital must not be accepted. The patient must be asked to decide which elective surgery list they wish to remain on.

5 NOTIFICATION

Admissions/booking staff must use the date that is stamped on the RFA as the listing date and add the patient to the elective surgery list within three working days of receiving the RFA.

5.1 Notification to the patient

Admissions/booking office staff must inform the patient in writing within three working days of them being added to the elective surgery list and of their clinical urgency category timeframe. They must also be advised of any other relevant information of their hospitalisation, which may include the anticipated length of stay, discharge procedures and post-operative follow up. The patient must also be informed of how to advise the hospital of any changes to their contact details or condition.
Any additional information for the patient's admission should be attached to the RFA as appropriate

5.4 Notification to the patient's general practitioner

The treating doctor or hospital must provide a notification letter to the patient's referring general practitioner advising them that the patient has been added to the elective surgery list as a result of their referral. The notification letter is to be sent within three working days of the patient being added to the list and is to include the patient's:

- full name and address
- placement on the elective surgery list
- the date of placement on the elective surgery list
- the proposed procedure
- the clinical urgency category and definition
- hospital contact information, including who to contact if the patient's condition changes

A copy of this notification letter must be sent to the treating doctor or hospital. Admissions/booking staff are to add this letter to the patient's medical record.
An example letter of notification to the general practitioner is available on the Elective Surgery Program Resources webpage.

6 MANAGING PATIENTS

6.1 Access to elective surgery

Access to elective surgery in NSW public hospitals must be managed according to clinical urgency, resource availability and time of a patient's placement on the elective surgery list (treat in turn principle).

6.2 Privately referred non-admitted patients

All medical and elective surgical procedures that are performed within operating theatres, procedure rooms and endoscopy suites must be added to the elective surgery list regardless of admission type. Privately referred non-admitted patients are also to be managed as per this policy and added to the elective surgery list in the Patient Administration System.

For further information on elective surgery list reporting requirements see the Data Dictionary Wait List Data Stream EDWARD Version: 2021

6.3 Delayed and declined patient outcomes

A delayed or declined outcome can be applied against a planned admission/planned procedure date where the procedure was not performed; however, the patient remains on the elective surgery list.

6.3.1 Delayed patient

A delayed outcome must be reported where a patient's planned admission/planned procedure has been delayed to a later date by reasons initiated by the hospital, for example, unavailability of doctor or unavailability of bed.

The patient must remain on the elective surgery list as being ready for care and a suspension must not be applied.

Admissions/booking office staff must record the reason the patient is being delayed on the patient administration system and RFA and offer the patient a new planned admission/planned procedure date within five working days of the delay.

6.3.2 Declined patient

A declined outcome must be reported where a patient has not accepted a planned admission/planned procedure date for reasons due to their own choice or unavailability, for example, they do not accept an alternate surgeon, or they are unavailable at that time.

Admissions/booking office staff must record the reason the patient is declining the planned admission or procedure date on the patient administration system and on the RFA. They must also review the reason for a declined planned admission/planned procedure date to determine:

- If a new date is to be offered
- If a 'deferred' suspension should to be applied (see section 6.4.2)
- If the patient is to be removed from the elective surgery list

A 'deferred' suspension must not be applied where a patient declines a planned admission/planned procedure date offer with an alternate surgeon or at an alternate hospital. Patients who decline two genuine offers are to be informed that they may be removed from the elective surgery list in consultation with their treating doctor.

6.4 Suspension

A person on the elective surgery list who experiences a period of time where they are clinically not ready for care ('**staged**') or personally unavailable ('**deferred**') but is expected to become ready for care or available in the future must have a suspension applied for the period they are not ready for care or unavailable.

At the time of registration on the elective surgery list all patients must be available to be admitted to hospital or begin the process leading directly to admission, except for patients who are 'staged' (see section 6.4.1).

Where a patient is required to be 'staged' for a prolonged period of time to achieve a desired outcome for surgery to occur for example, significant weight loss, the patient must not be placed on the elective surgery list, or they must be removed from the elective surgery list in consultation with the treating doctor.

Admissions/booking office staff must record the reason for staging or deferring a patient on both the electronic Patient Administration System and the RFA. Patients with current suspensions must be regularly reviewed to ensure they become 'ready for care/available' or are removed from the elective surgery list (see section 6.12).

6.4.1 Staged (Clinically 'not ready for care')

A person on the elective surgery list who is not presently available for treatment due to clinical reasons, or patients whose medical condition will not require or be amenable to surgery until some future date is Staged. An example of a Staged patient is a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time.

The treating doctor must identify the 'not ready for care' timeframe and a 'ready for care' clinical urgency category must be indicated for admission on the RFA.

Admissions/booking staff must first register the patient in their intended clinical urgency category, then record the Staged suspension period.

For further information please refer to the Data Dictionary Wait List Data Stream EDWARD Version: 2021

6.4.2 Deferred (patient unavailable for non-clinical reasons)

A suspension may only be applied where the period of unavailability is greater than one day.

Where a patient is clinically ready for treatment, however they are unavailable for surgery due to personal reasons, admissions/booking staff must record the unavailable period in the waitlist record as a deferred suspension. Any clinical urgency category 1 patient who requests deferral must be brought to the attention of the treating doctor.
The patient listing status should be returned to 'ready for care' once the unavailable/suspension timeframe is complete.

If a patient is unavailable on more than two occasions or exceeds the maximum cumulative number of unavailable/suspension days, consider removing the patient from the elective surgery list (see section 6.12).
The maximum cumulative of unavailable/Suspension days does not include days accrued as staged.

Clinical urgency category	Maximum cumulative days
Category 1 - Urgent	15
Category 2 - Semi-urgent	45
Category 3 - Non-urgent	180

6.5 Status review date

Admissions/booking office staff must set the status review date each time a patient's status changes from 'ready for care' to 'not ready for care/suspended' or where their status remains 'not ready for care/suspended' after assessment.

6.5.1 Status review report

Admissions/booking staff must, at least weekly, generate a report listing the details of each patient whose status review date will become due in the following month. During this review, patients can:

- Be assigned another status review date
- Be returned to ready for care with the appropriate clinical urgency category
- Have a planned admission date scheduled (see section 6.8.1)
- Be removed from the elective surgery list (see section 6.12)

6.6 Clinical review

The condition of the patient may change while the patient is awaiting treatment. Patients and general practitioners can initiate a review to ensure that the waiting time is appropriate for their clinical condition.

Patient listing status must remain in their current clinical urgency category while undergoing a clinical review and must not be moved into 'not ready for care'.

The clinical review must be arranged by the hospital at no cost to the patient and conducted by the treating doctor, a specialist consultant, or their delegates.

Examination may result in the patient being assigned a different clinical urgency category from the initial category that was assigned (see section 3.2.2). An authorised change in the clinical urgency category must be documented in the patient administration system and on the RFA. The name and signature of the relevant staff member who documented the change is also to be included.

If a patient declines an appointment or fails to attend a clinical review the admissions/booking staff must discuss the patient's status on the elective surgery list with the treating doctor or their delegate and senior management.

6.7 Changes to the patient's planned procedure

When changes are made to the originally listed procedure for the treatment of the same condition, admissions/booking office staff must document evidence to validate any change to a patient's listed procedure including:

- Name and signature of the relevant staff member
- Date and time of notification of the change
- Name of the person notifying of the change to the originally listed procedure
- Reason for the change

Where the changes are minor, and the principal procedure remains the same (for example a left total knee replacement replaces a right total knee replacement) the admissions/booking office must edit the procedure description field of the elective surgery list entry screen and a notation regarding the changes are to be made in the comments field.

Where the principal procedure changes, admissions/booking office must remove the original elective surgery list entry as "no longer required" and the treating doctor must submit new RFA for the new procedure. As this is a new procedure the listing date is the date as on the new RFA.

6.8 Admission process

To ensure equity and priority of access, when choosing patients from an elective surgery list for admission, admissions/booking office staff must treat all patients in accordance with the clinical urgency categories and in the order as they are added to the elective surgery list.
Staff must consider:

- Resource availability e.g. theatre time, staffing, post-operative bed requirements, equipment and hospital capacity
- Previous delays
- Pre-admission assessment issues and factors e.g. elderly people living alone or those having to travel long distances

Staff must also consult with relevant staff to meet individual patient needs including:

- Treating doctor
- Operating Theatres Manager
- Admissions
- Pre-admission clinic
- Elective surgery list coordinator
- Other departments if relevant e.g. medicine or radiology
- Community care and post discharge services for an effective communication to handover patient care to their general practitioner or other relevant community services as required
- Aboriginal liaison officer
- Interpreter

6.8.1 Allocating a date for surgery

When a patient is selected from the elective surgery list for surgery, admissions/ booking office staff must determine a planned admission date on which it is proposed that a patient will be admitted for their planned procedure. This may be the same as the planned procedure date, or it may be different.

The patient must be contacted by phone or patient's preferred contact method to determine acceptance of admission. Once a date is accepted, an admission letter must be sent to the patient.

A planned admission date can be arranged when a patient is in the 'not ready for care/suspended' category. The patient must be returned to 'ready for care' status prior to admission.

For patients allocated a 30-day clinical urgency category, a planned admission date must be given to the patient on registration.

For an example patient letter allocating a date for surgery to patients, please see the Elective Surgery Program Resources webpage.

6.8.2 Pre-admission assessment

All RFA forms must be reviewed for the need for a pre-admission clinic appointment to confirm the patient's suitability and safety to undergo the intended surgery. This optimises and supports management of the patient's perioperative risks associated with their planned surgery.

If the patient meets the local criteria that they are required to attend a pre-admission appointment and then fail to attend, their risk for surgery remains undetermined. Any decision to go ahead with the surgery must be discussed with the treating doctor prior to rescheduling the appointment and surgery.

For further information on pre-admission clinics please see the Agency for Clinical Innovation's Perioperative Toolkit.

6.8.3 Short-notice list

When offering dates at a short notice, admission/booking staff must consider the need for a pre-admission clinic appointment and be managed "in turn" within clinical urgency category as much as possible.

Patients must be given as much notice as possible about their proposed advancement on the list. Once a patient has been called in as a 'short-notice' list patient and their ensure the patient is not inconvenienced further.

A patient must not be marked as 'deferred' if they are unable to make a short notice offer.

6.9 Hospital-Initiated Delays

Postponements or delays to surgery must be avoided and only occur when all alternative options are exhausted. Decisions to delay a patient must involve relevant medical and operating theatre staff, bed manager, the elective surgery list manager and senior hospital management. The decision must consider the:

- Reason for the delay
- Clinical urgency category
- Patient's delay history
- Patient's length of time on the elective surgery list
- Medical input from treating doctor or delegate
- Patient's proximity to the facility

When a patient's planned admission date is delayed and needs to be rescheduled, administration/ booking office staff must record the reason for the delay and reschedule the patient on the next available list according to their clinical urgency category. The record is to include the original listing date and history of any previous admission dates and delays.

The patient must be advised of a new planned admission date within five working days of the delay.

Where possible, delayed patients must be prioritised on the procedure/treatment list to minimise the chance of further delay for example, placed first on list.

If a patient has been delayed twice and cannot be treated within the appropriate clinical urgency category timeframe, admissions/booking office staff must escalate to district/network senior management and a plan made to treat the patient within their clinical timeframe (see section 6.11).

For an example of a patient delay letter, please see the Elective Surgery Program Resources webpage.

6.9.1 Informing patients of delays

When communicating the surgery delay, admissions/booking office staff must provide the patient with the maximum possible notice. Category 1 patients must be notified of their delay by a senior member of the surgical/medical team or senior hospital manager.

6.9.2 Delay on the day of surgery or after admission

When a patient's surgery, procedure or treatment is delayed by the hospital on the day of their planned admission or their planned procedure date the patient must be informed by a senior member of hospital or district management and/or treating doctor or their delegate.

Offers of support that can be offered to the patient include	
Contacting a family member or friend	Counselling services
Aboriginal Liaison Officer support	Access to a complaint service
Social Worker support	Arranging and paying for transport home, accommodation, food etc

Admission / Booking Office staff must	
Admit and discharge the patient	Record the reason for the delay
Return the patients record to the elective surgery list with the original listing date and history	Reschedule the patient on the next available list according to their clinical urgency category
Advise the patient of a new PAD within 5 working days of the delay	

An example letter informing a patient of a necessary delay is available on the Elective Surgery Program Resources webpage.

6.10 Patient-initiated deferral

When a patient defers an agreed date for surgery or procedure for personal or social reasons, admissions/booking staff must record the reason the patient is declining the planned admission or procedure date on the elective surgery list and on the RFA. They must also review the reason for a declined admission date to determine whether:

- A new date is to be offered
- The patient is to be categorised as 'not ready for care/suspended' deferred
- The patient is to be removed from the elective surgery list

Patients are only permitted to defer maximum of two times for personal or social reasons.

6.10.1 Patient deferral after admission

If a patient arrives for surgery, treatment/procedure and decides to defer after admission, admissions/booking office staff must advise the treating doctor, admit and discharge the patient, then record the reason for deferral
The treating doctor or delegate must discuss the requirement for surgery with the patient.
If the surgery is still clinically required and the patient agrees, the patient's elective surgery list record must be returned to the list (rebooked) with the original listing date and history, including urgency categories and delays etc.
If the patient does not agree to have surgery after discussion with the treating doctor, then the patient's elective surgery list record must be reinstated with the original listing date and history, including urgency categories and delays. The record is then removed from the elective surgery list using the appropriate reason.

6.11 Demand management to treat patients on time

Patients added to the elective surgery list must be treated within their clinical urgency category timeframe through proactive surgical service demand and capacity management.

Admissions/booking office staff must review the elective surgery list weekly and identify patients that are likely to exceed or have already exceeded their clinical urgency category timeframes (see section 7). Treating doctors must ensure that they are available to perform procedures within the assigned clinical urgency category timeframes or in consultation with the hospital, arrange for another clinician to perform the procedure within the assigned clinical urgency category timeframe.

Hospital clinical directors of surgical services or equivalent must monitor the volume of each treating doctor's elective surgery list plus additions to the elective surgery list to ensure that there is capacity to undertake required surgery. If the treating doctor has insufficient capacity and/or a patient is identified as having exceeded or likely to exceed their clinical urgency category timeframes the hospital clinical directors of surgical services or equivalent should consider the following solutions in conjunction with the treating doctor, patient, and senior management:

- Additional theatre time at same or other facility
- Pooled lists where it is clinically appropriate for doctors in the same specialty to agree to include their public patients on a combined list for that specialty. Patients may be treated by any one of the doctors belonging to the group
- Transfer of patients to another treating doctor with a shorter elective surgery list at the same facility (see section 6.11.1).
- Transfer of patients to another treating doctor with a shorter elective surgery list at another facility (see sections 6.11.2 and 6.11.3).
- Private sector options where the district or network is responsible for expenses incurred (see section 6.11.4).

The patient must be informed of any change of surgeon or hospital and this contact must be recorded on the RFA form.

All patients requiring elective surgery/procedure (with an allocated surgical indicator procedure code) regardless of admission type are recorded on the inpatient patient administration system which holds the elective surgery list.

6.11.1 Transfer of patients to doctors with a shorter waiting time

The new treating doctor will determine the requirement to review the patient prior to surgery, procedure or treatment. If a review is required, it must be facilitated by the hospital at no cost to the patient. The patient's listing date and history must be that of the original booking. The patient's current clinical urgency category must be maintained, unless altered after clinical review by the new treating doctor.

The planned admission offer to the patient must be considered 'reasonable'. This must be determined for each patient and consider the circumstances of the patient for example, age, available support, public transport, physical condition and the required procedure.

The offer must be specific and include the name of the clinician, hospital and planned admission date or an estimate of the likely waiting period must be provided to the patient.

The offer must also be a credible alternative and be available if the patient decides to accept the offer. Where the patient does not accept two genuine offers of treatment (excluding offers made at short notice (within 24hrs) but including an offer with another doctor or at another hospital), the patient must be advised that they may be removed from the elective surgery list.

Hospital clinical directors of surgical services or equivalent must review the patient's status on the elective surgery list in consultation with the original treating doctor prior to the patient being removed from the elective surgery list.

6.11.2 Transferring patients to another facility in the same district or network

When a patient is booked at one hospital and subsequently has the procedure carried out at a different hospital within the same district or network, admissions/booking office staff at the receiving hospital must enter the booking with the same listing date, history and current clinical urgency category as the original hospital booking.

They must also inform the original hospital admissions/booking office staff that the booking has been accepted and added to the receiving hospitals elective surgery list.

Admissions/booking office staff at the original hospital must send the original RFA form to the receiving hospital and retain a copy for auditing at the original hospital. The booking at the original hospital must be removed using the relevant reason code on receiving confirmation of the patient's booking at the receiving hospital.

For further information please refer to the Data Dictionary Wait List Data Stream EDWARD Version: 2021.

6.11.3 Transferring patients to another district or network

Where an agreement exists with another district or network to undertake public patient surgery, the new facility/receiving hospital admissions/booking office staff must add the patient to the elective surgery list with the new listing date and advise the original hospital when the procedure is undertaken.

Original facility admissions/booking office staff must send the original RFA form to the new facility and keep a copy for auditing purposes. Staff must keep the patient on the elective surgery list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

6.11.4 Contracts with private hospitals

Where a contract exists with a private hospital to undertake elective surgery, treatment or procedures for the district or network, the contracted hospital must be managed as per the requirements of this Policy. The public hospital must be advised when the procedure is undertaken.

Admissions/booking staff of the original facility must send the original RFA form to the new facility and keep a copy for auditing purposes. The patient is to remain on the elective surgery list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

The date of the removal from the public hospital elective surgery list is the date of the admission at the contracted private facility.

For further information on the reporting requirements for the elective surgery list please see the Data Dictionary Wait List Data Stream EDWARD Version: 2021.

6.12 Removing patients from the elective surgery list

Patients may be removed from the elective surgery list for reasons other than admission.

Hospitals must exercise discretion on a case by case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other unavoidable circumstances.

Patients must not be removed from the elective surgery list if they decline an offer that was made at short notice.

An example letter for informing a patient that they have been removed from the elective surgery list is available on the Elective Surgery Program Resources webpage.

<table>
<tr><th>Reason</th><th>Admissions / Booking Office staff must</th></tr>
<tr><td>Patient declines treatment/clinical review or requests removal for other reasons for example patient has surgery elsewhere.</td><td rowspan="3">• Obtain authority from the treating doctor or delegate for clinical urgency category 1 patients prior to removal from the elective surgery list
Once the decision is made to remove a patient from the elective surgery list:
• Document discussions with the patient and treating doctor on the RFA
• Remove the patient from the elective surgery list on the PAS
• Document the reason for the removal and date of removal
• Advise the treating doctor within 24 hours of notification of the removal of the patient from the elective surgery list
• Advise the general practitioner that the patient has been removed
• Inform patient if they have any further questions on their healthcare needs to contact the treating doctor / GP</td></tr>
<tr><td>Patient defers treatment on 2 occasions (including genuine offers of another doctor/hospital) or in deferring exceeds the maximum number of Not Ready for Care/Suspended days:
Category 1 > 15 days
Category 2 > 45 days
Category 3 > 180 days</td></tr>
<tr><td>Patient fails to arrive for treatment on > 1 occasion without giving prior notice and with no extenuating circumstances.</td></tr>
</table>

Patient not contactable on 2 occasions (one by telephone and one by letter)	• Obtain, where possible, the patient's correct contact details via treating doctor; general practitioner; medical records; next of kin; person responsible; and telephone directory search • Record any evidence such as patient letters returned to sender • Remove patient from the elective surgery list • Document the reason for the removal and date of removal • Advise treating doctor and general practitioner that the patient has been removed • Document actions on RFA and electronic record
Patient deceased	• Obtain verification (usually verbally from the patient's relative, general practitioner or treating doctor) • Record the name of the person who has notified the hospital that the patient is deceased • Remove patient from the elective surgery list • Document the reason for the removal and date of removal • Document action on the RFA
Treating doctor advises surgery no longer required	• Once the decision is made to remove a patient from the elective surgery list: • Document discussions with the patient and treating doctor on the RFA • Remove the patient from the elective surgery list on the PAS • Document the reason for the removal and date of removal • Advise the treating doctor within 24 hours of notification of the removal of the patient from the elective surgery list. • Advise GP that the patient has been removed • Inform patient of the potential risks to their health and advise them to contact the treating doctor / GP to discuss

Hospitals must have a documented process for removing patients from the elective surgery list and retain the RFA form in the medical record of the patient.

6.12.1 Adding a patient to the elective surgery list who was recently removed

If a patient was removed from the elective surgery list, and in the following thirty days the elective surgery list record for the patient is to be re-activated for the same procedure, the patient must be re-booked with the original listing date and history, including clinical urgency category.

Admissions/booking office staff must consult the treating doctor for confirmation before adding the patient to the list.

7. RECORD KEEPING AND REPORTING

Hospitals must keep accurate records of elective surgery list information. Any changes made to a patient's booking must be validated with documented evidence, reason for change and be signed by the relevant staff member. Changes may include planned admission dates or planned procedure dates and treating doctor or hospital.

Accurate records are to be maintained for patient delays and deferrals and include the reason on both the Patient Administration System and the RFA form. RFA forms must have a dedicated section to record all changes and/or a designated form attached to the RFA.
Admissions/booking office staff must generate and review a weekly report to identify overdue patients (see section 8.1.1).

They must also provide monthly reports to the hospital general manager or their delegate with the following information:

- Patients who incurred a delay during the month (previous month)
- Patients on the list who have had two or more delays to their admission
- All delayed patients who have not had a rescheduled planned admission date allocated within five days

8. AUDITING THE ELECTIVE SURGERY LIST

8.1 Clerical audit

Clerical audit of the elective surgery list ensures that accurate information is provided to patients, clinicians and administrators when required.

Hospitals must identify a person responsible for conducting clerical audits of the elective surgery list and reporting the outcome of the audit to a senior manager. Records related to clerical audits are to be kept for a minimum three years.

At a district/network level, a person must be nominated to be responsible for monitoring the clerical audit program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits within their district/network.

8.1.1 Weekly clerical audit

A clerical audit must be conducted weekly which includes:

- Checking for duplicate bookings
- Ensuring a clinical urgency category is appropriately assigned
- Reviewing listing status of patients whose status review date will become due in the next week
- Reviewing exceeded planned admission and planned procedure date,
- Ensuring a delayed patient has been rescheduled for the next available theatre session in consultation with the treating doctor
- Identifying patients on elective surgery list admitted through the emergency department for the same procedure
- The number of patients removed from the elective surgery list and the reason for removal
- Identifying overdue patients

8.1.2 Clerical audit report

On completion of clerical audits, a report signed by the person responsible for conducting the audit must be sent to a senior manager and tabled at an appropriate surgery committee meeting.
This report must include the type of audit conducted, problems identified and recommendations for improvement.

8.1.3 Quarterly evaluation

Elective surgery list managers and coordinators must evaluate the local audit process quarterly including:

- Reviewing compliance with weekly and monthly audits
- Weekly and monthly audit reports are tabled at the relevant committee
- Availability of clerical audit records

8.1.4 Not ready for care / suspended patient audit

A 'not ready for care/suspended' patient audit must be conducted twice a year. A report must be provided to the NSW Ministry of Health's Systems Purchasing Branch for review.

8.2 Review of elective surgery list by treating doctor

Admissions/booking staff must provide a comprehensive list of their patients monthly to each treating doctor, or more frequently as requested**.**

Treating doctors must confirm this elective surgery list with elective surgery coordinators and make any changes required.

Where a district or network uses pooled lists, the hospital must nominate a medical officer to confirm patients on list and make any changes required as above.

8.3 Patient follow up audit

All patients on the elective surgery list for greater than six months from their listing date with no planned admission date or planned procedure date, must be contacted to ascertain if they still require admission.

Two contacts must be attempted, one by letter/email and if no response is received, a follow up telephone call to determine the patient's status on the elective surgery list. Correspondence must include:

- Information on alternative options where available
- Advice for clinical reassessment by treating doctor or general practitioner
- Hospital and district/network contact details

Patient responses must be documented in the patient 's medical record.

An example of a patient audit letter is available on the Elective Surgery Program Resources webpage.

9. DOCTOR'S LEAVE

A patient's clinical urgency category and listing date does not change because of doctor's leave. To ensure appropriate theatre scheduling, doctors must provide notice of intended leave.

A management plan must be implemented for all patients who, during the leave period already had a planned admission/planned procedure date or will exceed their clinical urgency category timeframe.

9.1 Types of leave

Type of leave	Action
Planned Leave e.g. Annual, Study, Extended Leave and parental Leave	Treating doctors must: • Provide at least six weeks' notice of intended leave • Develop management plan for affected patients. • Not add any patients to their elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent. Admissions/booking office staff must: • With the treating doctor, develop management plans for affected patients • Consult with relevant personnel including Head of Unit or specialty, Medical Administrator, Clinical Director, Divisional Manager, Operating Theatre Manager, Elective surgery list coordinator, Hospital Executive Officer and District/Network Chief Executive or delegate. • Not add any patients to the doctor's elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent.
Unplanned leave e.g. sick leave, bereavement leave	Admissions/booking office staff must: • Develop management plans for affected patients in conjunction with relevant personnel including head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. • Not add any patients to the doctor's elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent.
Planned resignation e.g. resignation from hospital or retirement	Treating doctors must: • Develop management plan for affected patients with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. Admissions/booking office staff must: • Transfer patients to a replacement treating doctor's elective surgery list (see section 6.11.1) and maintain the treat in turn principle. Maintain patients on the resigning doctor's list if they are not immediately transferred. • With the treating doctor, develop management plans for affected patients • Notify affected patients of the doctor's intention to leave and provide information about the patient's management plan • Not add any patients to the doctor's elective surgery list upon notification of planned resignation unless there is capacity or for an urgent case. This must be approved by the district/network program director of surgical services or equivalent. Hospital executive must: • Ensure appropriate arrangements are made to either locate replacement treating doctor or transfer patients to another surgeon in consultation with senior clinicians and management. • Organise clinical review as required for patients remaining on the departing doctor's elective surgery list. • Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the elective surgery list.

Type of leave	Action
Planned resignation e.g. resignation from hospital or retirement	Treating doctors must: • Develop management plan for affected patients with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. Admissions/booking office staff must: • Transfer patients to a replacement treating doctor's elective surgery list (see section 6.11.1) and maintain the treat in turn principle. Maintain patients on the resigning doctor's list if they are not immediately transferred. • With the treating doctor, develop management plans for affected patients • Notify affected patients of the doctor's intention to leave and provide information about the patient's management plan • Not add any patients to the doctor's elective surgery list upon notification of planned resignation unless there is capacity or for an urgent case. This must be approved by the district/network program director of surgical services or equivalent. Hospital executive must: • Ensure appropriate arrangements are made to either locate replacement treating doctor or transfer patients to another surgeon in consultation with senior clinicians and management. • Organise clinical review as required for patients remaining on the departing doctor's elective surgery list. • Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the elective surgery list.
Unplanned resignation or death	Admissions/booking office staff must: • Transfer patients to a replacement treating doctor's elective surgery list (see section 6.11.1) and maintain the treat in turn principle. If they are not immediately transferred, place patients on a list for an appropriate doctor or specialty. • Develop management plans for affected patient with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. • Not add any patients to the doctor's elective surgery list • Notify relevant general practitioners of the resignation/death Hospital executive must: • Locate replacement of treating doctor in consultation with senior clinicians and management. Clinical review is at the discretion of the accepting treating doctor.

An example of a notification to a general practitioner of resignation/death letter is available on the Elective Surgery Program Resources webpage.

9.2 Patient management plan for treating doctor's leave

Admissions / booking office staff must inform patients:

- Their position on the elective surgery list will not be affected
- The name of the replacement doctor (if available)
- If a clinical review is required
- About their expected waiting time
- Who to contact for more information

All contact with patients must be documented and be part of, or attached to, the patient's RFA form

10. APPENDIX

Clinical urgency categories reference list

Please note that IPC changes are made yearly. For an up to date searchable list please see the NSW Health Elective Surgery Program Resources webpage.

VERIFICATION OF DEATH AND MEDICAL CERTIFICATE OF CAUSE OF DEATH (PD2023_014)

PD2023_014 replaced PD2021_029

POLICY STATEMENT

NSW Health provides a uniform procedure for completing clinical assessments and documentation to verify death and when issuing a Medical Certificate of Cause of Death.

This Policy Directive describes the roles of medical practitioners, registered nurses/ registered midwives and qualified paramedics in relation to assessment and documentation when patients die within the NSW Health system.

SUMMARY OF POLICY REQUIREMENTS

Verification of death Determination of death in patients is preceded by a minimum observation period of five minutes to establish that irreversible cessation of cardiorespiratory function has occurred. The observation period is to be done by the clinician determining death. After five minutes of continued cessation of cardiorespiratory function, the:

- absence of pupillary responses to light
- absence of response to central painful stimulus
- absence of a central pulse on palpation
- absence of heart sounds on auscultation
- absence of respiratory effort

indicate irreversible cessation of cardiorespiratory function and the time of death is then recorded.

A medical practitioner must conduct the verification of death assessment. In cases where there is no medical practitioner available to verify death, registered nurses, registered midwives and qualified paramedics can do so. The Verification of Death form must be completed. Qualified paramedics must only verify death as outlined in NSW Ambulance Protocol A13 Verification of Death.

Where a body is transported to a NSW Health facility for verification of death assessment, a medical practitioner, registered nurse or registered midwife can assess death and complete the Verification of Death form. The Coroner will issue a death certificate in such cases.

In situations where the person has injuries incompatible with life or has been deceased for some time, the death is considered obvious and no clinical assessment is required.

Medical Certificate of Cause of Death

The medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death must, within 48-hours of the death, notify the Registrar of the Registry of Births, Death & Marriages using the Medical Certificate of Cause of Death form. The contact details of the medical practitioner who will complete the Medical Certificate of Cause of Death form must be included in the Verification of Death form.

In situations where it is necessary for a funeral director or government contractor to transport the body of a deceased person to a NSW Health facility for completion of the Medical Certificate of Cause of Death form and the name of the medical practitioner who will complete the Medical Certificate of Cause of Death form is not known, the registered nurse/ registered midwife may write "transfer to <name of NSW Health facility>" in the Medical Certificate of Cause of Death section on the Verification of Death form.

A medical practitioner is to only certify the cause of death if a diagnosis of cause of death can be made. If the medical practitioner is unable to ascertain the cause of death, the matter must be referred to the Coroner.

Training must be provided to relevant staff regarding assessment and documentation of death (available via My Health Learning).

Medical Certificate of Cause of Death: Procedures

1 BACKGROUND

1.1 About this document

This Policy Directive outlines the process for the assessment and documentation to verify death (previously referred as extinction of life), and the medical certification of death of patients within the NSW Health system. It describes the roles of medical practitioners, registered nurses/ registered midwives and qualified paramedics employed by NSW Health in relation to assessment and documentation when patients die within the NSW Health system.

Medical practitioners must comply with the death certificate requirements outlined in the Births, Deaths and Marriages Registration Act 1995 (NSW).

This Policy Directive does not apply to the Justice Health and Forensic Mental Health Network.

NSW Ambulance staff may only verify death in accordance with NSW Ambulance Protocol A13 Verification of Death.

This Policy Directive supports registered nurses and registered midwives to verify death across practice settings. The Nursing and Midwifery Board of Australia (NMBA) advises that "the extent of a nurse or midwife's scope of practice is determined by the individual's education, training and competence. The extent of an individual's scope of practice is then authorised in the practice setting by the employer's organisational policies and requirements."[1]

All staff must comply with the legislative requirements in the Coroners Act 2009 regarding the certification of death.

1.2 Key definitions

Intention to complete and sign a Medical Certificate of Cause of Death

In circumstances where there may be a delay in completion of the Medical Certificate of Cause of Death by a medical practitioner, it may be appropriate following verification of death by a registered nurse/ registered midwife or qualified paramedic, for a medical practitioner to provide a notice of intention to complete a Medical Certificate of Cause of Death which will allow a funeral director to remove the body. The certification as to the cause of death must take place within 48-hours of the death.

Medical Certificate of Cause of Death

The form issued by the NSW Registry of Births, Deaths & Marriages in which a medical practitioner notifies the Registrar, Registry of Births, Deaths & Marriages of a death and the cause of that death, pursuant to legislative requirements in Section 39 of the Births, Deaths and Marriages Registration Act 1995 (NSW).

Notification of deaths by medical practitioners to the Registrar at the Registry of Births, Deaths & Marriages

A requirement of the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death under the Births, Deaths and Marriages Registration Act 1995 (NSW). For further details see Section 2.2.

Public Health Organisation

A public health organisation is defined in Section 7 of the Health Services Act 1997 (NSW) as: a local health district and specialty health network, or a statutory health corporation, or an affiliated health organisation in respect of its recognised establishments and recognised services.

Verification of Death

A clinical assessment process undertaken to establish that a person has died.

1.3 Legal and legislative framework

NSW legislation relevant to this Policy Directive:

- *Births, Deaths and Marriages Registration Act 1995*
- *Coroners Act 2009*
- *Human Tissue Act 1983*
- *Health Services Act 1997.*

1.4 Policy framework

NSW Health policy documents relevant to this Policy Directive:

- NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (PD2010_054)
- NSW Health Policy Directive Conduct of Anatomical Examinations and Anatomy Licensing in NSW (PD2011_052)
- NSW Health Policy Directive Organ and Tissue Donation, Use and Retention (PD2022_035).

1.5 NSW State Forms

NSW Health State Forms relevant to this Policy Directive:

- Medical Certificate of Cause of Death (SMR010509) [NSW Registry of Births, Deaths and Marriages]
- Coronial Checklist (SMR010.513)
- Verification of Death (SMR010530)
- Death Certification Arrangements for Expected Home Death (SMR010531)

2 DOCUMENTATION REQUIREMENTS WHEN A PATIENT DIES

2.1 Reporting a death to the Coroner

To determine if a death should be reported to the coroner refer to the Coronial Checklist available from the hospital/ local health district, in conjunction with the NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (PD2010_054). The Coronial Checklist includes details of how to seek advice where there is uncertainty and provides contacts for the NSW State Coroner's Office or the Duty Pathologist, NSW Health Forensic Medicine (Sydney, Newcastle and Wollongong).

Nursing, midwifery and medical staff managing cases reportable to the Coroner must follow the steps outlined in the NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (PD2010_054). For deaths reportable to the Coroner, verification of death (extinction of life) is documented within Report of a Death of a Patient to the Coroner (Form A) (SMR010.510). No additional documentation relating to death is required.

It is advisable to seek advice from the Coroner regarding the mandatory reporting of deaths which fall within the requirements of Section 24 of the Coroners Act 2009 (NSW) which covers jurisdiction concerning deaths of children and disabled persons.

2.2 Medical certification of death

2.2.1 Legal responsibilities of medical practitioners

Death certificates certify the facts and circumstances of the death of a person. Under the Births, Deaths and Marriages Registration Act 1995 (NSW) the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, **must**, within 48-hours of the death:

a) Give the Registrar of Births, Deaths and Marriages, notice of the death and cause of death, and

b) If the medical practitioner is of the opinion that it is impracticable or undesirable to give notice of the cause of death of the person within that time, give the Registrar notice of the death, and of the medical practitioner's intention to sign a death certificate with the cause of death notified as soon as possible after that.

In NSW public health organisations, the *Medical Certificate of Cause of Death* Form must be used to give notice of death. This form asks for the date of death or range of dates where the exact date is not known.

A medical practitioner cannot give notice based on review of medical records only. The body must be viewed, or, the medical practitioner must have been treating the person prior to death.

If another medical practitioner has given notice, or the death has been reported to the Coroner under the *Coroners Act 2009, a* medical practitioner is not required to give repeat notice of death to the Registrar.

A medical practitioner must only certify the cause of death if a diagnosis of cause of death can be made. If the cause of death is uncertain, reasonable steps are to be taken to obtain sufficient information to enable the medical practitioner to determine the cause of death. Reasonable steps would include reviewing the medical record or contacting other health professionals involved in the recent care of the deceased person.

If the medical practitioner is unable to ascertain the cause of death or the death is otherwise reportable to the Coroner (see Section 2.1.), the matter must be referred to the Coroner and a Medical Certificate of Cause of Death must not be completed.

If the medical practitioner is a relative of the deceased, they should not complete the certificate unless they are the only medical practitioner in a remote area. Medical practitioners must also disclose any property, pecuniary or other benefit(s) that they anticipate acquiring from the death. Notification of death certificates may be requested from the Registrar of Births, Deaths and Marriages via phone 13 77 88.

2.2.2 Responsibilities for certification of death in NSW Health facilities

When a patient dies in a NSW Health facility where there are medical practitioners on site, it is preferable that a medical practitioner conducts the verification of death assessment. If verification of death is completed by another health professional, a medical practitioner is to certify the death as soon as practicable.
In the case of facilities where there is not 24-hour medical coverage, the medical practitioner is to certify death at the commencement of duties. Only a medical practitioner can complete the *Medical Certificate of Cause of Death*

2.3 Verification of Death

2.3.1 Roles of medical practitioners, registered nurses, registered midwives and qualified paramedics

A medical practitioner must conduct the verification of death assessment in situations where medical tests are required to declare death (for example, prior to organ donation).

In all other cases, where there is no medical practitioner available to verify death, registered nurses, registered midwives and qualified paramedics can do so. Qualified paramedics must only verify death as outlined in NSW Ambulance Protocol A13*Verification of Death*.

2.3.2 Clinical procedure for verifying death

Determination of death in patients is preceded by a minimum observation period of five minutes to establish that irreversible cessation of cardiorespiratory function has occurred. The observation period is to be done by the clinician determining death. After five minutes of continued cessation of cardiorespiratory function, the:

- absence of pupillary responses to light
- absence of response to central painful stimulus
- absence of a central pulse on palpation
- absence of heart sounds on auscultation
- absence of respiratory effort

indicate irreversible cessation of cardiorespiratory function and the time of death is then recorded.

In cases of expected deaths at home, the clinical assessment process for the verification of death must be completed.

Where a verification of death assessment has been completed and the practitioner is not certain if the person is deceased, they are to seek the opinion of a second health professional.

In a hospital setting, a medical practitioner should be called, if available. In the case of a registered nurse attending an expected death in a community setting, it is reasonable for the attending nurse to wait and repeat the verification of death assessment after a clinically appropriate time period has elapsed. A second opinion may be sought from a qualified paramedic by calling an ambulance if necessary.

Note that a different clinical procedure is conducted when a patient is certified dead for the purpose of organ donation. Such an assessment is conducted according to the NSW Health Guideline Organ Donation After Circulatory Death (GL2021_012).

In situations where the person has injuries incompatible with life (such as decapitation, severe incineration or extensive trauma), or has been deceased for some time (as evidenced by rigor mortis, dependent lividity or tissue decomposition), the death is considered obvious and no clinical assessment is required. This situation is most likely to occur when a body is brought to a hospital by a government contractor (see Section 2.4.).

2.3.3 Documentation

Registered nurses / registered midwives

Registered nurses/ registered midwives who are assessing and documenting death must use the Statewide Verification of Death (SMR010.530). The original form is provided to the funeral director and a copy is kept in the health care record.

In remote sites, in situations where it is necessary for a funeral director or government contractor to transport the body of a deceased person to a NSW Health facility for completion of the Medical Certificate of Cause of Death and the name of the medical practitioner who will complete the Medical Certificate of Cause of Death is not known at the time the Verification of Death is being completed, the registered nurse or registered midwife may write "transfer to <name of NSW Health facility>" in the Medical Certificate of Cause of Death section on the Verification of Death. Local procedures must be in place to ensure that the Medical Certificate of Cause of Death is completed within 48-hours of the death.

Qualified paramedics
Qualified paramedics are to provide the funeral director with the *Verification of Death* form and record details of the clinical procedure to verify death in the NSW Ambulance clinical record.

2.3.4 Tissue or body donation for deaths outside a health facility

Tissue and body donation may be relevant for some deaths outside of a health facility.
Tissue Donation

A potential donor of tissue for corneal, musculoskeletal and cardiac tissue (heart valve) transplantation is a deceased person for whom retrieval is possible within 24 hours after death.

In order to provide opportunities for families / carers to support the donation of tissues for transplantation, the staff member who verifies the death should sensitively inquire whether the deceased had indicated their wish to be a tissue donor. If so, they are to prompt the family / carer to contact the NSW Tissue Bank via the Lions NSW Eye Bank on (02) 9382 7288 (24 hours a day) to notify them of the death. For more information see the NSW Health Policy *Organ and Tissue Donation, Use and Retention (PD2022_035)*

Donation of Bodies to a School of Anatomy / Medical Science

The deceased person may have decided in their lifetime to donate their body after death to a School of Anatomy for the purposes of anatomical examination and medical research and will usually have completed a consent form during their lifetime to document this decision. Again, the family / carer should be prompted to contact the relevant School of Anatomy body donation program to notify them of the potential donor's death and to make arrangements for the transfer of the body. Further information is available in the NSW Health Policy *Conduct of Anatomical Examinations and Anatomy Licensing in NSW: Procedures and Guidelines* (PD2011_052).

2.3.5 Medical certification following Verification of Death

A medical practitioner must complete the *Medical Certificate of Cause of Death* within 48 hours of death. The contact details of the medical practitioner who will complete the *Medical Certificate of Cause of Death* must be included in the *Verification of Death* form to ensure this occurs.

For patients cared for at home where death is anticipated (e.g. patients known to NSW Health palliative care and affiliated or contracted palliative care services or hospital in the home patients with a resuscitation plan in place), it is recommended that there is agreement in advance on who will complete the medical certification of death. In such cases, the patient's general practitioner may agree to this responsibility (see Section 2.5).

2.4 Bodies transported for verification of death assessment by government contractors (individuals not under the care of NSW Health at the time of death)

In some circumstances, a body may be transported by a government contractor, Ambulance or the Police to a hospital for Verification of Death. If a qualified paramedic is involved in the case prior to a decision to transport the body, it is recommended that they complete the *Verification of Death* form as outlined in Section 2.3. This will assist with transfer of the body to a more suitable location.

Where a qualified paramedic is not involved and the body is transported to a hospital for Verification of Death, a medical practitioner, registered nurse or registered midwife can assess death and complete the *Verification of Death* form. The Coroner will issue a death certificate in such cases. A copy of the signed *Verification of Death* form does not need to be provided to the police.

2.5 Optional considerations for expected home deaths in regional and rural settings

Within regional and rural settings, there may be specific challenges in organising a medical practitioner to complete the *Medical Certificate of Cause of Death* due to greater distances involved and limited medical workforce. Local Health Districts may elect to put in place local policy and / or procedures to designate the medical practitioner responsible for completing the *Medical Certificate of Cause of Death* in advance of an expected death. This approach is encouraged by the State Coroner. Local procedure or policy development must involve consultation with primary care providers, funeral directors and potentially the Police and Coroner.

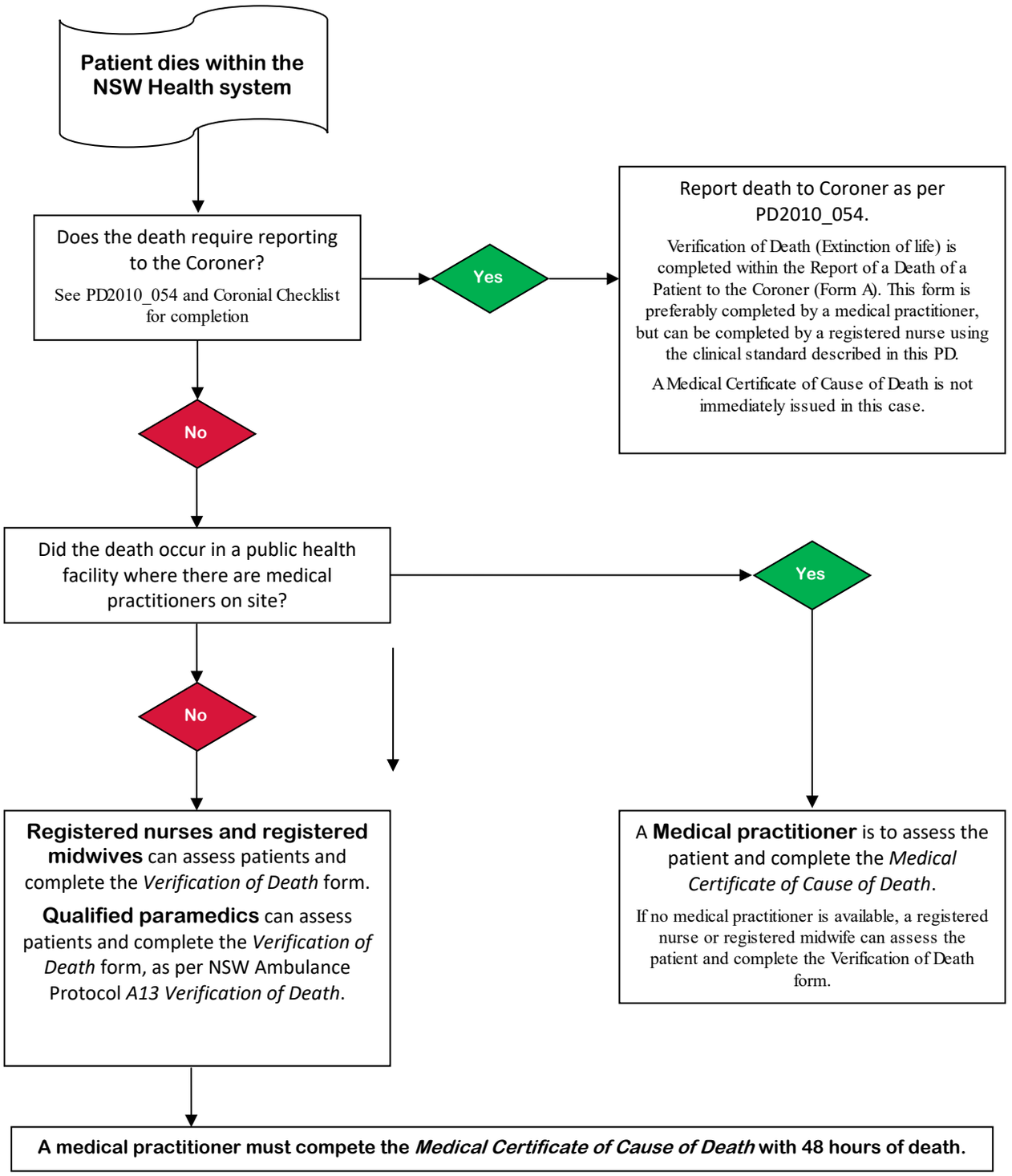
In many cases the patient's general practitioner will be a key part of the healthcare team for patients approaching and reaching the end of their lives who choose to be cared for and die at home.

It is recommended that general practitioners are involved in discussions about planning for completion of the *Medical Certificate of Cause of Death* as part of care planning. In many cases these discussions will be recorded in the patient's health record, however some local health districts and specialty health Networks may elect to formalise the agreement. To assist with formalising this process, a model *Death Certification Arrangements for Expected Home Death* form (see Appendix 2) has been developed and endorsed by the NSW Health State Forms Management Committee. Use of this form is encouraged, but not mandated where local health districts and specialty health networks have elected to develop a process for managing expected deaths in this way.

3APPENDICES

1. Roles and responsibilities for documentation when a patient dies within the NSW Health system
2. StateForm *Death Certification Arrangements for Expected Home Death*

3.1 Appendix 1: Roles and responsibilities for documentation when a patient dies within the NSW Health system



3.2 Appendix 2: State Form Death Certification Arrangements for Expected Home Death

NSW GOVERNMENT Health

Facility:

DEATH CERTIFICATION ARRANGEMENTS FOR EXPECTED HOME DEATH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

SMR010531

PURPOSE:

This form is recommended for use where Local Health Districts / Specialty Health Networks have put in place local policy and/or procedures to designate the medical practitioner responsible for completing the Medical Certificate of Cause of Death (MCCD) in advance of an expected home death. This form will assist with timely removal of the body from the patient's home and give certainty about who will complete the MCCD.

- The first section of the form is for completion by Local Health District / Specialty Health Network staff.
- The second section of the form is for completion by the GP or medical practitioner who agrees to complete the Medical Certificate of Cause of Death within 48 hours of the patient death. The GP or medical practitioner should return this form to the requesting service as soon as possible.

FOR COMPLETION BY REQUESTING SERVICE

Patient details

Family name _____ Given name(s) _____

DOB _____ Phone _____ MRN _____

Address _____

Patient Contact Person: _____ Relationship: _____

Palliative or Life-limiting Diagnosis: _____

Palliative Care Phase: ☐ Deteriorating ☐ Terminal

Details of requesting service:

☐ Specialist Palliative Care Service ☐ Community Health ☐ Aged Care ☐ Multipurpose Service (MPS)

Staff member requesting form: Print Full Name: _____ Signature: _____

Designation: _____ Date: _____

Organisation: _____ Phone: _____

FOR COMPLETION BY GP OR MEDICAL PRACTITIONER WHO ACCEPTS RESPONSIBILITY TO COMPLETE MCCD FOR EXPECTED HOME DEATH

Will you make yourself available at the time of the patient's death to view the body and complete MCCD?

☐ Yes ☐ No

Comment: _____

Can you be contacted after hours? ☐ Yes ☐ No

If No, are you prepared to provide a Medical Certificate of Cause of Death (MCCD) to the Funeral Director within 48 hours if the death is not a reportable death under the Coroners Act 2009?

☐ Yes ☐ No

GP/Medical practitioner's details:

A/H or Mobile No (if available): _____ Surgery Ph: _____

Print Full Name: _____ Signature: _____ Date: _____

ON COMPLETION, RETURN COMPLETED FORM TO:

Contact person/service _____

FAX _____ or EMAIL _____

Original - Funeral Director Photocopy - Medical Record Page 1 of 1

Holes Punched as per AS2828.1: 2012 BINDING MARGIN - NO WRITING

DEATH CERTIFICATION ARRANGMENTS FOR EXPECTED HOME DEATH

SMR010.531

NH700037 260815

WILL MAKING IN PUBLIC HEALTH FACILITIES (GL2023_006)

GL2023_006 replaced IB2018_002

GUIDELINE SUMMARY

NSW Health staff must not be involved in the preparation of a patient's will or attempt to exert influence over the terms of a patient's will.

Where a patient asks for assistance in making a will, the matter must be referred to the hospital's social work team to enable referral to external, independent advice. Staff involvement must be minimal and generally only for the purpose of facilitating the patient's access to their solicitor or the NSW Trustee & Guardian.

KEY PRINCIPLES

NSW Health staff working in public health facilities (including those in community settings) must not be involved in the preparation of a patient's will or attempt to exert influence regarding the terms of a patient's will under any circumstances.

In the event that a patient asks or nominates a staff member to be the executor of their will, or appoints a staff member to be the executor of their will, the staff member must decline the offer or renounce the appointment.

Staff members must not act as a witness to the patient's signature in the preparation of a patient's will. Where a patient in a public health facility (or a patient's family or carer on behalf of a patient), requests assistance with making a will, or with changing an existing will, staff are to refer the request to the hospital's social work team.

The role of the hospital's social work team is limited to assisting the patient, patient's family or patient's carer in contacting appropriate external resources or advisory services, such as legal services or the NSW Trustee & Guardian, where appropriate.

The assistance provided by the hospital's social work team may include (as relevant), where the patient's affairs are managed by the NSW Trustee & Guardian, referring the patient to the NSW Trustee & Guardian.

In circumstances where a patient or their carer would like to discuss the patient's will with a solicitor and the patient's affairs are not managed by the NSW Trustee & Guardian, the hospital's social work team may make inquiries with the patient as to whether there is a will already in existence and/or held by a solicitor. This can be done by asking the patient or their carer, checking the patient health records and/or contacting family members with the patient's consent.

If a will exists and is being held by the patient's solicitor, then the solicitor holding the will may be contacted by a staff member on behalf of the patient and notified that the patient requires their assistance. The matter is to be handed over by the staff member to that solicitor with the patient's consent as appropriate.

Where a patient's affairs are not managed by the NSW Trustee & Guardian and the patient has no knowledge of an existing will, the hospital's social work team may assist the patient in contacting a solicitor of the patient's choice. Staff must not recommend any particular solicitor to the patient.

Where the patient does not know of a solicitor, the hospital's social work team may assist the patient in contacting either:

- The NSW Trustee & Guardian – for professional and independent trustee services, writing of wills, acting as Executor in deceased estates, administering trusts and Powers of Attorney and delivering financial management services; or

- The Law Society of NSW – for access to a list of local solicitors for the geographical area that are experienced in the field of the making of wills and for providing legal advice, from which the patient may then choose a solicitor.

Once a solicitor has been selected by the patient, the hospital's social work team may contact the nominated office or solicitor on the patient's behalf with the patient's consent, or assist the patient in contacting the nominated office or solicitor.

A solicitor preparing a will on behalf of a patient in a public hospital may need to establish the patient's testamentary capacity. It is not the role of staff to establish testamentary capacity of the patient. However, on written request by the patient and/or the patient's solicitor, and with the patient's consent, staff may provide the relevant health information to the patient's nominated solicitor. The provision of information for this purpose is to be coordinated by the hospital's social work team.

All staff contact with the NSW Trustee & Guardian, the patient's authorised representative, solicitors, or family members regarding a patient's will, must be documented in the patient's health record.

Contact Details

NSW TRUSTEE & GUARDIAN	
Trustee Services	1300 364 103
Managed Clients	1300 360 466
THE LAW SOCIETY OF NSW	
Sydney	(02) 9926 0300
Outside Sydney	1800 422 713

ADVERTISING LEGAL SERVICES (IB2015_066)

IB2015_066 rescinds IB2013_060

PURPOSE

This Information Bulletin sets out changes in legislation relating to the advertising of personal injury legal services.

KEY INFORMATION

The prohibition on the advertising of personal injury legal services in NSW that was referred to in Information Bulletin IB2013_060 has been repealed.

Lawyers may advertise legal services in the circumstances described in Rule 36 of the *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015*:

- a solicitor or principal of a law practice must ensure that any advertising, marketing, or promotion in connection with the solicitor or law practice is not false, misleading or deceptive or likely to mislead or deceive, offensive or prohibited by law; and
- a solicitor must not convey a false, misleading or deceptive impression of specialist expertise and must advertise or authorise advertising in a manner that uses the words "accredited specialist" or a derivative of those words unless the solicitor is a specialist accredited by the relevant professional association.

The practical effect of these changes is that agencies should treat the advertising of legal services, including personal injury legal services, in a similar way to the advertising of any other services.

ADMISSION TO DISCHARGE CARE COORDINATION (PD2022_012)

PD2022_012 rescinds PD2011_015.

POLICY STATEMENT

NSW Health organisations have a duty of care to ensure that care coordination provides the care needed to identify and manage safe and appropriate care to all patients within NSW Health. It must ensure all clinical staff are aware of their obligations to coordinate patient care and follow the principals of admission to discharge care coordination.

SUMMARY OF POLICY REQUIREMENTS

NSW Health must comply with admitted patients transitioning through the five stages of care coordination outlined in this Policy Directive.

1. Pre-Admission / Admission
2. Multidisciplinary Team Review
3. Estimated Date of Discharge
4. Referral and Liaison for patient transfer of care
5. Transfer of care out of Hospital

Pre-Admission/Admission must develop and use an admitted patient 'Discharge Risk Assessment' Tool'.

All departments (including the emergency department) must have procedures in place for the care of discharged patients at risk, especially between the hours of 2200hrs and 0800hrs. Where procedures and checklists already exist (including in paediatrics) it must be confirmed that they comply with the requirements of this Policy Directive.

Multidisciplinary team review structured allocates set time, duration and frequency of all multidisciplinary team reviews (Electronic Patient Journey Board MDT rapid huddle) in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.

An Estimated Date of Discharge (EDD) is allocated, documented and displayed near the bedside and on the Patient Flow Portal (PFP) electronic patient management tools (EPJB), and are reviewed for each patient. The patient and carer must be kept informed of the estimated date of discharge during their stay.

Referrals and liaison for patient transfer of care must ensure that the Discharge Checklist or equivalent is completed for all relevant admitted patients before they return to the community.

All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer and appropriate service prior to transfer of care, in plain language.

While the five stages will apply to most patients having an inpatient stay, the stages may require adjustment for some patient groups. Patients having scheduled admissions for a course of treatment (e.g. chemotherapy, dialysis or a multi-staged procedure) may not require a review for each admission in the absence of a change in personal/social circumstances or clinical condition. Planned day only or extended day only patients are to have an assessment of their discharge needs and arrangements put in place prior to their admission.

All Local Health Districts and Speciality Health Networks (Districts/Networks) have duty of care to ensure that patients have a safe and appropriate discharge plan.

For those being discharged from Mental Health Inpatient Units this Policy Directive serves as an addition to the overarching principles outlined in NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045).

1. BACKGROUND

1.1 About this document

Care Coordination is the process where patient care needs are identified and managed. The patient/carers must be involved in care planning from admission through to discharge.

This Policy Directive applies to clinical staff involved in the care of inpatients across all NSW Health Hospitals. It outlines a five-stage process to inform staff and patients throughout their hospital stay. Implementation of this approach will enhance patient outcomes, safety and experience.

A patient's discharge from hospital demonstrates that a patient's care continues beyond the treatment they receive in hospital as they continue to receive care from another service/facility/or in the community. This could be by a patient's General Practitioner (GP), community health providers, including Aboriginal Community Controlled Health Services (ACCHS), or other organisations by the patient and/or their carer's.

1.2 Key definitions

Multidisciplinary Team (MDT) Care	When professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. *Mitchell G.K., Tieman, J.J., and Shelby-James T.M. (2008), Multidisciplinary care planning and teamwork in primary care, Medical Journal of Australia, Vol. 188, No. 8, p.S63.*
Estimated Date of Discharge (EDD)	The EDD predicts the likely date that a patient will be **clinically ready** to leave the hospital, defined as all members of the treating MDT agree when active care is completed, and the patient will be safe to transition to their next phase of care or discharge home. It provides everyone involved in the patient's care, including the patient and their family/carers, with a date to coordinate the patient's needs and discharge planning.

2. PRE-ADMISSION/ADMISSION

At the time of first contact with the patient (pre-admission clinic or admission to an inpatient ward) a locally developed 'Discharge Risk Assessment' or equivalent must be completed by the treating nurse or midwife. A discharge risk tool is used to identify those patients who may have needs that require further assessment and follow-up before they are discharged home or to ongoing care from the acute hospital service.

Health Services are responsible for ensuring that a discharge risk is completed for all admitted patients. The results from this discharge risk tool are to be used to inform the overall management of the patient. Each Health Service, Hospital, and clinical units must develop a process for flagging those patients who have been identified as having a discharge risk with the multidisciplinary team and to implement procedures for contacting the appropriate health professionals to provide a discharge risk assessment.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) standard has identified that organisations develop electronic discharge tools to mitigate risk. An electronic discharge summary (eDS) must be used where available.

The 'Discharge Risk Assessment' must be used to gather information on all appropriate patients at admission or pre-admission. The key areas to be addressed are:

1. Is the patient likely to have self-care problems?
2. Does the patient live alone, is the patient homeless?
3. Does the patient have responsibilities to care for others?
4. Has the patient used community services before admission?
5. Are there other psychosocial factors that may impact on the patient's recovery?
6. Does the patient usually take three or more medications and have their medications changed in the last two weeks?
7. Is the Patient at risk of/or suffering from a current mental illness?
8. Is the patient of Aboriginal background?

This is important in the context of identifying potential service providers located in an Aboriginal Controlled Community Health Service. This will prompt an immediate inpatient referral to an Aboriginal Hospital Liaison Officer, identifying risk criteria for specific diseases as well as cultural considerations.

The 'Discharge Risk Assessment' must be completed on initial presentation and whenever the patient's clinical or social status changes and whenever further information becomes available.
When a discharge risk is identified by any member of the multidisciplinary team, it must be documented and ensure that procedures are in place to highlight risks to the multidisciplinary team and make referrals to the relevant health professions for further assessments and intervention.

2.1 Pre-admission

For planned admissions, discharge planning must begin before the patient is admitted. The discharge risk assessment is to be conducted during this time.
Patients with an identified risk must be referred early to the relevant inpatient allied health service and/or community teams, including Aboriginal Controlled Community Health Service so planning for transfer can begin. This must include the proposed length of admissions and the goals for admission.

2.2 Planned patients

Discharge planning must occur for patients having day-only procedures. Facilities may nominate their own processes to ensure the discharge risk assessment is completed. For example:

- utilising a pre-admission preparation toolkit,
- nominating staff responsible for assessment of day-only patients, ideally this is to occur prior to the day of their procedure.

2.3 Planned patients

All patients with a planned admission must have their discharge risk assessment completed by the treating clinician at presentation or before admission to hospital, such as at a pre-admission clinic.

Completion of this assessment will allow the identification of discharge risks. The treating clinician is responsible for ensuring that all necessary referrals are made before admission, where possible, and confirmed during the acute phase of care.

2.4 Non-planned patients

For non-planned patients who are admitted to hospital through the emergency department or through direct admission, their discharge risk assessment must be completed within the *first 24 hours* of admission by the inpatient treating nurse or midwife.

2.5 Rural and remote patients

Consideration must be given to time, distance and dislocation involved for rural patients (and their carers / families) when hospitalised in a larger facility a long way from home.

Early identification of rurality or displacement will enable early mobilisation of support for carers and families who are isolated from support networks and are vulnerable. A needs assessment on admission would enable care planning sensitive to rurality to decrease hardship (emotional, social, financial and environmental), increase access to information and improve communication. This includes using telehealth as an option for family involvement in multidisciplinary team rounding and at discharge for follow up appointments and rehabilitation closer to home.

In some rural settings, and with some models of care local medical practitioners and allied health professionals are not always available. Local Health Districts (districts) and Speciality Health Networks (networks) must ensure patients can access these services if they are required with local processes in place to ensure appropriate input into decision making regarding assessment, treatment and discharge planning.

2.6 Homeless patients

All districts / networks have a duty of care to ensure that patients have a safe and appropriate discharge plan, including discharge to appropriate accommodation.
Where a patient does not have a general practitioner and requires follow up treatment and ongoing management in the community, options of general practitioners and outreach service providers must be given.

For homeless patients or those patients identified as at risk of being homeless, plans need to be put in place prior to discharge to ensure that no patient exits an NSW Health facility into homelessness. Access and referral to specialist outreach services and support information must be provided and can be found at NSW Family & Community Services website (Housing NSW).

3. MULTIDISCIPLINARY TEAM

3.1 Roles and responsibilities

All members of the multidisciplinary team are expected to work collaboratively across disciplines to ensure improved patient outcomes and have defined roles and responsibilities in assisting in the care coordination process.

Health Services, hospitals and departments will need to ensure local procedures are in place to support a designated time for the multidisciplinary team care in inpatient wards/units to meet.

3.2 Team huddles

Multidisciplinary huddles are to take place daily throughout the working week thus ensuring short stay patients' needs are met.

The multidisciplinary team members must agree on the treatment plan, incorporate the discharge risks into the patient care plan, and set or review and update each patient's estimated date of discharge.
In some models of care (particularly in rural settings) regular participation from some members of the multidisciplinary team may be limited. Local processes need to be in place to ensure appropriate input into decision making regarding discharge planning.

Multidisciplinary huddles are a daily action planning tool and *do not* replace patient rounding, or in depth 'case review' meetings, patient rounding in which a patient care and treatment are discussed in more detail and a patient and their family carer are invited to actively participate.

Multidisciplinary huddle stages

Multidisciplinary Huddles	
Start of the day huddle	High level view of the predicted demand for the day, using the information in the Patient Flow Portal (PFP). Average of 30 seconds to share and highlight numbers.
Main body of the huddle	Progression of each patient towards the next transition of care and discharge (average of 30 seconds per patient – note that some patients will take longer than others). Discussing the patient's clinical plan and reviewing and updating the patients EDD is pivotal. To assess the need for Allied Health interventions from Day 1. Any other clinical concerns to be raised.
End the huddle	Raising ward related matters such as staff, any need for escalation of issues e.g. about particular complex patients, and opportunities to bring outliers back to the ward. Average of 30 seconds to close the huddle.
Follow-up	A range of actions after the huddle, such as updating the EPJB, actioning appropriate clinical care and referrals, i.e., allied health, medical consults and updating the patient/carer.

3.2.1 Positive multidisciplinary team huddles

The multidisciplinary team huddle is a quick daily meeting discussing care coordination requirements and discharge decisions. The huddle will discuss every patient on the ward, including outliers where appropriate. The huddle can also be known by other names, such as care coordination rounding, rapid huddle or electronic patient journey board rapid round.

The huddle must have a *forward outlook*, with a focus on the treatment plan and the tasks need for safe discharge, a discussion and amendment of each patient's estimated date of discharge, agreement about what is required next and key actions for team members in the *next 24-48 hours* including confirmation of discharges for today and tomorrow.

It must be led by a senior clinician such as the Nursing Unit Manager, Nursing Team Leader, and/or Senior Allied Health / Medical Consultant to ensure the meetings maintain structure and efficiency and be conducted at the Electronic Patient Journey Board (EPJB) or equivalent.

Patients who have been identified for discharge on the day of the huddle must be prioritised for early review and management.

Detailed clinical discussion about complex patient requirements can occur in case conferencing or handover, rather than in the huddle. Consider developing an 'multidisciplinary team huddle' script / template to provide structure and consistency to the meeting.

3.2.2 Preparation for multidisciplinary team huddles

Team members must decide on key roles to perform within the huddle. This must be established based on the professions involved in the patients care (e.g. Medical, allied health and nursing).

An agreed time must be decided for the huddle, frequency and duration. The duration of the rapid huddle is to be approximately 30 seconds each patient. (e.g. 15mins for 30-bed ward).

Ground rules must be established with the team, thus providing good communication and efficiency.

- Mandatory attendance by these key roles
- Ensure handovers are completed before the huddle, so that the most up-to-date information is provided to the multidisciplinary team.
- Start on time and finish on time
- Turn off phones: minimising interruptions
- Nominate a team member to respond to urgent correspondence

- Discussion centres around the electronic patient journey board (which means the electronic patient journey board must be set up in a way that facilitates meaningful discussion)
- Every member of the huddle has the opportunity to raise quality and safety issues that may affect patient outcomes.
- A nominated person updates the electronic patient journey board during the rapid huddle or afterwards.

4. ESTIMATED DATE OF DISCHARGE

The estimated date of discharge will be set based on the multidisciplinary team plan of care. It must be reviewed and updated as required during the electronic patient journey board rapid multidisciplinary team huddle or equivalent, and communicated to the patient, family/carers and relevant community service providers.

This process of capturing and reviewing a patient's estimated date of discharge is not required for patients admitted in an Emergency Department or an Emergency Department Short Stay Unit (EDSSU).

For many patients, the estimated date of discharge will change due to clinical issues. Discussions with the patient and their family/carer/s, general practitioner's community health and service providers must occur early and updated regularly for effective care planning. The estimated date of discharge is to be reviewed in the multidisciplinary team huddle and updated in the patient flow portal as changes occur. Any changes to the estimated date of discharge for clinical reasons or delays in transfer beyond the estimated date of discharge are to be recorded and relevant staff informed. In this situation it is necessary to contact any relevant community service providers to advise them of the updated estimated date of discharge.

Hospitals must ensure an agreed local process is developed identifying the clinician/s responsible to ensure that the estimated date of discharge is updated in the patient flow portal or patient administration system (PAS).

- A patient's estimated date of discharge must be visible near their bed, reminding staff of the date they are working towards and informing the patient and their family or carer.
- The estimated date of discharge must be updated in the NSW Health patient flow portal (or PAS) within the first 24 hours of the patient's admission then reviewed and updated daily.
- The multidisciplinary team must use the estimated date of discharge to synchronise referrals to other teams and/or disciplines that are not involved in regular multidisciplinary team reviews.
- The estimated date of discharge is used by patient flow managers and hospital executive teams for predictive planning and management of patient flow.

The patient flow portal reports module provides the hospitals with the tools to review their estimated date of discharge compliance and accuracy for review and management.

Hospitals are to have in place a business continuity plan (BCP) in the unlikely event that the patient flow portal is off-line.

4.1 Inter-ward transfers

In the case of inpatient units such as Intensive Care, Coronary Care, Medical Assessment and Short Stay Units (Surgical Short Stay / 23hr units), the estimated date of discharge will be the predicted date that the patient will be clinically appropriate and ready for an inter-ward transfer to another inpatient unit.

If the patient's clinical plan is to be discharged from any of the units mentioned above (rather than transferred to another inpatient unit) then the estimated date of discharge will be the predicted discharge date for the patient.

4.2 Inter-hospital transfers

Patients awaiting transfer to another facility must have their estimated date of discharge set as the date that the accepting hospitals medical team has accepted care of the patient and the patient is clinically appropriate for safe transfer to the accepting facility.

This includes waiting for a transfer to a Residential Aged Care Facility (RACF), rehabilitation services and respite accommodation.

4.3 Patient detained for involuntary treatment

The estimated date of discharge for patients detained for involuntary treatment is the date that the multidisciplinary team believes the patient will be clinically fit for discharge/transfer from the current inpatient unit.

If the patient has an Involuntary Patient Order (IPO) or dependency certificate any expiry/review dates relating to this order can also be recorded in the patient flow portal.
In line with principles of least restrictive care, the Order expiry date is not the estimated date of discharge for the patient unless the team believe the patient will be clinically fit for discharge on this date.

4.4 Setting and estimated date of discharge for patients with complex needs

When setting and estimated date of discharge for patients with complex clinical needs the following things may help to determine a likely date of discharge/transfer:

- If the patient has had previous admissions how long where they?
- What is the patient's diagnosis and what is the average length of admission for patients with similar diagnosis?
- What is the treatment plan? If commencing/restarting medications how long is anticipated this will have a therapeutic effect
- What is the patient's provisional discharge plan?
- What is likely level of recovery and function for the patient, does their current social circumstance support this?
- What are the patients' goals? Establishing the patients previous baseline function, including their detailed social situation.

The estimated date of discharge for patients with complex needs will usually require assessments by several multidisciplinary team members and therefore the patients estimated date of discharge may require several revisions throughout the patient's admission.

4.5 Non-clinical delays

If a patient is unable to be transferred or discharged due to non-clinical delays then the estimated date of discharge *must not* be changed.

The patients estimated date of discharge will remain as the date that the patient was clinically ready to leave the hospital but was therefore unable to be discharged on their estimated date of discharge. This is primarily due to non-clinical delays such as waiting for a residential aged care facility to have capacity or waiting for a transfer to another hospital etc.

The patients estimated date of discharge days (EDD#) will then display as a negative number, each day the EDD# column will be indicating the number of days that the patients estimated date of discharge has lapsed. This will identify the number of days that a patient has been waiting for discharge/transfer and provides an opportunity for the facilities to identify and understand the non-clinical delays to discharge in their facility.

The patient flow portal 'Waiting for What' tool assists clinicians in identifying the delays to discharge and therefore by definition every patient with an estimated date of discharge in the past must have a non-clinical delay. Therefore, these patients must have an attached 'Waiting for What' (W4W) entry in the NSW Health Patient Flow Portal.

These delays include waits for:

- Out of Hospital Services
- Suitable Accommodation
- Guardianship
- National Disability Insurance Scheme (NDIS)
- Aged Care Assessment Teams (ACAT)
- Residential Aged Care Facilities (RACF)
- Respite service
- Community Service
- Home modification
- Discharge Equipment
- Family / Carer to pick up the Patient
- Inter-Hospital or Inter-ward Transfers and Transport
- Inter Hospital transfer to Tertiary/specialist hospital for acute services
- Return to sender post specialist care
- Waiting for rehabilitation bed
- Waiting for respite bed
- Palliative Care Services
- Community Treatment Orders

The free-text sections in the 'waiting for what' entry can be used to document delayed transfer times e.g. when a bed is ready, or when home modifications are due to be completed.
Facilities and Health Districts must have robust processes in place to open, manage, escalate 'waiting for what' delays and review data trends.

If a patient's condition changes or deteriorates whilst they are waiting for a service, then the estimated date of discharge will need to be revised and updated in the patient flow portal to reflect their new estimated date of discharge.

4.6 Good to Go

The Good to Go (G2G) is used in either the patient flow portal, electronic patient journey board or bed board list to show that a confirmed patient is ready for discharge from the hospital.

Discharge includes transfers to other hospitals and care facilities. A good to go must *not be* used to flag patient ready for transfer within the same hospital (IWTs).

Districts and hospital patient flow teams can see confirmed and potential good to go in the patient flow portal bed board and allocations module to make decisions about capacity and demand planning.
Good to go must be used to flag patient discharges 24/7, 7 days a week, and is the responsibility of the treating Nurse in the following scenarios:

- discharge confirmed - **select G2G 'Yes'** and the likely discharge time.
- discharge is a potential- **select G2G 'Query'** where a final review, test or action is needed before confirmation.
- discharge delayed - **select G2G 'No'** for patients with an estimated day of discharge is delayed (e.g. Transfer W4W or Out of Hospital W4W's).
- patient deemed unsuitable for discharge - - **select G2G 'No'** e.g.
  - previously discharge confirmed update G2G ‘Yes’ to ‘No’
  - previously a potential for discharge update G2G ‘Query’ to ‘No’

Good to go entries on patients who have not been discharged will be cleared at midnight each day.

5. REFERRALS AND LIAISON

5.1 Referring to service providers

Service providers are to be involved in planning for the patient’s transfer from the acute setting. Liaison will need to occur with all appropriate providers including the patient’s general practitioner and any additional health providers the patient currently receives services from.

The needs of the patient’s children and family members must also be considered. All family members’ needs are identified and planned for with appropriate referrals made to care providers to family/dependents (as needed).

Once a patient’s requirements are identified, discussions with the appropriate providers *must occur* using the estimated date of discharge as the start date.

Discussions with providers must occur early to provide enough time to make the appropriate arrangements.

Where the patient’s service provider is located in an Aboriginal Controlled Community Health Care Service (ACCHS) or a general practitioner clinic where the patient may not see the same provider on each occasion, the organisation must be asked to nominate an alternate contact to ensure that transfer /discharge care arrangements are managed appropriately.
During the acute episode of care, it is important to identify what services the patient will require upon discharge. *Each facility is required to develop referral structures to enable staff to easily contact the relevant service providers.*

Multidisciplinary team members are to undertake assessments early in the admission to determine the services required upon discharge. Referral details must be recorded in one place in the patient’s medical record, and on any relevant individual referrals (e.g. general practitioner and community health) and the referral status flagged on your ward’s electronic patient journey board.

It may not be possible to complete a patient assessment in hospital prior to the transfer of care. The multidisciplinary team must look for opportunities for early discharge where acute, rehabilitation and subacute care can continue to be provided in the community.

If a need for services has been identified, a referral to the appropriate community service provider or general practitioner must be made. Follow-up by the organisation with the patient will then take place on their return to the community. This follow up may include the need for a more complete assessment in the home environment.

6. TRANSFERRING HOME

6.1 Discharge checklist

Staff must use their locally developed discharge checklist to meet the needs of patients before leaving the hospital. The nurse unit manager / midwifery unit manager is responsible for ensuring that these details are checked and completed by the treating nurse/ midwife and agreed to by the patient and / or carer before leaving the hospital.

The Discharge Checklist must cover the following information:

- Estimated Date of Discharge
- Destination of Transfer
- Notification/Transport Booked
- Personal Items Returned
- Referral Services Booked
- Care Plan
- Assistive Technology (equipment)
- Patient Educational Resources

Discharge summary provided to patient that includes medication information, community and general practitioner referral information, follow up appointments and patient educational resources. This must be provided in plain language and explained to the patient.

Staff are strongly encouraged to use an electronic checklist if available. Each individual Health Service, Hospital and Clinical Unit are to build on these fundamentals in the checklist to address specific local circumstances.

Shared care roles and responsibilities are to be clearly defined for the various services providers involved in the patient's care. Joint care planning with Community Managed Organisations, National Disability Insurance Scheme (NDIS) and private service providers must be undertaken.

NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045). Provides an example Transfer of Care / Discharge Checklist for those being discharged from Mental Health Inpatient Units.

6.2 Discharge medications

Patients with an identified medication risk as per the check list or advice from the multidisciplinary team are to be prioritised for the pharmacist's review over non-urgent cases.
Each Pharmacy department will need to establish a system to effectively prioritise patients to facilitate safe discharge and meeting the estimated date of discharge.

Patient transport needs are to be considered in the discharge planning processes. This is particularly important in the case of regional or remote patients as some patients may be eligible for subsidies for the cost of long-distance travel.

6.3 Patient transport

The Patient Transport Service (PTS) manages non-emergency patient transport bookings through the patient flow portal. Bookings on the day of Inter Hospital Transfer or day of discharge are only to be made in exceptional circumstances.

Early booking for the next available patient transport service ambulance will prevent patients waiting long periods for the transport to arrive by improving resource management and ensuring appropriate transport is available for patients when required.

7. IMPLEMENTATION

7.1 Health Service Chief Executives are responsible for

Establishing mechanisms to ensure that the essential stages of care coordination are applied in each facility and are sustained as part of the normal care coordination and discharge planning.

7.2 Patient flow systems framework

The Patient Flow Systems Framework was developed through state-wide collaboration that used Redesign Methodology to identify elements that contribute to good patient flow.

The seven key elements, Quality, Standardised Practice, Care Coordination, Demand and Capacity Planning, Variation Management, Demand Escalation and Governance have been developed to enable a system wide approach to identify and resolve delays within the current system to create capacity. Care Coordination has been identified as one of the seven key elements in the patient flow systems framework.

8. FURTHER EDUCATION

The PFP Care Coordination webpage includes advice and direction on how to improve Care Coordination. This includes definition of care coordination, links to policy directives, PDF Care Coordination factsheet for printout and general overview of the importance of care coordination to patient outcomes.

Completing a specific training module is no longer a mandatory requirement however completing the current My-Health Learning module titled *Care Coordination (46356692)* would meet these requirements and will continue to be available.

A link to Care Coordination training resource in My Health Learning will also be available on this page. My-Health Learning module online titled *Care Coordination (46356692)* will be available to support staff with clinical practice requirements.

Please liaise with your line Manager, Clinical Nurse Educator, Midwife or Patient Flow Manager for further education and support.

A number of education materials and resources are also available on the NSW Health PFP to support clinical staff in meeting their obligations under this Policy Directive.

9. REFERENCES

Online resources are available via:

- My-Health Learning module titled Care Coordination (46356692)
- Patient Flow Portal website
- Clinical Care Coordination Rounds: Presentation by A/Prof Golo Ahlenstiel
- Behavioural Insights Unit V1.0 Newsletter April 2016; Ideal Patient Journey
- NHS England » Principle 1: Plan for discharge from the start to setting expected dates of discharge and clinical criteria for discharge
- The NSW Family Focused Recovery Framework 2020-2025: A framework for NSW Health services provides a guide for services to improve support to families where a parent lives with mental health issues and has dependent children through implementing a family focused approach.

10. GLOSSARY OF TERMS

Listed in alphabetical order and in context to this policy document	
Discharge	The relinquishing of patient care in whole or part by a health care provider or organisation.
Discharging clinician	The medical officer, nurse practitioner, midwife or suitably authorised healthcare employee responsible for discharging the patient.
Discharge documentation	Refers to both the discharge summary and the patient directed discharge letter.
Discharge referral	A referral occurring in the context of discharge, see ‘referral’.
Discharge report	An additional document to the discharge summary usually completed by Allied Health professionals to provide greater detail on discharge.

Discharge summary	A collection of information about events during care by a provider or organisation as outlined in section 2.
Electronic Patient Journey Board (EPJB)	The Electronic Patient Journey Board (EPJB) is designed to help NSW Health staff to coordinate patient care as part of the Patient Flow Systems Framework. The EPJB is customised for each ward based on their specific needs and provides information about every patient relating to their care coordination and patient flow management.
Estimated date of Discharge (EDD)	The estimated date of discharge (EDD) predicts the likely date that a patient will be clinically ready to leave the hospital, defined as all members of the treating MDT agree when active care is completed and the patient will be safe to transition to their next phase of care or discharge home.
Good to Go (G2G)	Good to Go (G2G) is used in either the PFP EPJB or Bed Board list to show a confirmed patient discharge today from the hospital.
Inter Hospital Transfer (IHT)	An inter hospital transfer (IHT) of a patient from a sending facility to an accepting facility under the care of an accepting Doctor.
Inter Ward Transfer (IWT)	An inter ward transfer (IWT) occurs when a patient is transferred from one ward to another ward within the same facility.
Multidisciplinary team (MDT)	Involves a range of health professionals from different disciplines or organisations working together to deliver comprehensive patient care.
Patient directed discharge letter	A personalised letter or documentation for the patient written in plain English, summarising their hospital admission.
Patient Flow Portal (PFP)	The Patient Flow Portal (PFP) provides access to a suite of modules used by NSW Health Hospital Staff and administration support and executive teams to monitor and manage patient flow.
Presenting problem	Most relevant symptom/s, disorder/s, or concern/s expressed by the patient when seeking care.
Primary care provider	Discharge summary recipient including the patient's nominated General Practitioner (GP), Residential Aged Care Facility (RACF), Aboriginal Medical Service (AMS), Justice Health, agency or community-based clinician or other community-based service provider.
Principal diagnosis	The diagnosis established after study to be chiefly responsible for occasioning the patient's care at the facility.
Residential Aged Care Facility (RACF)	This is the term used to describe a residential aged care facility (RACF) or aged care home operated by an approved provider.
Referral	The communication, with the intention of initiating care transfer, from the provider making the referral to the receiver. Referral can take several forms, most notably: a) Request for management of a problem or provision of a service, e.g. a request for an investigation, intervention or treatment. b) Notification of a problem with hope, expectation, or imposition of its management, e.g. a discharge summary in a setting which transitions care responsibility on the recipient.
Waiting For What (W4W)	Waiting for What (W4W) is used in the PFP to record delays to care or discharge so that they can be fixed and analysed to improve patient care.

11. APPENDIX LIST

11.1 Implementation / Compliance checklist

Implementation checklist and compliance self-assessment

Local Health District / Facility:	

Assessed by:	Date of Assessment:		
Development and use of an admitted patient 'Discharge Risk Assessment' Tool'. All departments (including the emergency department) must have guidelines in place for care of discharged patients at risk especially between the hours of 2200hrs and 0800hrs. Where guidelines and checklists already exist (including in paediatrics) it should be confirmed that they comply with the requirements of this policy.	❑	❑	❑
	Notes:		
Structured (set time, duration and frequency) multidisciplinary team reviews (Electronic Patient Journey Board MDT rapid huddle) in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.	❑	❑	❑
	Notes:		
An Estimated Date of Discharge (EDD) is allocated, documented and displayed near the bedside and on the Patient Flow Portal (PFP) electronic patient management tools (EPJB), and reviewed for each patient. The patient and carer must be kept informed of the EDD during their stay.	❑	❑	❑
	Notes:		
Ensuring the Discharge Checklist or equivalent is completed for all relevant admitted patients before they return to the community.	❑	❑	❑
	Notes:		
All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer and appropriate service prior to transfer of care, in plain language.	❑	❑	❑
	Notes:		

INTRAVASCULAR ACCESS DEVICES INFECTION PREVENTION AND CONTROL INSERTION AND POST INSERTION CARE (PD2019_040)

PD2019_040 rescinds GL2013_013

PURPOSE

The purpose of the NSW Health Intravascular Access Device (IVAD) Infection Prevention and Control Insertion and Post Insertion Care Policy is to provide guidance to NSW Health Organisations (HO's) including Affiliated Health Organisations on the minimum standards for insertion, management and removal of IVADs, in order to minimise the adverse health impacts on patients and reduce burden of healthcare associated Infections (HAIs). This Policy is to be read in conjunction with NSW Health Infection Prevention and Control Policy.

MANDATORY REQUIREMENTS

All clinical staff who insert IVADs or care for a patient with an IVAD must comply with this Policy Directive. For each insertion a record of insertion must be completed.
Every IVAD insertion, management and removal must be documented at the time of care or as soon as possible afterwards.
HO's must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices for clinicians.
HO's must support clinicians to ensure adherence with this Policy Directive.
Aseptic technique must be adhered to during each IVAD insertion, management and removal to reduce the risk of local or systemic infection.

IMPLEMENTATION

NSW Health Organisations (HOs) and the governance structure for the implementation of this Policy Directive to reduce the risk of healthcare associated infections (HAIs).

Clinical Excellence Commission

- Provides tools to support the implementation, monitoring and evaluation of this policy.

Health Education and Training Institute (HETI)

- Compliance with the existing mandatory education components (Aseptic technique, Hand Hygiene and Infection prevention and Control Practices from HETI online) applies.

Chief Executive of Local Health District and Specialty Health Network

- Assigns leadership responsibility, personnel and resources to implement and comply with this Policy.

Directors of Clinical Governance

- Ensure that this Policy is communicated to all managers and health workers.
- Ensure local infection prevention and control programs and systems are in place to implement and monitor this Policy.
- Monitor and provide regular reports on the progress and outcomes of infections related to IVADs.
- Monitor, evaluate and address issues with compliance with this Policy.

Clinical leaders and senior managers

- Provide resources and equipment necessary for compliance with this Policy.
- Implement and evaluate local infection prevention and control systems.

Infection prevention and control professionals

- Provide leadership in infection prevention and control surveillance and reporting.
- Provide advice on compliance with the insertion, management and removal of IVADs policy within their health organisation.

-

- Provide leadership in the management of HAIs or other transmission risks and in the communication of these risks to health workers, patients, volunteers, carers and visitors.

Clinical Staff Inserting, Caring for, Managing and Removing IVAD Devices

- Comply with IVAD Infection Prevention and Control, Insertion and Post Insertion Care policy this Policy.
- Are trained, competent and assessed in the insertion, management and removal of an IVAD device in accordance with this Policy Directive.
- Ensure IVAD insertion and care is documented in the patient's health record.
- Assess and document daily the ongoing need for an IVAD device.

Intravascular Access Devices (IVAD) – Infection Prevention and Control Procedures

BACKGROUND

Background

Intravascular access devices (IVADs) are commonly used in a variety of settings. They are used to provide a route for administering intravenous medications, fluids, blood products and nutrients and may be used for haemodynamic monitoring, short to long term intravascular access, renal therapies and blood specimen collection.
Intravascular access devices provide direct access to the patient's bloodstream and therefore pose a serious risk for infection of microorganisms to be introduced either at the time of insertion or while the device is in situ. Device-related infections are associated with increased morbidity and mortality, prolonged hospital stay and additional healthcare costs.
Central Venous Access Devices (CVAD) pose a risk of air embolism in patients during insertion and removal (1).
Correct use and management of IVADs minimises the risks of device related infection to patients (2).
The health service organisation must have a process for the appropriate use and management of invasive medical devices (3).

About This Document

This Policy outlines the minimum infection prevention and control requirements for IVADs for NSW Health Organisations (HOs). It has been developed for clinicians who insert, use/manage and remove devices and for persons responsible for surveillance and control of infections in hospital, outpatient, and home healthcare settings. It is recognised that in a clinical emergency, the principles of insertion outlined in this Policy may be difficult to meet. In these situations a risk assessment should be undertaken and the intravascular device replaced as soon as clinically appropriate.
This Policy integrates evidenced-based knowledge with clinical expertise to:

- Support appropriate device management within NSW HOs
- Prevent device related infections
- Prevent adverse events
- Assist NSW HOs to meet the requirements for Standard 3 of the National Standards for Quality Healthcare Services

Scope

This Policy focuses on infection prevention and control (IP&C) for IVADs. Some aspects outside of IP&C are also included to assist in guiding the overall management of IVADs.
This Policy sets out the minimum standards to ensure the safe use of devices and should be used in conjunction with the manufacturer's instructions relating to individual catheters, connections, administration set dwell time, and compatibility with antiseptics, medications and other fluids. HO's who use these devices must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices.
The Policy is applicable to all patient care settings in which devices are inserted, managed or removed.
This Policy is applicable across all patient populations (e.g. adults, ambulance, pre-hospital, hospital in the home, paediatrics and neonatology).
The following devices have been included in this Policy:

- Peripheral intravenous cannula (PIVC)
- Midline catheters
- Central venous access devices (CVAD)
    - Peripherally inserted central catheter (PICC)
    - Tunnelled cuffed and non-cuffed central venous catheter
    - Non-tunnelled central venous catheter
    - Implantable Venous Ports (Port)
- Umbilical catheters
- Peripheral artery catheters
- Pulmonary artery catheters
- Haemodialysis catheters

The following items are out of scope for this Policy:

- Technical or procedural aspects related to the above devices
- Sub-cutaneous devices
- Arteriovenous (AV) fistulas
- Anticoagulants
- Intraosseous devices

Key definitions

A detailed glossary of terms can be found at the back of the Policy

Central Venous Access Device (CVAD)	• A catheter inserted through an upper or lower peripheral or central vein where the catheter tip terminates in:
	  ○ For upper body access: superior vena cava/right atrial (SVC/RA) cavo-atrial junction.
	  ○ For lower body access: the common iliac vein or abdominal vena cava
	• These catheters are used for the administration of parenteral fluids and medications that are typically not suitable via a short peripheral catheter. They are also used for the measurement of central venous pressure in critical care setting.
	  ○ *Centrally*- inserted central venous catheters have a skin entry point in the neck or trunk.
	  ○ *Peripherally*- inserted central catheters have a skin entry point on a limb or the scalp.
	  ○ *Non-Tunnelled*- the catheter insertion and exit points are the same
	• *Tunnelled* - the catheter is inserted through one point and then "tunnelled" under the skin to a remote exit point**.**

Implantable Venous Port (port):	Long term CVAD, which is surgically placed under the skin from the insertion site to a separate exit site. The exit site is typically located in the chest, but can be located elsewhere for comfort and aesthetic reasons (e.g. inner bicep, abdomen and thigh). They can be multi lumen. Ports consist of two main parts: the portal reservoir and a catheter. The tip of the catheter resides in the cavo-atrial junction. Also known as a port-a-cath or a venous port.
Intravascular access device (device)	Catheters, tubes, or devices inserted into the vascular system, including veins, arteries, and bone marrow.
Midline Catheter	A long peripheral catheter inserted into the upper arm via the basilic, cephalic, or brachial vein, with the internal tip located at or near the level of the axilla and distal to the shoulder.
Non-tunnelled CVAD- Also known as Percutaneous CVAD	A device that enters the venous system. Non-tunnelled catheters are generally used for short term therapy and in emergency situations.
Peripheral Artery Catheter	An arterial line (also art-line or a-line) is a thin catheter inserted into an artery.
Peripheral intravenous cannula (PIVC)	A catheter (small, flexible tube) placed into a peripheral vein for intravenous access.
Peripherally inserted central catheter (PICC)	A catheter inserted through the veins of the upper extremities in adults and children; upper or lower extremities in neonates, catheter tip is located in the superior or inferior vena cava, preferably in the cavo-atrial junction
Health Organisation (HO)	For the purpose of this Policy a Health Organisation is: Local Health District, Speciality Health Networks, Statutory health corporation that provides inpatient services, or Affiliated health organisation in respect of its recognised establishments that provide inpatient services.
Pulmonary Artery Catheter	Also known as a Swan-ganz catheter, is a catheter inserted into a large central vein, with the tip residing in a pulmonary artery. Its purpose is diagnostic and therapeutic; it is used to detect heart failure or sepsis, monitor therapy, evaluate the effects of drugs, frequent blood sampling and to infuse medication.
Tunnelled CVAD	A central vascular access device (CVAD) with a segment of the catheter lying in a subcutaneous tunnel with the presence of a cuff into which the subcutaneous tissue grows to offer security for the catheter; indicates that the skin exit site and vein entry site are separated by the subcutaneous tunnel.
Umbilical Catheter	Catheter that is inserted into one of the two arteries or vein of the umbilical cord.

1 EDUCATION & DOCUMENTATION

1.1 Staff Education and Training

- All staff involved in the insertion, management and removal of IVADs must complete an educational program that is appropriate for the care being provided as determined by their HO.
- Clinicians are responsible and accountable for attaining and maintaining currency of skills for device insertion, management and removal within their scope of practice (4).
- HOs should have systems in place to recognise prior competence/skills assessment of the clinician from other HOs.
- The role, responsibilities and accountability for each type of clinician involved with these devices must be clearly defined in organisational policy or procedure (4).

1.1.1 Competency Assessment for Intravascular Access Devices (IVADs)

- Clinicians who insert, manage and remove IVADs must undergo training and formal competency assessment, as determined by the HO and is consistent with best practice.
    - Competency assessment must be conducted to establish proficiency to perform these skills independently and may be undertaken on an ongoing basis as necessary.
    - Competency validation must be documented in accordance with organisational policy.
- Clinicians working towards formal competency must be supervised by an experienced and competent clinician

1.2 Patient Education

- The level of the education program provided to the patient and/or caregiver should be determined by the:
    - criticality of the patient
    - cognition of the patient
    - ability to manage the IVAD
    - type and duration of the IVAD
- The clinician should educate the patient and/or caregiver while in hospital or hospital in the home and before discharge on:
    - the procedure and need for the device
    - signs and symptoms of infection
    - signs of air embolism
    - what to do if it becomes disconnected or accidentally removed
    - practice and principles of caring for the device
    - infection prevention strategies for their device
- **Patients and/or carers in the community must be provided with appropriate material that includes who to contact for advice or in the case of an emergency**

1.3 Documentation

- Documentation in health care records must provide an accurate description of each patient/client's episodes of care or contact with health care personnel NSW Policy Directive Health Care Records - Documentation and Management (5).
- Each HO must determine where clinical information relating to devices is to be documented in the patient's health record and that this is applied consistently so that clinical information can be readily accessed as needed. This is particularly important for devices with a longer dwell time.
- All clinical incidents must be reported and documented as per the NSW Health, PD2014_004 Incident Management Policy (6).
- Follow Australian Commission on Safety and Quality in Health Care (ACSQH) guidelines for labelling requirements. NSW Health Policy Directive User-applied Labelling of Injectable Medicines, Fluids and Lines (7)

1.3.1 Insertion

- Minimum documentation requirements at insertion by the proceduralist/procedure assistant are: A Central Venous Line Insertion Record or equivalent must be completed by the proceduralist inserting the device or their assistant for all CVADs which should include the below information:
    - Patient education and consent, refer to Consent to Medical Treatment (8).
    - Date and time of insertion, number of attempts, reason for insertion, local anaesthetic (if used), and the technique used, including visualisation and guidance technologies.
    - Site preparation, infection prevention and safety precautions taken.
    - The type, length, and gauge/size of the device (for PIVC); including the lot number for all CVADs and implanted devices.
    - Identification of the insertion site by anatomical descriptors and landmarks.
    - Confirmation of the location of the catheter tip for all CVADs prior to initial use.
    - Confirmation of patency and ready for use.
- This Record must be placed in the patient's health care record.

1.3.2 Post-Insertion

While the patient is admitted to hospital the condition of every IVAD must be documented at least once per nursing shift. The documentation must detail (4):

- Condition of the site, dressing, catheter securement, dressing change details, site care, and any changes related to the device or site.
- Length of CVAD catheter from skin to hub (to assess potential migration).
- Patient reported symptoms.
- Device function (e.g. patency, lack of resistance when flushing, presence of a blood return upon aspiration).
- Equipment/infusion type used for administration of Intravenous (IV) therapy.
- The Visual Infusion Phlebitis (VIP) score if used or any signs of infection

1.3.3 Administration Sets

All labelling of administrations sets used in continuous infusion must be documented in accordance with NSW Health Policy Directive User-applied labelling of injectable medicines, fluids and lines (7). If the lumen has an indwelling lock solution, the lumen must be clearly labelled so that it is not inadvertently flushed into the patient (7).

1.3.4 Removal

Minimum documentation requirements on removal of devices is:

- Date and time of device removal, reason for removal, condition of the site, and whether the catheter length and/or tip were complete and intact.
- Dressing applied.

Any continuing management of complications including site observation and documentation post removal.

2.3.5 Infection

Incidents of infection/phlebitis at the insertion site must be reported to Incident Information Management System (IIMS) or as per other local reporting requirements (6).

If a catheter related site infection or Blood Stream Infection (BSI) is suspected or confirmed this must be documented clearly in the patient medical record, if cultures are obtained, document the source of culture(s). The documentation should include a management plan and actions taken.

If IVAD site infections are suspected to have progressed to a systemic infection (bacteraemia) then notify as a Safety Assessment Code (SAC 2; all staphylococcus aureus bacteraemia must be recorded as a SAC 2).

Compliance with reporting mandatory Key Performance Indicators (KPIs) including routine reports on IVAD associated infections should be communicated to relevant stakeholders, peak organisational, governing and executive committees (6, 9).

2 PRE-INSERTION

2.1 Considerations when Choosing a Device

The risk of infection can be dependent on device site and selection. The following should be considered (10) as contributing to this risk: (see Section 4.2 for more information).

- Comorbidities, prolonged use and sites with frequent movement.
- History of mastectomy, arteriovenous (AV) fistula or graft, haematological disorders, history of device complications, obesity, coagulopathy, previous surgery, failed or difficult device access or immunocompromised.
- Therapeutic purpose: the infusate characteristics, complexity of infusion regime, availability of peripheral access sites.
- Estimated length of time: long-term intermittent therapy, treatment anticipated for more than 3 weeks.
- Vein status: veins may be difficult to access, torturous, fragile, hidden or deep.

3.1.2 Bundles

Infection prevention and control bundles reduce the risk of healthcare associated infections (11, 12). Facilities should develop bundles that are both evidence based and include local clinical risks. The principles for developing a bundle include:

- A manageable list of interventions that are descriptive and meet local requirements.
- Processes for documentation and assessment that considers clinical judgment in decision making.
- Input from the multidisciplinary team in developing the bundle.
- Monitoring and communication to clinical teams.

3 INSERTION

3.1 Prophylaxis, antimicrobial impregnation, coating or bonding

- The following should not routinely be used for the prevention of infection when inserting an intravascular device:
    - Systemic antibiotic prophylaxis (13-17).
    - Antibiotic or antiseptic ointment (13, 18).
    - Antimicrobial-impregnated catheters may be considered for specific population based on patients' risk factors and clinical presentation (19-21).
- The use of bonded connections and valves are beneficial in reducing the risk of air embolism and infection (22).

1. Device Selection, Site Selection, and Device Securement

3.1.1 Peripheral Intravenous Cannula (PIVC)

Device Selection

- Clinicians should use the smallest gauge and shortest length PIVC that will accommodate the anticipated therapy to reduce the risk of phlebitis.
- See Attachment 1 PIVC Device Selection Guide more information.

Site Selection

- Optimal site selection for PIVC is the distal areas of the upper extremities (e.g. Forearms) (3, 13).
- Basilic or cephalic veins on the posterior (dorsal) forearm are the preferred site for catheterisation (3).
- The site selected should be accessible and functional during surgery and procedures.
- Veins should be selected on the non-dominant forearm if practical (especially if the catheter is to remain in position for any length of time) (3).
    - Avoid veins of the lower extremities unless necessary, due to risk of tissue damage, thrombophlebitis, and ulceration.
    - Rotate PIVC site and arm where possible for repeated cannulations.
    - Replace a catheter inserted in a lower extremity, to an upper extremity as soon as possible.
    - Avoid compromised areas, areas of flexion e.g. antecubital fossa and areas of pain on palpation.

- For paediatrics, preference should be given to sites that are long lasting for duration of therapy (e.g. hands, forearm and upper arm).
    - Upper or lower extremities or the scalp (last option) can be used as the catheter insertion site (13).
    - Avoid hand or fingers, or the thumb/finger used for sucking in infants.
    - Avoid the right arm of infants and children after procedures treating congenital cardiac defects that may have decreased blood flow to the subclavian artery.

Securement

- The catheter should be stabilised with a transparent dressing and sterile adhesive tape or sterile adhesive/wound closure strips, to prevent catheter dislodgement (13, 23).
- For paediatrics use of IV board/splints are recommended to secure PIVC placed in or adjacent to areas of flexion. Follow local policy or guidelines for strapping and securement of PIVCs.

3.1.2 Midline Catheters

Device Selection

- Use the smallest gauge of midline catheters that will accommodate the prescribed therapy to reduce the risk of phlebitis and thrombosis (24, 25).

Site Selection

- Vein selection should be based on the biggest and most superficial vein above or directly below the antecubital fossa to allow normal arm movement and function. The catheter should not be placed at the antecubital fossa crease/fold or pass the axillary crease/fold.

Securement

- A sutureless securement device is preferred to reduce the risk of infection (26).

3.1.3 Central Venous Access Device (CVAD)

Device Selection

- Use the smallest gauge of CVAD that will accommodate the anticipated therapy to reduce the risk of phlebitis (27).
- The minimum necessary number of lumens and add-ons (manifolds, stopcocks and multi-extension sets) should be used.
- Heparin-coated catheters are not recommended (28).

Site Selection

- For PICCs select the basilic (preferred), cephalic, and brachial veins (with sufficient size) of the antecubital space or brachial veins (29, 30).
- In neonates the upper and lower extremities have similar complication rates.
- Use a subclavian or internal jugular site rather than a femoral site where possible, in adult patients to minimise infection risk for non-tunnelled CVC placement (31).
    - If the patient has chronic kidney disease, consider the internal jugular vein or, secondarily, the external jugular vein, weighing benefits and risks for each access site due to the risk of central vein stenosis (32).
    - Subclavian vein should be avoided for temporary access in patients with chronic renal failure due to the risk of central vein stenosis (33).
    - In patients with chronic renal failure be aware if a limb is being preserved for future haemodialysis access.

- For internal jugular sites, the right side of the patient is favoured as vessel anatomy allows direct access to the superior vena cava/inferior vena cava and provides a shorter and easier route for the practitioner inserting the device (34).

Securement

The CVAD must be secured (26) at the skin insertion point and anchor point (if present) by:

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.1.4 Implanted Venous Port (port/IVP)

Device Selection

- Catheters made of radiopaque silicone rubber or polyurethane are preferred.
- Ports made of various materials including plastic, titanium, silicone rubber, polyurethane, and a combination of these substances can be used.
- The life of the septum is dependent on the gauge of needles used to access the port and the type of needle used i.e. if a larger needle is used, the septum will wear out after fewer punctures than when a smaller gauge needle is used (35).

Site Selection

- Port pocket site selection should allow for placement in an area that provides good port stability, does not interfere with patient mobility, does not create pressure points or interfere with clothing (36).

Securement

- The suture line closing the port should not be located over the septum of the port (36).
- Umbilical catheters are commonly secured using the goalpost method, refer to local guideline or procedures for more information.

3.1.5 Peripheral Artery Catheter

Device Selection

The catheter must be flexible, resistant, as radiopaque as possible, thin walled with a high internal to external diameter ratio (37).

Site selection

- The radial artery is preferred due to its accessibility and good collateral flow, however the femoral, brachial or pedal artery may also be used (1).
- The brachial site should not be used in paediatrics (13).

Securement

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.1.6 Pulmonary Artery Catheter

Device Selection

The catheter must be flexible, resistant, as radiopaque as possible, thin walled with a high internal to external diameter ratio (37).

Site selection

- The preferred site is the right internal jugular vein followed by the left subclavian vein.
- The femoral and antecubital veins should be avoided if possible.

Securement

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.2 Confirmation of Tip Position for Central Catheters

The catheter tip position must be confirmed when a device is inserted, by any of the following techniques prior to use (38, 39):

- ECG CVAD tip confirmation
- Chest x-ray or image intensifier
- Fluoroscopy imaging and Digital Subtraction Angiography (DSA)
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Pressure monitoring of the central venous waveform in operating theatre until formal confirmation post-surgery

Once the CVAD distal tip position is confirmed via any of the above, the "final Tip position" of the catheter must be documented (the total catheter length and external/inserted length (skin to hub) in the patients' medical record. This then becomes the clinician's primary referral source for written confirmation of tip position.

- This must be completed by the clinician inserting the device, their assistant or delegate for all insertions.

3.3 Standard Precautions (At Insertion)

Standard precautions are the minimum precautions required and must always be applied when caring for patients (4).

- *During an emergency situation (e.g. rapid deterioration and ambulance) time does not always permit use of aseptic technique or full maximal barrier precautions, the clinician should make every effort within their environment to maintain asepsis and adhere to standard precautions. If inserted in an emergency, the IVAD must be replaced as soon as the patient is stable (within 24 hours).*

The precautions outlined in sections 4.4.1 to 4.4.4 are the minimum requirements when inserting a device.

3.3.1 Hand Hygiene

- Perform hand hygiene before insertion procedures, refer to table 2 below.
- Hand hygiene should be performed before and after palpating catheter insertion sites as well as before and after inserting*, replacing, accessing, repairing, or dressing.*
- Palpation of the PIVC insertion site should not be performed after the application of antiseptic, unless non-touch technique is maintained or sterile gloves are used. If you need to palpate the planned insertion site after skin antisepsis to confirm anatomy, repeat the application of antiseptic.

The use of gloves does not eliminate the need for hand hygiene (before putting on gloves and after removal).

Table 2: Hand Hygiene for Device Insertion

Activity		Hand Cleansing Product*	Duration of Hand wash*
Aseptic Procedure	Insertion of PIVC	ABHR*	30-60 seconds
		Liquid antimicrobial soap and running water	40-60 seconds
	Peripheral Arterial Catheter	ABHR*	60 seconds minimum
		Liquid antimicrobial soap and running water	
	Insertion of CVAD, Midline and Umbilical Catheters	Liquid antimicrobial soap and running water	2 minutes
		Alcohol Based Surgical Hand Rub (ABSHR*)	Refer to manufacturer's instructions. Note: Prior to surgical rub, wash hands, forearms and nails using a non-medicated soap and running water.

Manufacturers recommendations should be followed for the amount of solution and duration

3.3.2 Aseptic Technique

- All clinicians involved in the insertion of devices must have appropriate training and assessment of aseptic technique, refer to section 2.1 Staff Education and Training.
- Aseptic technique must be maintained for the duration of the procedure, this includes:
  - Hand hygiene.
  - Maintaining aseptic fields.
  - Once insertion site has been prepped aseptic technique must be maintained and the site must not be touched (unless sterile gloves are worn).
  - Procedures must be performed using non-touch technique protecting key sites and key parts. The cap/cover must remain on the device to maintain asepsis.
  - Personal protective equipment (PPE) must be worn as per standard precautions.
  - Ensure a logic, efficient and safe order of the procedure.
  - Equipment or items dropped on the floor must be discarded (even if there is a cap/cover on) and replaced.
  - Ultrasound transducers used for imaging the vascular system for insertion of venous access devices should be used with a sterile probe cover and sterile gel. The transducer probe must be cleaned and disinfected adequately in between use. Follow manufacturers' instructions for use.
  - A clean environment must be maintained throughout the procedure. Environmental controls to achieve this include; IVAD insertion trolley or procedure tray is to be cleaned, no room cleaning (buffing or polishing) immediately prior to, or during the procedure. The procedure should take place in a closed room or with curtains drawn around the patient zone to minimise air currents.

3.3.3 Personal Protective Equipment

Clinicians should wear appropriate personal protective equipment based on risk assessment and likelihood of exposure to bodily fluids.

Glove Use

- The use of non-sterile examination or sterile gloves will depend on the procedure being undertaken, contact with susceptible sites or clinical devices, the risks involved and the HO guidelines or procedures that are in place.
- For PIVC insertion gloves should be worn immediately after performing hand hygiene.
    - HOs should have in place local guidelines or procedures determining the type of gloves for PIVC insertion based on local needs and clinical risk.
    - Gloves considered in local guidelines or procedures may include; sterile procedural gloves, sterile gloves, non-sterile gloves.
- See below 4.4.4 Maximal Barrier Precautions for more information (4).

3.3.4 Maximal Barrier Precautions

- Use maximum sterile barrier precautions. This involves:
    - Except for PIVC and arterial line insertions, mask, hair covering including beard if necessary, sterile gown and sterile gloves are required to be worn by all personnel involved in the procedure.
    - PIVC and arterial lines insertion require compliance with asepsis.
    - The insertion site is to be covered with a large sterile drape during catheter insertion.

3.4 Skin Preparation

- Hair at the insertion site should be removed using clippers to improve adherence of the dressing.
- The skin should be physically cleaned with soap and water (if necessary) prior to applying the antiseptic solution before inserting the catheter.
- The same antimicrobial agent must be used for all phases of the patient's skin preparation, to ensure full residual benefit and consistent action (17).
- Palpation of the insertion site should not be performed after the application of antiseptics, unless aseptic technique is maintained.
    - **If the health worker needs to re-establish the identification of the vein, the site should be re-prepped with the antiseptic solution and allowed to thoroughly dry (17).**

Table 3: Skin Preparation for Adults and Children ≥ 2 months (40, 41)

Skin cleansing prior to ***PIVC*** insertion	0.5-2% chlorhexidine gluconate (CHG) and 70% isopropyl alcohol
Skin cleansing prior to all other device insertions	2% chlorhexidine gluconate (CHG) in 70% isopropyl alcohol
If there is a contraindication to chlorhexidine, povidone iodine 10% in 70% alcohol can be used as an alternative.	

- The application of antiseptic should be a measured quantity and avoid over application. If the site is accessed prior to full evaporation of the product, this can lead to reduced efficacy.
- All solutions must be allowed to dry before beginning insertion, do not wipe or blot.
- Some of the alcoholic chlorhexidine solutions now contain colour to allow easier identification.
- Sterile saline or water solutions alone are not acceptable antiseptic solutions and should only be used to clean the skin of gross contaminants prior to applying antiseptic solution.
- Take care when applying liquid solutions to minimise the risk of eye injury to the patient due to splashes.
- Care should be taken during internal jugular approaches that solutions containing chlorhexidine are not introduced to the ear canal as this can lead to deafness.

4.5.1 Skin preparation in neonates

NSW public health organisations who care for **neonates** must have a local policy or guideline in place for skin preparation and/or antisepsis for pre-term infants. This should consider:

- Using topical antiseptics with extreme caution, particularly alcohol based preparations.
- The risk of chemical burns in premature babies.
- Avoiding Povidone Iodine for skin antisepsis.

4 POST INSERTION MANAGEMENT

4.1 General Information

- If Total Parenteral Nutrition (TPN) is being administered, where possible, health workers should utilise one lumen exclusively for that use (42, 43).
- Consider use of an extension set between an IVAD and needleless connector to reduce catheter manipulation (4).
- Refer to section 2.3 Documentation for minimum documentation requirements.

4.2 Daily Review for In-patients

- All intravascular devices must be checked (table 4) at each shift for ongoing need and promptly removed when no longer required.
- The insertion site must be visually inspected by the clinician at least hourly with continuous infusion, at least every eight hours if no infusion (15). For further information refer to Intentional Patient Rounding - Information for Clinicians and Health Professionals (44). For high-risk medicine clinicians should refer to the local protocols or Australian Injectable Drugs Handbook (AIDH) - 7th Edition (45).
- Ensure medical staff review the need for IV therapy including antimicrobials on a daily basis and switch to oral administration as clinically appropriate.

Table 4: Daily Assessment

Daily Assessment			
Phlebitis - Erythema - Tenderness - Swelling - Pain - Palpable venous cord - Purulent discharge	Systemic Infection - Rigor - Fever - Tachycardia - Hypotension - Malaise - Nausea/vomiting	Infiltration/extravasation • Insertion Site - Blanched, taut skin - Oedema - IV fluid leaking - Burning/stinging pain • Change in infusion flow	• Catheter position • Integrity of suture • Dressing integrity • Occlusion/patency • Ongoing need for line
For PICCs & Midlines, if limb swelling is suspected, compare the mid-upper limb circumference with the initial value recorded on the CVAD Insertion Record to quantify this. If a significant increase in circumference is confirmed, venous thrombosis should be considered and investigated appropriately.			

(Source: I-care QLD (15, 17, 28, 36, 46-48)

5.3 Patients in the Community

- All intravascular devices should be checked (refer to table 4) at every clinical visit and removed when no longer required.
- Patients should be educated to visually inspect the insertion site when continuous infusions are running. This must include signs and symptoms of complications and who to contact if needed.

5.4 Transferring and transporting patients with CVADS

- There is an increased risk of CVAD dislodgment and falling out during transfer or transportation of patients.
- Devices should be visually inspected and secured before transfers occur.
- Consideration should be given to the weight of lumen sets and lines must be supported with additional fixation to reduce the risk of unplanned dislodgement.
- If catheter is not in use, check that the catheter is clamped prior to commencing transport.

5.5 Accessing Devices

- To reduce the risk of infection, manipulations of an intravascular device should be kept to a minimum and use a continuous flow system wherever possible.
- Where continuous flow is not possible, then the device should be flushed and locked as per local guidelines and procedures.
- The catheter lumen should be kept sterile and should never be left open to the air.
- Aseptic technique must be maintained at all times.
- Ensure line clamps are used when accessing a CVAD to reduce the risk of air embolism (22).

Table 5: Accessing Devices

<table>
<tr><th colspan="2">PIVC, Midline, PICC, CVC (tunnelled & non-tunnelled), Umbilical Catheters, Pulmonary Artery & Peripheral Artery Catheters, Port</th></tr>
<tr><td>Aseptic Technique Principles (49), relevant to the procedure.
Sequencing
Hand Hygiene
Environmental control
Maintain asepsis
PPE</td><td>Antiseptic
70% isopropyl alcohol swab OR
0.5-2% chlorhexidine gluconate & 70% isopropyl alcohol
PORT/IVP with needle insertion
2% chlorhexidine gluconate & 70% alcohol</td></tr>
<tr><td colspan="2">Accessing a Catheter
All intravenous access ports should be meticulously cleaned with a large wipe (scrub the hub) for at least 15 seconds generating friction by scrubbing in a twisting motion with a single-use 70% alcohol-impregnated swab or alcoholic chlorhexidine or if allergic 10% povidone-iodine and allowed to air dry prior to accessing the system (50, 51).
The catheter should be accessed with a sterile single-use device.
Accessing a Port
Only a non-coring (e.g. Huber) needle should be used to access implanted ports. Safety needle is preferred.
Use a new needle for each access attempt.
Needles should be changed every seven days or more frequently for continuous infusions if necessary.
Reinsertion through the immediately preceding needle site should be avoided.</td></tr>
</table>

(Source: I-care QLD (15, 17, 28, 36, 46, 47))

4.3 Blood Collection

- Blood sampling via a CVAD is appropriate for some patient populations based on individual patient risk assessment prior to collection.
- Risks of venepuncture can include anxiety, pain, damage to skin and nearby nerves, and hematoma in patients receiving anticoagulants or with bleeding disorders (4).
- Limit drawing blood from IVADs as it increases hub manipulation and the potential for contamination (4).
- Blood samples from PIVC should not be drawn due to the risk of haemolysis, unless it is directly after insertion.
- Blood cultures should never be collected through a PIVC due to the increased rate of contamination at the time of collection.
- PICC in newborns should not be used for blood sampling or infusing blood products.

4.4 Dressings

- Use a sterile, transparent semi-permeable dressing to protect the insertion site from contamination. Allow continuous observation of the site and to stabilise and secure the device.
- For patients aged ≥18 years with a CVAD (CVC and PICC), chlorhexidine-impregnated dressings may be used to protect the insertion site from contamination (51, 52).
- Use of chlorhexidine impregnated dressings in infants and children may require individual risk assessment and prescription, should be considered in local guidelines (53-55).
- When the patient is diaphoretic or has excessive bleeding or oozing from the site, use sterile gauze secured with a sterile transparent, semi-permeable dressing until this is resolved (51, 56).
- Umbilical catheters do not routinely use an occlusive dressing over the insertion site, refer to local guideline or procedure for more information.
- When the patient has multiple devices, each should be dressed separately unless the puncture sites are too close together.
- All equipment used for the dressing of the insertion site must be sterile.
- Dressing must be placed so the insertion site is visible for regular inspection, therefore do not place non-sterile or opaque tape directly over the insertion site.
- All dressings must be replaced if it becomes damp, loosened, no longer adherent, soiled, there is evidence of inflammation and/or there is an accumulation of fluid.

Table 6: Dressing Change Intervals

Dressing Type	Replacement Intervals
Transparent, semi-permeable, self-adhesive polyurethane	Every 7 days or sooner if the dressing is no longer intact, evidence of inflammation or moist
Gauze	Every 24 - 48 hours or whenever loose, soiled or moist
Chlorhexidine-impregnated	Every 7 days or at each dressing change

(Source (13, 47, 57)

4.5 Needleless Injection Ports

- Removal of a needleless injection port must be performed using aseptic technique.
- Anytime a needleless injection port is removed from the catheter, this is to be discarded and a new sterile injection port should be attached, using appropriate aseptic technique.
- Needleless injection ports that are not bonded to the central line should be changed(17, 42):
    - At least every 7 days (coinciding with administration set changes) OR
    - At the frequency recommended by the manufacturer OR
    - If the integrity of the needleless injection port is compromised (e.g. residual blood remains within the port).

Needleless Injection Ports can also be known as: needleless IV catheter systems, swabable capless valves, swabable capless access device, needleless access ports, needle-free injection port, needleless connector and needle-free connector.

4.6 Arterial Catheters

- Replace disposable or reusable transducers at 96-hour intervals or when clinically indicated. Replace other components of the system (including the tubing, continuous-flush device, and flush solution) at the time the transducer is replaced (13).
- Keep all components of the pressure monitoring system (including calibration devices and flush solution) as a closed system (13).

4.7 Administration Sets

- IV administration sets include both the IV lines and any additional attachments such as needleless injection ports, sideline syringe infusion pumps, three-way stopcocks, multi-flow adaptors and extension tubing that may be added.
- IV administration sets must be attached to the patient so that no tension is applied to the catheter to reduce the risk of dislodgement.
- Ensure all components of the administration system are compatible (including sideline syringe infusion pump or burettes and needleless injection ports) to the devices to minimise leaks and breaks in the system.
    - All connections must be luer-lock.
- Refer to section 2.3 Documentation for labelling requirements.

Disconnection of Administration Sets

- A continuous circuit should be maintained as intermittent disconnections of administration sets increases the risk of infection.
- All administration sets must be replaced;
    - After being disconnected.
    - If the catheter is changed or
    - After blood has refluxed into the administration set and the blood is unable to be cleared by flushing.
- When an administration set is changed, the IV fluid bag must also be changed.

NB: infusions with blood and blood products and high value medicines, consideration may require on the continuation of the product and a risk assessment should be conducted to assess if product should be discarded and replaced with new lines or continue with existing set. Where an obvious contamination has occurred all lines must be changed.

- Disconnection of administrations sets must be avoided for routine care, such as showering, changing nightwear/gowns. If disconnected, IV lines must be replaced.
- Controlled disconnections where reconnection of the set is immediate may be appropriate in certain situations based on clinical requirements (e.g. changing IV access or infusions in operating theatres, administration of blood products or medical imaging departments).
    - For transient controlled disconnections, aseptic technique must be maintained to prevent contamination of the set.
    - If disconnection becomes more than transient or if the ends become contaminated in any way they must be discarded and replaced.

In-line Filters

In-line filters are not recommended for prevention of BSI, however certain agents such as chemotherapeutic, immunological drugs etc. require filtering for other reasons (15, 17, 46, 58).

Table 7: Frequency of Line Change

Administration Set Use	Frequency of Change
Continuous use (NOT containing lipids, blood or blood products)	Do not need to be replaced more frequently than every 96 hours unless device-specific recommendations from the manufacturer indicate otherwise (51). Change intermittent infusion sets without a primary infusion every 24 hours or whenever their sterility is in question (59).
Blood and blood products	Must be changed when the transfusion is complete, or every 12 hours if the transfusion is not complete (60). The maximum number of blood products as per the manufacturer's recommendations has been reached. Any number of red cell units may be transfused during a 12-hour period, provided the flow rate remains adequate (60). Platelets must be transfused via a new blood administration set. Note: Manufacturer's recommendations defining the maximum number of units per blood administration set must not be exceeded.
Lipid containing solutions and parenteral nutrition	Changed every 24 hours or as recommended by the manufacturer.
Lipid containing medications (e.g. Propofol, Clevidipine)	Changed at minimum every 12 hours or as per the manufacturers' instruction (61).
Chemotherapeutic agents	Remove immediately after use. On completion of infusion including the line flush. The chemotherapy infusion episode may include more than one agent, it is common practice to utilise the same administration set, with line flush in between in order to ensure the full dose has been administered.

4.8 Flushing

- Flushing is recommended to promote and maintain patency and prevent the mixing of incompatible medical solutions. Sterile 0.9% sodium chloride for injection must be used by clinicians, unless the manufacturer recommends flushing with an alternate solution (15-17, 46, 47, 62).
- Clinicians must flush catheters immediately:
    - After placement
    - Before and after each fluid infusion or injection
    - Prior to and after drawing blood
- PIVCs must be flushed at least every 8hrs, for hospital patients or every 24 hours for patients in the community, if not on a continuous infusion.
- CVADs not being accessed must be flushed and locked every 7 days.
- Ports/IVP not being accessed must be flushed and locked every four to six weeks.

4.9 Locking

- Sterile 0.9% sodium chloride for injection should be routinely used to lock a catheter no longer required for continuous infusions, unless the manufacturer recommends catheter lumens be locked with an alternate solution (17).
    - HO's who determine a need to use alternative locking solutions (e.g. heparin, antibiotic, antimicrobial and antiseptic), must have local policy or guidelines to support the appropriate use of these solutions.
- Locks containing medication must be prescribed by a Medical Officer or Nurse Practitioner.
- Refer to NSW Health Policy, Medication Handling in NSW Public Hospitals (63).
- Catheters with a medicine 'in situ' to lock the catheter must be labelled as per NSW Health Policy, User- applied labelling of Injectable Medicines, Fluids and Lines (7).

4.10 Catheter Migration

- A catheter that has migrated externally must not be re-advanced (64). The treating medical team must be notified immediately if this has occurred.
- If a CVAD is noted to have migrated inwards from the documented marking point, the CVAD must be retracted to the original insertion measurement as documented on the insertion form (65).
    - The medical team must be notified and a risk assessment for infection/contamination should be conducted.
    - This procedure can only be done by a clinician who has achieved CVAD competency. Refer 2.1 Staff Education and Training for more information.

5 REPLACEMENT AND REMOVAL

5.1 Device Duration

- All devices must be checked at each shift and removed when no longer required or if mechanical complications occur (42).
- Assess any devices in patients transferring from other healthcare facilities who may have a documented or non-documented device in situ. The clinician should inspect for infection, mechanical complications and correct distal tip position. Correct position can be determined through previous documentation and correct external lengths comparison, or via radiological confirmation.

- When adherence to aseptic technique is compromised (i.e. catheters inserted during a medical emergency, ambulance), replace the catheter as soon as possible (e.g. when the patient is stable or within 24 hours) (66-68).
- Devices should be removed based on the following clinical indications:
    - The catheter is no longer required
    - Evidence of systemic infection
    - Damaged catheter
    - Evidence of local infection (redness, swelling, oozing or pain at catheter exit site)
    - Persistent catheter occlusion
    - Confirmation of thrombosis

5.1.1 PIVC

The routine replacement of PIVC may not prevent infection or phlebitis (69, 70). Current research supports replacing a PIVC on clinical indication but the device should not be left in indefinitely and in most cases PIVC dwell time should not exceed 72-96 hours (71). A PIVC should not be used for an extended period. The need for a PIVC beyond short term vascular access should defer to a suitable long term device (refer to section 4.2). The decision to implement PIVC replacement on clinical indication must be based on a formal risk assessment.

Criteria for clinical indication based PIVC replacement

- There is good availability of staff appropriately trained in the insertion and maintenance of devices on each shift.
- There is an assurance that PIVC surveillance in the healthcare facility is adequate, including regular inspection of the site and device, and of PIVC-related Staphylococcus aureus bacteremia (SAB).
- There is consistent documentation regarding device insertion (site ease and date), site appearance and complications experienced with devices.
- Remove PIVC if patient develops signs of local infection, pain or tenderness and follow local reporting guidelines (e.g. IIMS)

Criteria for routine replacement of PIVC

- Replacement is likely to be uncomplicated and the risk is judged to be less than retention.
- May be appropriate in the context of high rates of PIVC related complications
- The PIVC is likely to be needed for another 24 hours.
- The decision should be document in the patient's health record.
- PIVC replacement in neonates and children should be based on clinical indication and ongoing need for the device.

5.1.2 Midline Catheters

- Midline catheters that are inserted at the bedside using sterile technique may stay in place for 2 to 4 weeks (72).

5.1.3 Umbilical Catheters

- This will be determined by the clinical condition of the baby and availability of alternative access (73).

- Remove and do not replace the umbilical catheter if there any signs of catheter-related BSI, vascular insufficiency in the lower extremities, or thrombosis are present.
- An umbilical catheter may be replaced if it is malfunctioning, breaks or splits, and there is no other indication for catheter removal.
- Refer to local policy or guideline for further information.

5.1.4 Peripheral Arterial and Pulmonary Artery Catheters

- Do not routinely replace arterial catheters to prevent infections. Replace only when there is a clinical indication (74).

5.1.5 CVADS

- Do not routinely replace CVADs or haemodialysis catheters. Replacement should be based on clinical indication and need (51, 75).
- Do not remove CVADs on the basis of fever alone. Use clinical assessment to determine whether infection is evident elsewhere or if there is another non-infectious cause of the fever, refer 7 Diagnosis of Infection & Surveillance.

5.1.6 PORTS

- Ports are a long term vascular access solution.
- The life of a port is limited to the number of needle punctures. The number of punctures varies depending on the gauge of the needle used but is approximately 1000-2000 (follow manufacturers instruction) (76).
- Replace ports based on clinical indications.

5.2 CVAD Guidewire Exchange

- Guide-wire exchanges to replace catheters is not recommended. A small number of patients may benefit from this in exceptional circumstances based on patient assessment, risk and suitable environment. Not advised for haemodialysis and tunnelled catheters.
- Guidewire exchanges must not be performed in the presence of BSI (77).

5.3 Catheter Removal

- Processes must be in place to ensure appropriate authority or order/instruction and written documentation to remove devices. HOs should develop standing orders or local protocols/processes for the routine removal of PIVCs (e.g. nurse initiated PIVC removal).
- Standard precautions and aseptic technique must be used to prevent catheter site infections (4).
- Following device removal, the site must be sealed with a sterile airtight dressing until the site is healed.
    - Umbilical catheters are not routinely dressed on catheter removal, but must be clean and dry.
    - If the patient is being discharged the patient or carer should be educated on the signs and symptoms of infection and complications and advised what to do if symptoms present.
- On removal the clinician should visually check the integrity of the line.
- Routine collection of the tip is not required except in circumstances where infection is suspected. Refer section 7 Diagnosis of Infection and Surveillance.

- PORT/IVP and tunnelled cuffed CVADs are only to be removed by a Medical Officer or Nurse Practitioner/Clinical Nurse Consultant who has been deemed competent in this skill.
    - Ports require surgical removal in theatre or interventional radiology.

Table 8 Requirements for Removal of CVADs

Requirements for Removal of CVADs: To prevent air embolism during CVAD removal HOs must have CVAD removal detailed in their local guideline or procedure.

- Refer to Clinical Focus Report- Central Venous Access Devices and Air Embolism (1)
- Removal of CVAD must only be undertaken by trained or supervised clinicians. Refer to 2.2.1 Competency Assessment for CVAD.
- Removal of the CVAD must be undertaken using an aseptic technique that will minimise the risk of infection.
- The patient is to be positioned supine with head slightly down (if tolerated) during CVAD removal. This is to increase the pressure in the large veins to above that of atmospheric pressure, which reduces the risk of aspirating air into the venous circulation.
- Following CVAD removal, the site must be sealed with an airtight dressing which remains insitu for at least 24 hours to reduce the risk of late air embolism. Refer to Safety Notice 004/14 Removal of Central Venous Access Devices (CVAD). The patient must remain in the supine position (or Semi-Fowlers if supine not tolerated) for between 30 and 60 minutes following CVAD removal (78). At least one set of observations should be done during this period, as well as immediately prior to retrieving the patient to the upright position. Observe for sign of respiratory distress, assess site for bleeding or haematoma and report any changes in status immediately.
- The removal of the CVAD and the presence of an intact tip must be noted in the patient's health record.
- Following removal, the CVAD site will require daily review and dressing until healed.
- Routine observations are to be conducted after the removal of the IVAD.

5.3.1 Removal of Catheter in Suspecting Line Infection

- Do NOT remove a functioning device based solely on temperature elevation (4).
- Remove PIVC if patient develops signs of local infection, pain or tenderness(4).
- If an infection is suspected the treating medical team must be notified and an assessment made for the ongoing need of device, persisting relapse of catheter related BSI, patient deterioration and alternative IV access.
- Patients transferring from other healthcare facilities with a documented device insitu should have the device reviewed upon arrival by a clinician for infection, mechanical complications and correct distal tip position, either through previous documentation and correct external lengths comparison, or via radiological confirmation. Without documentation, consider removal.

6 DIAGNOSIS OF INFECTION AND SURVEILLANCE

6.1 Diagnosis of Infection

- For a suspected catheter related BSI (79), obtain blood cultures (see 7.1.1).
- If pus, exudate or erythema is present at the insertion site, swab the site prior to removal of the device and send for culture.

- Catheter tip cultures are not a substitute for blood cultures for the determination of a bacteraemia, a negative tip culture does not exclude infection (79, 80).

6.1.1 Blood Cultures

- Two sets (4 bottles) of blood cultures should be collected in suspected infection for each new episode. This should occur prior to commencement of antimicrobials treatment. If patient is hemodynamically unstable, take 1 set prior to commencement of antimicrobials. Do not delay the administration of antimicrobials in patients with severe sepsis or septic shock.
- Collect one set from the pre-existing device and one set from a peripheral site.
    - If a peripheral set is not possible, a blood culture set from each of 2 or more lumens is required.
- The bottle should be well filled with a minimum 10mL per bottle (for adult patients only)
    - If volume of blood to be collected is an issue, preference should be given to aerobic bottles.
    - In neonates, collect an aerobic blood culture with 0.5-1mL, refer to local policy or guideline for additional information.
- Note the collection site on the request form at the time of collection.
- For further information, refer to local policy or guideline and Sepsis Kills Adult Blood Culture Guideline, Sepsis Kills Paediatrics Blood Culture Guidelines and Sepsis Kills Neonatal Blood Culture Guidelines.

6.1.2 Culturing of Tips

- Do not send catheter tips for culture on routine line removal, unless infection is suspected.
- Catheter tips should be cut using an aseptic technique.
- Ensure the site and type of catheter are noted on the request form as well as the appropriate clinical information.

6.1.3 Reporting of Catheter-related BSI

- HOs must have procedures in place for the timely reporting of all positive cultures to the treating medical and infection prevention and control teams.
- Open disclosure should be performed for all suspected or actual catheter related infections, as per the NSW Health Open Disclosure Policy.
- For healthcare associated BSIs (Staphylococcus aureus and Vancomycin resistant enterococcus) HO should follow internal reporting and escalation processes and key performance indicator requirements (e.g. IIMS). The NSW health incident management process must be followed for identification, investigation and management of these incidents as SAC 2 (6).

LIST OF ATTACHMENTS

1. PIVC Size & Use Guide
2. Related Documents
3. Additional Resources
4. Implementation Checklist

Attachment 1: PIVC Device Selection Guide

This is a guide for PIVC device selection and should be used whenever practical. However clinical risks and patient characteristics may require a different size to be used (e.g. paediatrics and neonates).

PIVC Size	Use
14G	Trauma patients Rapid, large-volume replacement
16G	Trauma patients Major surgery Intra-partum or post-partum GIT Bleeding Multiple line access Multiple blood transfers High volume of fluids
18G	Blood products Multiple line access Large volume of fluids Major surgery Imaging requiring power injection of CT contrast
20G	General use IV maintenance IV antimicrobials IV analgesia Power Injection
22G	Small or Fragile veins Cytotoxic therapy
24G	Small or Fragile veins Cancer services Day only infusion services Paediatrics
Delivery of Irritant medications: Use the most appropriate cannula size for the vein as use of a peripheral intravenous cannula that is too large for the vein increases the risk of phlebitis. Refer Safety Notice 009/16 Avoiding thrombophlebitis with intravenous amiodarone (revised 10 Feb 2017).	

Attachment 2: Related Documents

- NHMRC, Australian Guidelines for the Prevention and Control of Infections in Healthcare (3)
- NSW Health Policy Directive, Infection Prevention and Control Policy (81)
- Clinical Excellence Commission, Infection Prevention and Control Practice Handbook (49)
- Clinical Excellence Commission, Healthcare Associated Infection: Clinical Indicator Manual version 2.0 (9)
- NSW Health Policy Directive, Medication Handling in NSW Public Health Facilities (63)
- NSW Health Policy Directive, Clinical Procedure Safety (82)
- ACSQHC, National Safety and Quality Healthcare Service Standards (second edition) (83)
- NSW Health Policy Directive, User-applied labelling of injectable medicines, fluids and lines (7)
- ACSQHCs, National standard for user-applied labelling of injectable medicines, fluids and lines (84)
- Clinical Excellence Commission, Clinical Focus Report- Central Venous Access Devices and Air Embolism (1)
- NSW Health, Health Care Records-Documentation and Management (5)

Attachment 3: Additional Resources

- Australian Injectable Drugs Handbook (AIDH) - 7th Edition https://www.shpa.org.au/australian-injectable-drugs-handbook-aidh-7th-edition
- Cancer Institute NSW, eviQ Cancer Education Online- Central Venous Access Devices
- Cancer Institute NSW, eviQ Cancer Education Online- Clinical Resources, Central Venous Access Devices
- Clinical Excellence Commission- Training framework for clinicians new to inserting central lines in NSW
- My Health learning - Central Venous Access Devices
- My Health Learning -Invasive Device Protocols
- Intensive Care NSW- Central venous Access Device Post Insertion Management Guideline
- NSW Health Multicultural Service- Patient Information Sheets
- Sepsis Kills Paediatrics Blood Culture Guidelines http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/259419/paediatric-blood-culture-guideline.pdf
- Sepsis Kills Neonatal Blood Culture Guidelines
- Safety Notice 004/14 Removal of Central Venous Access Devices (CVAD)
- Centers for Disease Control and Prevention- Central Line-associated Bloodstream Infections
- Health Protection Surveillance Centre- Central Vascular Catheters
- Health Protection Surveillance Centre- Peripheral Vascular Care Bundles
- Health Protection Scotland- Preventing infections when inserting and maintaining a peripheral vascular catheter (PVC)
- The Joint Commission- CLABSI Toolkit
- Association for Professionals in Infection Control- CLABSIs

Attachment 4: Implementation Checklist

Note: This implementation planner is NOT mandatory – it is a tool for HOs to use to monitor implementation of this policy.

LHD/ Facility:	**Assessed By:**				**Date:**
Implementation Requirements	**Not Applicable**	**Not Started**	**Partial Compliance**	**Full Compliance**	**Action Required**
Local guideline or procedures in place for Peripheral Intravenous Catheters (PIVC)	☐	☐	☐	☐	
Local guideline or procedure in place for Midline Catheters	☐	☐	☐	☐	
Local guideline or procedure in place for Central Venous Access Devices (CVADs), including implanted venous ports (ports).	☐	☐	☐	☐	
Local guideline or procedure in place for Umbilical Catheters.	☐	☐	☐	☐	
Local guideline or procedure in place for Peripheral Artery Catheters.	☐	☐	☐	☐	
Local guideline or procedure in place for Pulmonary Artery Catheters	☐	☐	☐	☐	
Roles and responsibilities for each type of clinician involved with these devices is clearly defined in the guideline or procedure.	☐	☐	☐	☐	
Clinicians who insert, manage and remove CVADs have undergone training and formal competency assessment. Assessments are documented and accessible for review	☐	☐	☐	☐	
Facility wide monitoring of clinician CVAD insertion practices to ensure only trained/experienced clinicians undertake or supervise CVAD insertion.	☐	☐	☐	☐	
All staff involved in the insertion, management and removal of devices have completed periodic educational program and assessment.	☐	☐	☐	☐	
Ongoing education is provided to HWs on preventing and controlling infection risks in relation to intravascular devices.	☐	☐	☐	☐	
Patients are provided with infection prevention and control education on their device and this education is documented.	☐	☐	☐	☐	
It has been determined where devices are to be documented in the patient health record. The CVAD Insertion Record or equivalent is completed for every CVAD insertion.	☐	☐	☐	☐	
There is an evaluation method to ensure that insertion sites are assessed and documented daily in the patient health record.	☐	☐	☐	☐	

12. MEDICAL CARE					12.95
Processes are in place to support and evaluate the appropriate use of alternative locking solutions (e.g. heparin or antimicrobial). Locks containing medication are prescribed by a medical officer or nurse practitioner.	□	□	□	□	
Confirmation of tip position is documented on the central venous line insertion record or equivalent for all central device insertions.	□	□	□	□	
HOs who care for neonates have a local policy or guideline in place for skin preparation and/or antisepsis for pre-term infants.	□	□	□	□	
Criteria for PIVC replacement based on clinical indication has been met by the HO.	□	□	□	□	
Processes are in place to ensure appropriate authority to remove devices.	□	□	□	□	
Procedures in place to investigate positive cultures that are attributed to devices.	□	□	□	□	
All reportable device related BSI events are reviewed at the HO on a case by case basis to identify potential opportunity for clinical practice improvement.	□	□	□	□	
Surveillance systems are in place to monitor adverse events and incidents related to devices.	□	□	□	□	
Compliance with this Policy Directive and Procedures is monitored and reported to the nominated peak committee.	□	□	□	□	

9 GLOSSARY

Administration Set	A tubing set composed of components that is used to deliver infusions.
Air Embolism	The presence of air in the vascular system that obstructs venous blood flow primarily to the lungs and brain (85).
Alcohol Based Hand Rub (ABHR)	An alcohol-containing preparation (gel, foam or liquid) designed for reducing the number of viable microorganisms on dry, unsoiled hands.
Alcohol Based Surgical Hand Rub (ABSHR)	Hand rub performed preoperatively by the surgical team to eliminate transient flora and reduce resident skin flora.
Antimicrobial	A chemical substance , usually a medicine, that inhibits or destroys bacteria, viruses fungi or protozoa (81).
Antiseptics	Antimicrobial substances that are applied to the skin to reduce the number of micro flora (e.g. topical alcohols, chlorhexidine and iodine).
Asepsis	Free from infection or infectious (pathogenic) material.

Aseptic Technique	Aseptic technique consists of a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during clinical procedures. The five essential principles of aseptic technique are sequencing, environmental control, hand hygiene, maintenance of aseptic fields and personal protective equipment (PPE). While the principles of aseptic technique remain constant for all procedures, the level of practice will change depending upon a standard risk assessment (81)
Assistant	A trained or experienced clinician who supports or aids a clinician inserting a CVAD.
Arteriovenous Fistula (AV)	Vascular access used to access the blood for haemodialysis treatment.
Blood stream infections (BSIs)	The presence of live pathogen(s) in the blood, causing an infection.
Catheter Exchange	Replacement of existing central venous access device (CVAD) with a new CVAD using the same catheter tract (4).
Central Related Blood Stream Infection (CR-BSI)	A laboratory-confirmed, primary blood stream infection in a patient with a intravascular access device in place, and the BSI is not related to an infection at another site (4)
Central Venous Access Device (CVAD) **Also called a central venous line or central venous catheter (CVC).**	A catheter introduced via a large vein into the superior vena cava or right atrium for the administration of parenteral fluids, medications or for the measurement of central venous pressure, this includes femoral venous catheters. • Centrally- inserted central venous catheters have a skin entry point in the neck or trunk. • Peripherally- inserted central catheters have a skin entry point on a limb or the scalp. • Non-Tunnelled- the catheter insertion and exit points are the same • Tunnelled - the catheter is inserted through one point and then “tunnelled” under the skin to a remote exit point.
Clinician	For the purpose of this policy, a clinician is defined as a medical practitioner (including Locum Medical Officers), nurse or midwife. Experienced Clinician- A clinician with a high level of competence in CVAD insertion and a comprehensive understanding of the management of potential complications. Trained Clinician- Clinician who has completed a training program consistent with best practice for the insertion of CVADs. Untrained Clinician- Clinician who has commenced, but not completed, a training program consistent with best practice for the insertion of CVADs.
Competency	Competence- Capability of the individual to apply knowledge, critical thinking, interpersonal, decision making, and psychomotor skills to intravascular access devices (4). Competence is the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance (86) For the purpose of the guideline, a competent clinician is one who has completed a training program in the insertion of PIVCs or who is in, or has completed, a specialist medical training program Competency- An integration of behaviours in the varied circumstances of the work environment demonstrating the individual’s ability to perform the desired job related activities and tasks (4). Competency Assessment- The process of reviewing and documenting the individual’s demonstrated ability to perform a job, role, specific tasks, or other patient care activities (4).

Electrocardiogram **ECG**	Is a test that measures and records the electrical activity of the heartbeat
Erythema	Redness of skin along a vein track that results from vascular irritation or capillary congestion in response to irritation, may be a precursor to or indication of phlebitis (4).
Extravasation	Inadvertent infiltration of vesicant solution or medication into surrounding tissue; rated by a standard tool (4).
Flushing	The act of moving fluids, medications, blood, and blood products out of the vascular access device into the bloodstream; used to assess and maintain patency and prevent precipitation due to solution/medication incompatibility (4).
Guidewire	A long, flexible metal structure, composed of tightly wound coiled wire in a variety of designs; contains safety mechanisms that allow it to be inserted into the vein or artery (4).
Hand Hygiene	A general term applying to processes aiming to reduce the number of microorganisms on hands. This includes application of a waterless antimicrobial agent (e.g. ABHR) to the surface of dry unsoiled hands; or use of soap / solution (plain or antimicrobial) and running water (if hands are visibly soiled), followed by patting dry with single-use towels (81)
Healthcare Associated Infection (HAI)	Refers to infections acquired in healthcare facilities and infections that occur as a result of healthcare interventions and which may manifest after people leave the healthcare facility (81)
Health Organisation	For the purpose of this Policy a Health Organisation is: Local Health District, Speciality Health Networks, Statutory health corporation that provides inpatient services, or Affiliated health organisation in respect of its recognised establishments that provide inpatient service
IIMS	The NSW Health Incident Information Management System
Implantable Venous Port (port/IVP):	Long term CVAD, which is surgically placed under the skin from the insertion site to a separate exit site. The exit site is typically located in the chest, but can be also located elsewhere for comfort and aesthetic reasons (e.g. inner bicep, abdomen and thigh). They can be multi lumen. TIVPs consist of two main parts: the portal reservoir and a catheter. The tip of the catheter resides in either the superior or inferior vena cava. Also known as a port-a-cath or a venous port.
Infection	The presence and growth of a pathogenic microorganism(s) having a local or systematic effect (49).
Infiltration	Inadvertent administration of a non-vesicant solution or medication into surrounding tissue (4).
Intravascular device (device):	Catheters, tubes, or devices inserted into the vascular system, including veins, arteries, and bone marrow (4).
Key Parts	Key parts are those parts of equipment / instruments / consumables that if contaminated by infectious material increases the risk of infection. Contamination may occur by direct or indirect contact with the key site(s), other key-parts, or liquid infusions (81).
Key Sites	The area on the patient that must be protected from pathogenic microorganisms. Key Sites are medical device access sites, surgical sites or open wounds (81).

Locking	The instillation of a solution into an intravascular access device (device) used to maintain patency in between device use and/or reduce risk of catheter related BSI.
Maximum Barrier Precautions	Surgical mask, hat (head and facial hair cover), eye protection, sterile gown and sterile gloves. Equipment and clothing used to avoid exposure to pathogens, including sterile coverings for the clinicians and patient: mask, gown, protective eyewear, cap, gloves, large or full body drapes, and towels (4).
Midline Catheter	Catheter used in a vascular access procedure that is inserted inside a major vein for a period of weeks so that blood can be repeatedly drawn or medication and nutrients can be injected into the patient's bloodstream on regular basis
Monitor	To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.
Must:	Indicates a mandatory action
Needleless Injection Port	A device that allows intermittent access to a device with an administration set or syringe without the use of needles (4). Also known as: Needleless IV catheter systems, Swabable capless valve, swabable capless access device, needleless access ports, needle-free injection port, needleless connector and needle-free connector.
Neonate	Pertaining to the first 4 weeks of life.
Non-tunnelled CVAD **Also known as Percutaneous CVAD**	Enter the venous system at the point of insertion and are fixed in place at this site, with the catheter and attachments protruding. Non-tunnelled CVADs are also known as percutaneous CVADs. Non-tunnelled catheters are generally used for short term therapy and in emergency situations. A vascular or nonvascular access device inserted by puncture directly through the skin and the intended location without a portion of the device allowed to remain in a subcutaneous tract (4).
Osmolality	The number of osmotically active particles in a solution (4).
Palpation	Examination by application of the hands or fingers to the surface of the body in order to detect evidence of disease or abnormalities in the various organs; also used to determine location of peripheral superficial veins and their condition (4)
Peripheral Arterial Catheter	An arterial line inserted in radial artery; can be placed in femoral, axillary, brachial, posterior tibial arteries.
Peripherally Inserted Central Catheter (PICC)	A medium to long term CVAD inserted in a large peripheral vein, preferably the basilic vein, and then advanced until the tip rests in the superior vena cava or cavo-atrial junction
Peripheral Intravenous Cannula (PIVC):	A catheter (small, flexible tube) placed into a peripheral vein for intravenous access.
Personal Protective Equipment (PPE):	Refers to a variety of infection prevention barriers and respirators used alone, or in combination, to protect mucous membranes, skin, and clothing from contact with recognised and unrecognised sources of infectious agents in healthcare settings. The equipment worn to minimize exposure to a variety of hazards, including blood-borne pathogens; examples of PPE include items such as gloves, eye protection, gown, and face mask (81) .
Phlebitis	Inflammation of a vein; may be accompanied by pain, erythema, oedema, streak formation, and/or palpable cord (48).

Pulmonary Artery Catheter (PA)	Also known as a Swan-ganz catheter, is a CVAD inserted into a large central vein, with the tip residing in a pulmonary artery. Its purpose is diagnostic and therapeutic; it is used to detect heart failure or sepsis, monitor therapy, evaluate the effects of drugs, and infuse medication.
Should	Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action.
Sterile Technique	Is a set of specific practices and procedures performed to make equipment and areas free from all microorganisms and to maintain that sterility
Supervisor	An experienced clinician (also refer to definition of experienced clinician).
Surveillance	Active, systematic, ongoing observation of the occurrence and distribution of disease within a population and of the events or conditions that increase or decrease the risk of such disease occurrence.
Total Parenteral Nutrition (TPN)	The intravenous provision of total nutritional needs for a patient who is unable to take appropriate amounts of food enterally; typical components include carbohydrates, proteins, and/or fats, as well as additives such as electrolytes, vitamins, and trace elements (4).
Tunnelled CVAD	A central vascular access device (CVAD) with a segment of the catheter lying in a subcutaneous tunnel with the presence of a cuff into which the subcutaneous tissue grows to offer security for the catheter; indicates that the skin exit site and vein entry site are separated by the subcutaneous tunnel (4)
Vesicant	An agent capable of causing tissue damage when it escapes from the intended vascular pathway into surrounding tissue.
Visual Infusion Phlebitis (VIP) score	

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PATIENTS WITH INHERITED BLEEDING DISORDERS IN HOSPITALS WITHOUT A HAEMOPHILIA TREATMENT CENTRE (PD2023_005)

PD2023_005 replaced PD2022_013

POLICY STATEMENT

Any clinician treating a patient with an inherited bleeding disorder who may require replacement therapy in a hospital that does not have a designated Haemophilia treatment Centre must seek the advice of a specialist clinician from a designated Haemophilia Treatment Centre.

Advice must be sought immediately when the patient requires emergency surgery or emergency factor therapy replacement. Advice must be sought during the planning of elective surgery for a patient if the procedure is to be carried out in a hospital that does not have a designated Haemophilia Treatment Centre.

SUMMARY OF POLICY REQUIREMENTS

Patients with inherited bleeding disorders requiring emergency surgery or emergency clotting factor replacement therapy at a non-Haemophilia Treatment Centre hospital must be treated promptly.

The patient's senior treating medical officer must consult with a haematologist (local or haematologist at a Haemophilia Treatment Centre) and a designated Haemophilia Treatment Centre must be urgently contacted to determine whether the patient is to be transferred to a facility (usually a designated Haemophilia Treatment Centre) where definitive care can commence and clotting factor is available.

If the patient does not need to be transferred, the product needed to treat them must be ascertained. A treatment plan for the patient must be discussed between the patient's senior treating medical officer at the non-Haemophilia Treatment Centre hospital and the director (or their assigned delegate) of the Haemophilia Treatment Centre and the plan must be documented in the patient's medical record.

Patients with bleeding disorders, particularly high-risk patients, are to have elective surgery performed in a designated Haemophilia Treatment Centre whenever possible.

A patient who has a specific reason for having a procedure carried out in a non-Haemophilia Treatment Centre hospital may be able to do so provided that:

a) the patient or person responsible for the patient has been made aware of the potential risks attached to having surgery in a hospital with no designated Haemophilia Treatment Centre, and
b) the director (or assigned delegate) of a designated Haemophilia Treatment Centre approves the alternative arrangement.

The patient's senior treating medical or dental officer must contact the director (or assigned delegate) of a designated Haemophilia Treatment Centre ideally before the patient is placed on an elective surgery waiting list, but not less than two weeks before the date of the planned surgery, to discuss the proposed surgery. Failure to do so may delay the surgery, if approved.

A written patient treatment and monitoring plan, which has been approved by the director of the Haemophilia Treatment Centre, must be put in place.

Once the director (or assigned delegate) of the designated Haemophilia Treatment Centre has approved the patient's treatment and monitoring plan, the patient's senior treating medical or dental officer or the haematologist at the non-Haemophilia Treatment Centre hospital must:

1. complete the *Bleeding Disorder Elective Surgery Information for Clinical Review* state form and send it to the Office of the Chief Health Officer using the eHealth NSW Secure File Transfer Service (Kiteworks).

and

2. notify the hospital blood transfusion staff that they can order the clotting factor from Lifeblood using BloodNet. Staff must include the wording:
"Endorsed by [Name] Haemophilia Treatment Centre Director [Name] or delegate [Name] on [Date]" in the free text "comments" section of the BloodNet order form. Failure to include the completed statement will lead to a delay in receiving product.

The patient's senior treating medical or dental officer must liaise daily (or more frequently as required) with the director (or assigned delegate) of the designated Haemophilia Treatment Centre during the period the patient is being treated in the non-Haemophilia Treatment Centre hospital.

The patient outcome and a summary of factor usage must be provided to the director (or assigned delegate) of the designated Haemophilia Treatment Centre.

The entire Patients with inherited bleeding disorders in hospitals without a Haemophilia Treatment Centre policy is available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_005

VICTIMS RIGHT ACT 1996 (PD2005_287)

1. INTRODUCTION

1.1 This circular provides information on the *Victims Rights Act 1996* which was proclaimed on 2 April 1997 and the concomitant requirements on the NSW Health system.

1.2 This circular should be read in conjunction with the **NSW Health Victims of Crime Policy** released in 1995. Copies of the policy are available from the Health Services Policy Branch of the Central Office of the Department.

2. THE *VICTIMS RIGHTS ACT 1996*

2.1 This Act establishes:

- a statutory **Charter of Victims Rights**;
- the **Victims of Crime Bureau** as a branch of the Attorney General's Department;
- the **Victims Advisory Board**; and
- amendment to the *Criminal Procedure Act 1986*, by inserting legislative changes relating to victim impact statements.

3. CHARTER OF VICTIMS RIGHTS

3.1 The Charter

3.1.1 Victims of crime in New South Wales now have a **statutory** (ie enshrined in legislation) Charter to protect and promote their rights. The new Charter is similar to the non-statutory charter which it replaced and is consistent with the NSW Health Victims of Crime Policy. The new Charter, established in the *Victims of Crime Act 1996*, establishes standards for the appropriate treatment of victims of crime and is overseen by the Victims of Crime Bureau.

3.1.2 Any agency or person exercising official functions in the administration of the affairs of the State (other than judicial functions) must, to the extent that it is relevant and practicable to do so, have regard to the Charter of Victims Rights in addition to any other relevant matter. (*Victims Rights Act 1996*, Part 2, Section 7 (2))

3.1.3 The Charter of rights of victims of crime, provides among other things:

- that a victim should be treated with courtesy and compassion, and that the rights and dignity of the victim are respected;
- a victim should be informed at the earliest practical opportunity, by relevant agencies and officials, of the services and remedies available to the victim; and
- a victim should have access where necessary to available welfare, health, counselling and legal assistance responsive to the victim's needs.

3.2 Breaches of the Charter

3.2.1 If a victim considers a Government agency has not abided by its statutory obligations under the *Charter*, a victim can complain to the Victims of Crime Bureau about the agency.

3.2.3 The Bureau has the responsibility to take all necessary action to resolve the matter. Where the Bureau receives a complaint relating to a Health Service, the Bureau will contact the nominated Complaints Contact Officer in the Health Service, for investigation and a report on the complaint.

3.2.4 Where the Bureau is unable to resolve the matter satisfactorily, the Bureau will be obliged to make a report to the Attorney General, who can table this in Parliament.

3.3 Full details of the **Charter of Victims Rights** are attached at *appendix 1*,

3.4 Additional information on the Charter of Victims Rights, is attached at *appendix 2.* This attachment provides information on:

- Why Do We Need A Charter?
- Who Is A Victim?
- What Does The Charter Do?
- What Specific Rights Are Protected?

4. THE ROLE & FUNCTIONS OF THE VICTIMS OF CRIME BUREAU

4.1 Establishment of Victims of Crime Bureau

4.1.1 The Victims of Crime Bureau (VCB) has been established within the Attorney General's Department under the *Victims Rights Act 1996.* The primary goal of the VCB is to coordinate the delivery of appropriate services to meet the needs of victims of crime.

4.2 What Is The Role Of The VCB?

4.2.1 The VCB is responsible for:

- providing support and referral services to victims of crime;
- coordinating the delivery of victims' support and counselling services by government and community agencies; and
- overseeing the implementation of the statutory *Charter of Victims Rights.*

4.2.2 The VCB will also be an information resource for victims of crime and for community and victim support agencies. This role will ensure that information about the range of victim support services operating across the State is readily available and accessible to all.

4.2.3 It will also ensure that victims have access to information which will help them to understand, and participate in, the criminal justice system.

4.3 How Will The VCB Receive Referrals?

4.3.1 While victims of crime will be able to directly contact the VCB for assistance, the VCB will also receive referrals from police and other services who have contact with the victim at the time of the crisis.

4.4 What Happens Once A Victim Is Referred To The VCB?

4.4.1 Once contact has been established with a victim, staff at the VCB will make an assessment of the victim's needs.

4.4.2 Information will be supplied to a victim based on this assessment, and, if necessary, a referral made to attend other agencies for specialist services.

4.4.3 The overall aim will be to provide an integrated counselling/referral service so that a victim will have immediate access to counselling and other necessary assistance.

4.4.4 It is important to note that the VCB does **not** offer or provide on-going counselling services, but coordinates the delivery of such services by government and community agencies.

4.5 Further information on the following is attached at *appendix 3*:

- Other Functions Of The VCB
- The VCB And Other Agencies
- Education & The VCB

5. THE VICTIMS ADVISORY BOARD

5.1 The Victims Advisory Board established under the Act, has the following functions:

- to advise the Minister on policies and administrative arrangements relating to support services and compensation for victims of crime;
- to consult victims of crime, community victim support groups and Government agencies on issues and policies concerning victims of crime; and
- to promote legislative, administrative or other reforms to meet the needs of victims of crime.

5.2 NSW Health is represented on the Board.

6. NSW HEALTH VICTIMS OF CRIME POLICY

6.1.1 The goal of the **NSW Health Victims of Crime Policy** is:

> *To ensure that counselling, support and information is available to victims of crime and their families as soon as possible after a crime to minimise secondary trauma and assist in recovery.*

6.1.2 The role of the Department/Area Health Services, hospitals, specialist teams and units and Community Health Centres is clearly set out in the Policy, and is summarised in *appendix 4* for information.

7. AREA HEALTH SERVICE RESPONSIBILITIES

7.1 Under the NSW Health Victims of Crime Policy, Services are required to nominate a position to coordinate the planning and implementation of local protocols. A list of Area Health Service *Contact Officers* for Victims of Crime is attached at *Appendix 5*.

7.2 The Department, in conjunction with the Victims of Crime Bureau, Area Health Services and other Services will be developing protocols for the management of complaints from victims of crime. In the meantime, Area Health Services have nominated a person to whom complaints about the implementation of the Charter can be referred. A list of Complaints Officers is attached at *Appendix 5*.

8. FURTHER INFORMATION

8.1 For further information, please contact Ms Melissa Gibson, Manager, (02 9391 9506) Health Services Policy Branch, NSW Health Department.

8.2 Further information on the Victims of Crime Bureau, including information kits on the VCB, can be obtained from Ms Marianne Curtis, Manager, of the Bureau on 02 9374 3000.

Appendix 1

CHARTER OF VICTIMS RIGHTS

The following comprises the Charter of rights of victims of crime, as listed in the *Victims Rights Act 1996*, Part 2:

Courtesy, compassion and respect
A victim should be treated with courtesy, compassion, and respect for the victim's rights and dignity.

Information about services and remedies
A victim should be informed at the earliest practical opportunity, by relevant agencies and officials, of the services and remedies available to the victim.

Access to services
A victim should have access where necessary to available welfare, health, counselling and legal assistance responsive to the victim's needs.

Information about investigation of the crime
A victim should, on request, be informed of the progress of the investigation of the crime, unless the disclosure might jeopardise the investigation. In that case, the victim should be informed accordingly.

Information about prosecution of accused
A victim should, on request, be informed of the following:
(a) the charges laid against the accused or the reasons for not laying charges,
(b) any decision of the prosecution to modify or not to proceed with charges laid against the accused, including any decision for the accused to accept a plea of guilty to a less serious charge in return for a full discharge with respect to the other charges,
(c) the date and place of hearing of any charge laid against the accused,
(d) the outcome of the criminal proceedings against the accused (including proceedings on appeal) and the sentence (if any) imposed.

Information about trial process and role as witness
A victim who is a witness in the trial for the crime should be informed about the trial process and the role of the victim as a witness in the prosecution of the accused.

Protection from contact with accused
A victim should be protected from unnecessary contact with the accused and defence witnesses during the course of court proceedings.

Protection of identity of victim
A victim's residential address and telephone number should not be disclosed unless a court otherwise directs.

Attendance at preliminary hearings
A victim should be relieved from appearing at preliminary hearings or committal hearings unless the court otherwise directs.

Return of property of victim held by State
If any property of a victim is held by the State for the purpose of investigation or evidence, the inconvenience to the victim should be minimised and the property returned promptly.

Protection from accused
A victim's need or perceived need for protection should be put before a bail authority by the prosecutor in any bail application by the accused.

Information about special bail conditions
A victim should be informed about any special bail conditions imposed on the accused that are designed to protect the victim or the victim's family.

Information about outcome of bail application
A victim should be informed of the outcome of a bail application if the accused has been charged with sexual assault or other serious personal violence.

Victim impact statement
A relevant victim should have access to information and assistance for the preparation of any victim impact statement authorised by law to ensure that the full effect of the crime on the victim is placed before the court.

Information about impending release, escape or eligibility for absence from custody.
A victim should, on request, be kept informed of the offender's impending release or escape from custody, or of any change in security classification that results in the offender being eligible for unescorted absence from custody.

Submissions on parole and eligibility for absence from custody of serious offenders
A victim should, on request, be provided with the opportunity to make submissions concerning the granting of parole to a serious offender or any change in security classification that would result in a serious offender being eligible for unescorted absence from custody.

Compensation for victims of personal violence
A victim of a crime involving sexual or other serious personal violence should be entitled to make a claim under a statutory scheme for victims compensation.

(Nov 1997)

Appendix 2

The Charter of Victims Rights

1 Why Do We Need A Charter?

1.1 The *Charter of Victims Rights* builds upon principles already adopted by government agencies throughout New South Wales.

1.2 These principles value the needs of victims, and recognise these needs as factors to be taken into consideration in the decision making processes related to the administration of justice in this State.

1.3 By incorporating these principles into a statutory charter, the government is ensuring a recognised position for victims within the NSW criminal justice system.

2 Who Is A Victim?

2.1 Under the *Charter*, a victim includes a person who, as a direct result of a criminal offence suffers physical or emotional harm, or loss or damage to property.

2.2 Where the criminal offence results in the death of the person, a member of that person's immediate family will also be included as a victim of crime for the purposes of the *Charter.*

3 What Does The Charter Do?

3.1 The *Charter* places a statutory obligation upon government agencies to ensure that a victim is at all times treated with courtesy and compassion, and that their rights and dignity are respected.

3.2 The Victims of Crime Bureau is currently liaising with all relevant government agencies to establish guidelines and protocols in the treatment of victims and the effective delivery of services to meet the needs of victims and compliance with *Charter* obligations.

4 What Specific Rights Are Protected?

4.1 The *Charter* recognises rights of victims to:

- information about, and access to, welfare, health and counselling services;
- privacy and protection;
- information about the investigation of the crime, the prosecution of the accused and the trial process;
- assistance with the preparation of a victim impact statement where relevant;
- information about an offender's release, escape or eligibility for unescorted absence from custody;
- make submissions concerning parole and eligibility for unescorted absence from custody of serious offenders.

5 What Happens If There Is A Breach Of The Charter?

5.1 If a victim considers a Government agency has not abided by its statutory obligations under the *Charter*, a victim can complain to the Victims of Crime Bureau about the agency.

5.2 The Bureau has the responsibility to take all necessary action to resolve the matter. Where the Bureau is unable to resolve the matter satisfactorily, the Bureau will be obliged to make a report to the Attorney General, who can table this in Parliament.

(Nov 1997)

Appendix 3

VICTIMS OF CRIME BUREAU

1 Other Functions Of The VCB

1.1 Advice and assistance will also be offered by the Bureau with regard to:

- ensuring that victims are aware of their rights to claim compensation for injuries suffered;
- completing victim compensation applications, where necessary;
- providing victims with an information kit to assist in the preparation of a victim impact statement.
- assisting a victim to have their details recorded in the Victim's Register to ensure the victim is informed by the Department of Corrective Services of an offender's impending release or escape from custody; and,
- to oversee the approved counselling scheme.

2 The VCB And Other Agencies

2.1 The VCB is intended to complement and enhance existing services by promoting the development of a cohesive and comprehensive network of victim support services in NSW. It will assist with inter-agency co-ordination of victims' services, as well as the development of co-operative strategies between agencies at the local level.

2.2 A close working relationship will be developed with this and other community support groups.

3 Education & The VCB

3.1 The VCB will provide an educational role by organising seminars and training sessions for both Government and non-Government agencies, to promote awareness of victims' needs and their position within the criminal justice system.

(Nov 1997)

Appendix 4

NSW HEALTH VICTIMS OF CRIME POLICY

1 What Is the Role of the NSW Health Department?

1.1 To ensure that victims of crime receive appropriate counselling and information as soon as possible after the crime, through either local health services or through referral services. To promote the development of local networks that will ensure appropriate referrals and maximise access. The local networks will include such resources as private therapists, the Sydney City Mission Victims of Crime Telephone Counselling Service, the New South Wales Police Service and the Victims of Crime Bureau amongst others.

2 What Is the Role of Area Health Services?

2.1 Area and Rural Health Services are responsible for the development of local operational plans or protocols. These protocols should recognise the Charter of Victims Rights in both their formulation and implementation. Local protocols should be developed with involvement from Hospital staff, including medical staff, nursing staff and social work departments. The protocols should recognise specialist units, private therapists and other relevant services in the Area skilled in the treatment and care of victims of crime. The protocols should recognise the need for both information and counselling services to be made available for victims of crime.

2.1.1 Protocols should include:

- the provision of culturally appropriate counselling by staff trained in trauma counselling and critical incident stress debriefing or referral to other appropriate services;
- the provision of information to the victim, including information on the VCB;
- procedures for networking with both government and non government agencies; and
- programs to raise community awareness about the needs of victims of crime and of consequent health services.

3 What Is the Role of Hospital Staff?

3.1 Many victims of crime enter the Health system via public hospitals, where they will receive treatment and subsequent referral. The role performed by hospital staff is vital in ensuring that victims are given access to counselling and information. Staff employed in these areas should be involved in the design and implementation of local protocols.

4 What Is the Role of Specialist Teams and Units?

4.1 There are numerous specialist teams and units throughout NSW. These teams are staffed by highly trained and experienced individuals. Teams such as those which specialise in the counselling of children, the treatment of the aged, the care of the mentally ill and the care of the disabled should be involved in the implementation of local protocols. The victim is more likely to receive optimal care with input from these professionals.

5. What Is yhe Role of Community Health Centres?

5.1 Community Health Centres should be involved in the development of protocols as they have multidisciplinary staff who provide counselling and therapy services and who are skilled in community development.

(Nov 1997)

Appendix 5

Area Health Service	V. of Crime Contact Officer	Complaints Contact Officer
Central Coast Area Health Service	Ms Dorothy MacLean Director, Social Work Central Coast Area Health Service PO Box 361 GOSFORD NSW 2250 Ph (02) 4320 3613 Fax (02) 4325 0566	Mr Jon Blackwell Chief Executive Officer Central Coast Area Health Service PO Box 361 GOSFORD NSW 2250 Ph (02) 4320 2111 Fax (02) 4325 0566
Central Sydney Area Health Service	Ms Anne Connolly Women's Health Coordinator Central Sydney Area Health Service C/- Royal Prince Alfred Hospital 59 Missenden Road CAMPERDOWN NSW 2050 Ph (02) 9515 3272 Fax (02) 9515 3282	Ms Annette Gardner Complaints Manager Central Sydney Area Health Service C/- Royal Prince Alfred Hospital 59 Missenden Road CAMPERDOWN NSW 2050 Ph (02) 9515 9600 Fax (02) 9515 9611
Far West Health Service	Ms Voula Smith Young Persons Mental Health Worker Far West Health Service PO Box 457 BROKEN HILL NSW 2880 Ph (08) 8087 8800 Fax (08) 8088 2926	Ms Voula Smith Young Persons Mental Health Worker Far West Health Service PO Box 457 BROKEN HILL NSW 2880 Ph (08) 8087 8800 Fax (08) 8088 2926
Greater Murray Health Service	Ms Lee Purches, Social Worker Wagga Wagga Community Health Service PO Box 159 WAGGA WAGGA NSW 2650 Ph (02) 6938 6411 Fax (02) 6938 6410	Mr Michael Moodie Chief Executive Officer Greater Murray Health Service Locked Mail Bag 10 WAGGA WAGGA NSW 2650 Ph (02) 6921 5588 Fax (02) 6921 5856
Hunter Area Health Service	Ms Ros Giles Area Advisor in Social Work Social Work Department John Hunter Hospital Locked Bag 1 Hunter Region Mail Centre, NSW 2310 Ph (02) 4921 3703 Fax (02) 4921 3704	Dr Katherine McGrath Chief Executive Officer Hunter Area Health Service Locked Mag Bag No. 1 NEW LAMBTON NSW 2305 Ph (02) 4921 4960 Fax (02) 4921 4969
Illawarra Area Health Service	Mr Peter Orr Senior Psychosocial Worker Wollongong Community Health Centre Unit 28/29 341-349 Crown Street WOLLONGONG NSW 2500 Ph (02) 4229 2755 Fax (02) 4228 5623	Mr Terry Clout Director, Health Services Operations Illawarra Area Health Service Private Mail Bag 3 PORT KEMBLA NSW 2505 Ph (02) 4275 5105 Fax (02) 4276 1447

Macquarie Health Service	Ms Rhonda Gleeson Sexual Assault Coordinator Dubbo Community Health Centre 2 Palmer Street DUBBO NSW 2830 Ph (02) 6885 8999 Fax (02) 6885 8901	Mr John Ballie Area Director, Nursing Services Macquarie Health Service PO Box M61 DUBBO NSW 2830 Ph (02) 6881 2318 Fax (02) 6881 2225
Mid North Coast Health Service	Dr Kevin Wolfenden Director of Primary Health & Extended Care Mid North Coast Health Service PO Box 35 TAREE NSW 2430 Ph (02) 6551 1397 Fax (02) 6551 2413	Mrs Wilna Taylor Director of Nursing & Service Quality Mid North Coast Health Service PO Box 126 PORT MACQUARIE NSW 2444 Ph (02) 6583 0721 Fax (02) 6584 9531
Mid Western Health Service	Ms Sue Burke Women's Health Coordinator Mid Western Health Service Bloomfield Hospital ORANGE NSW 2800 Ph (02) 6360 7960 Fax (02) 6361 4126	Ms Sue Burke Women's Health Coordinator Mid Western Health Service Bloomfield Hospital ORANGE NSW 2800 Ph (02) 6360 7960 Fax (02) 6361 4126
New England Health Service	Ms Megan Jones A/Coordinator, Community Health PO Box 256 MOREE NSW 2400 Ph (02) 6752 9217 Fax (02) 6752 4025	Ms Megan Jones A/Coordinator, Community Health PO Box 256 MOREE NSW 2400 Ph (02) 6752 9217 Fax (02) 6752 4025
Northern Sydney Area Health Service	Mr Roger Dunston Head of Department of Social Work Royal North Shore Hospital Pacific Highway ST. LEONARDS NSW 2065 Ph (02) 9926 7580 Fax (02) 9906 5495	Mr Roger Dunston Head of Department of Social Work Royal North Shore Hospital Pacific Highway ST. LEONARDS NSW 2065 Ph (02) 9926 7580 Fax (02) 9906 5495
Northern Rivers Health Service	Ms Marcia Dwonczyk, Director, Primary & Extended Care Services Northern Rivers Health Service Locked Mail Bag 11 LISMORE NSW 2480 Ph (02) 6620 2122 Fax (02) 6621 7088	Ms Marcia Dwonczyk, Director, Primary & Extended Care Services Northern Rivers Health Service Locked Mail Bag 11 LISMORE NSW 2480 Ph (02) 6620 2122 Fax (02) 6621 7088

South Eastern Sydney Area Health Service	Dr Tony Sara Director of Clinical Services Sydney Hospital Macquarie Street SYDNEY NSW 2000 Ph (02) 9382 7491 Fax (02) 9382 7515	Mr Robert Beetson Complaints Coordinator South Eastern Sydney A H S PO Box 430 KOGARAH NSW 2217 Ph (02) 9382 9898 Fax (02) 9382 9859
South Western Sydney Area Health Service	Ms Margaret Scrimgeour Asst to Director of Clinical & Nurs Serv. Private Mail Bag No 17 LIVERPOOL NSW 2170 Ph (02) 9828 5714 Fax (02) 9828 5914	Ms Margaret Scrimgeour Asst to Director of Clinical & Nurs Serv. Private Mail Bag No 17 LIVERPOOL NSW 2170 Ph (02) 9828 5714 Fax (02) 9828 5914
Southern Health Service	Mrs Carol Madge Director of Health Service Development Southern Health Service PO Box 1845 QUEANBEYAN NSW 2620 Ph (02) 6299 6199 Fax (02) 6299 6363	Ms Sally Calder Manager Policy & Primary Health Care Southern Health Service PO Box 1845 QUEANBEYAN NSW 2620 Ph (02) 6299 6199 Fax (02) 6299 6363
3	Ms Elena Murty Policy Adviser Wentworth Area Health Service PO Box 63 PENRITH NSW 2751 Ph (02) 4724 2811 Fax (02) 4731 1265	Mr Geoff Murphy Director, Executive Support Wentworth Area Health Service PO Box 63 PENRITH NSW 2751 Ph (02) 4724 2375 Fax (02) 4731 1265
Western Sydney Area Health Service	Ms Jennifer Sheehan Planning Officer Western Sydney Area Health Service Area Executive Unit, Westmead Hosp. Cnr Darcy and Hawkesbury Roads WESTMEAD NSW 2145 Ph (02) 9845 7010 Fax (02) 9689 2041	Ms Stephanie Prinitis Executive Assistant Western Sydney Area Health Service C/- Westmead Hospital Cnr Darcy and Hawkesbury Roads WESTMEAD NSW 2145 Ph (02) 9845 7285 Fax (02) 9689 2041

RESEARCH GOVERNANCE IN NSW PUBLIC HEALTH ORGANISATIONS
(GL2011_001)

GL2011_001 rescinds PD2005_207.

PURPOSE

The purpose of this guideline is to facilitate and support the responsible conduct of quality research in NSW Public Health Organisations through an effective research governance framework.

KEY PRINCIPLES

Health and medical research is integral to quality health care systems. It leads to improved health outcomes through enhanced prevention and treatments, and changes in professional practice. Engaging in research activities to advance health and wellbeing is encouraged and supported by NSW Health as part of its overall commitment to improving the health of the people of New South Wales (NSW). While investing in health and medical research can lead to far-reaching benefits for the wider community, it also has the potential to involve risk; risk to participants, institutions, and investigators. Public support, confidence and trust in research conducted in NSW Health is reliant upon an effective governance framework which manages these risks and ensures that all research meets the highest ethical, scientific, regulatory and professional standards.

USE OF THE GUIDELINE

This guideline summarises the principles, standards and requirements for the responsible conduct of quality research. It also clarifies the responsibilities and accountabilities of key parties involved in research taking place in NSW Public Health Organisations. Public Health Organisations are responsible for using this guideline to develop their local operating procedures which clearly define the roles, responsibilities and accountabilities of parties involved in research taking place within their premises. The local operating procedures should also define systems and processes to ensure compliance with the principles, standards and requirements of associated legislation and NSW Health policy directives as outlined in this document.

Chief Executives of Public Health Organisations are responsible for ensuring that appropriate research governance personnel, systems and structures are in place (section 4.1).

Specific responsibilities and accountabilities apply to **investigators** (section 4.2). **Directors of research** or their equivalent, **Research Governance Officers**, **heads of departments** who host and support research and **managers of investigators** all play a key role in research governance (section 4.3).

All parties involved in research taking place in Public Health Organisations, regardless of their position, employment status and level of engagement in the research are responsible for familiarising themselves with and adhering to the principles, standards and requirements outlined in this guideline.

The Guideline can be downloaded from
http://www.health.nsw.gov.au/policies/gl/2011/GL2011_001.html

117(27/01/11

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PRESSURE INJURY PREVENTION AND MANAGEMENT (PD2021_023)

PD2021_023 rescinded PD2014_007

POLICY STATEMENT

All staff involved in patient care in NSW Health facilities/services are responsible for minimising the risk of pressure injuries through timely identification and management of modifiable risk factors and when pressure injuries are present appropriate treatment is provided.

SUMMARY OF POLICY REQUIREMENTS

On presentation/admission to a health service, all patients are to be screened to identify pressure injury risk factors, using an agreed risk screening process to guide clinical decision making.

If risk factors are identified, in partnership with the patient/family/carer, a plan of care with agreed strategies/interventions is to be developed considering the patients preferences and goal of care.

All care and treatment delivered to people who are at risk of pressure injury development or with an existing pressure injury is to be person centred and culturally sensitive.

A multidisciplinary approach to care provision to ensure appropriate intervention/strategies are implemented based on risk factor/s. The care plan is to be reviewed regularly for effectiveness, with referral to specialist providers as required.

Individuals with identified risk factors are to have regular skin assessments to monitor the effectiveness of prevention strategies.

Systems are in place to ensure adequate expertise, resources, products and equipment are readily available and accessible to provide best practice in pressure injury prevention and management.

All pressure injuries are to be documented in the medical record, specifying the classification and dimensions, anatomical location and if the pressure injury was acquired during the current episode of care or was pre-existing.

Clinical staff, who care for patients at risk of developing pressure injuries or with existing pressure injuries, are to undertake training in pressure injury prevention and management.

Systems and processes are to be in place to report/notify hospital/health service acquired pressure injury incidents, monitor and analyse pressure injury data, and implement relevant quality improvement activities to improve patient care as required.

A patient's pressure injury prevention and management health care needs are to be integrated into their transition of care planning process.

Pressure Injury Prevention and Management: Procedure.

1 BACKGROUND

1.1 About this document

Pressure injuries are a frequently occurring health problem and reduce quality of life through pain and discomfort. They are a costly, and often preventable with many individuals at risk due to aging, frailty, and multimorbidity.[1,2,3] *The Australian Commission on Safety and Quality in Health Care (ACSQHC)* has designated pressure injuries as a Hospital Acquired Complication (HAC). HAC is a complication for which clinical risk mitigation strategies may reduce, but not necessarily eliminate, the risk of a complication occurring.4 Prevention of pressure injuries is the responsibility of all staff who work in health, regardless of location and position. Staff, patients and carers have a role to play in the prevention of pressure injuries.[3]

The Policy Directive is revised in accordance with the International Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, 2019.[3] The Guideline is a collaboration between three partner organisations – the European Pressure Ulcer Advisory Panel (EPUAP), the National Pressure Injury Advisory Panel (NPIAP) and the Pan Pacific Pressure Injury Alliance (PPPIA). The goal of the guideline is to provide an update of evidence-based recommendations for the prevention and treatment of pressure injuries.[3]

The National Safety and Quality Health Service Standards (NSQHSS), Comprehensive Care Standard [5], describes the systems and strategies to provide comprehensive care and identify risk of harm including the development of pressure injuries. This Policy also aligns with the Partnering with Consumers Standard, which ensures that systems are in place to design, deliver and evaluate care in partnership with consumers.[5]

The Comprehensive Care Standard requires that:

- Systems are in place to support clinicians to deliver comprehensive care
- Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed, comprehensive care plan
- Safe care is delivered based on the comprehensive care plan, in partnership with patients, carers and family, including patients who are at the end of life
- Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.[5]

Evidence-based approaches to pressure injury prevention and management include:

- Timely identification of risk factors
- A standardised and documented risk screening process to identify if an individual is at risk of developing a pressure injury and guide clinical decision making
- Regular skin assessment for individuals with identified risk factor/s
- Communication of identified risk
- Engaging with patients and their carer/s in a culturally sensitive manner
- Developing, implementing and reviewing of a plan of care that is:
    - Tailored to the individual's goal of care, preferences and addresses their risk factors
    - Focused on prevention and wound healing if a pressure injury is present
    - Comprehensive and interdisciplinary
    - Delivered by staff with appropriate knowledge and skills who use evidence based prevention and management strategies and resources
    - Inclusive of access to appropriate products and equipment
- Systems to monitor and analyse pressure injury data, and to implement quality improvement activities.[3,5]

It should be noted that even when all appropriate prevention strategies are consistently implemented to reduce the risk, in some cases pressure injuries are unavoidable, e.g. patients with skin failure at end of life.[3,12]

Pressure Injury Prevention and Management resources are available on the Clinical Excellence Commission website for different care settings, including flowcharts Prevention and Management of Pressure Injuries for:

- Inpatients
- Residents of Multi-Purpose Service (MPS) Long Stay Facilities and NSW Health Residential Aged Care (RAC) Facilities
- Non-Inpatients (Community Services, Ambulatory Care or Clinics).

1.2 Key definitions

Active support surface
A powered support surface that produces alternating pressure through mechanical means, providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternating of air pressure in air cells on a programmed cycle time. Also called an alternating pressure support surface or a dynamic support surface.[3]

Bony prominence
An anatomical projection of bone.[3]

Carers
People who provide care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged.

Carers provide emotional, social or financial support.[6] Carers provide support for activities of daily living and include parents and guardians caring for children.

Classification of pressure injuries
Pressure injuries are classified using the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) 2009/2014 classification system cited in the Australian Wound Management Association *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012.*[7]

Community Services
Services provided in the community setting and include but not limited to, Generalist Community Health Services, Palliative Care Services, Hospital in the Home, Child and Family Health Services, Chronic Care Services, Continence Services, Ostomy Services, Diabetes Services and Podiatry Services.

Mucosal pressure injury
Mucosal membrane pressure injuries are pressure injuries of the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts. Mucosal pressure injuries are primarily caused by medical devices exerting sustained compression and shear forces on the mucosa. Classification systems for pressure injuries of the skin and underlying tissue cannot be used to categorize mucosal pressure injuries.[3]

NSW public health facility
Any clinical unit or service that delivers public healthcare services. Health facilities include hospitals, multi-purpose services, emergency services, ambulatory care services, Aboriginal Medical Services and community health services and clinics.

Plan of care
Outlines the types and frequency of services required and the service provider details to meet care needs and mitigate identified risk factors.

Pressure Injury
Localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear and friction. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object.[3,10]

Pressure injury risk identification
A process to support identification of an individual's risk of developing a pressure injury.

Primary Care Provider
Primary healthcare providers include but are not limited to – General Practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal Health Workers.

Risk screening
A process to support identification of an individual's risk of developing a pressure injury.[3]

Reactive Support Surface
Powered or non-powered support surface with the capability to change its load distribution properties in response to an applied load.[11]

Skin assessment
Examination of the entire skin surface from head to toe to check integrity and identify any characteristics indicative of pressure damage/injury. This entails assessment for erythema, blanching response, localised temperature changes compared to surrounding skin, oedema, induration and skin breakdown. Consider different skin tones. The skin beneath devices, prosthesis and dressings are to be checked when practical and safe to do so.[3]

Staff
Any person working within the NSW Health system including clinicians, contractors, students and volunteers.

Unavoidable Pressure Injuries
Pressure injuries which occur despite consistent application of pressure injury prevention interventions. The implemented interventions were consistent with the patient's needs, goals, and recognised standards of practice, and there is evidence of monitoring and evaluation/revision of the interventions.[12]

Wound-related pain
An unpleasant sensory and emotional experience associated with a pressure injury. Patients may use different words to describe pain including discomfort, distress and agony.[8] Patients with cognitive impairment or expressive dysfunction may be unable to communicate their pain.

2 GOVERNANCE

Health services are to have a senior manager and/or a governance group responsible for the health service pressure injury policies, procedures and protocols, ensuring there are systems and processes in place to monitor and analyse pressure injury data and conduct/support relevant quality improvement activities.[5]

3 PARTNERSHIP WITH PATIENTS AND/OR CARERS

Health services are to have systems to engage and partner with consumers and carers in care, to the extent that they choose. Education is to be provided to patients and their carers to address their pressure injury risk factors, and appropriate prevention and management strategies. This is to be supplemented with written information in plain language and resources for culturally and linguistically diverse populations. Information is easy to understand which will support partnerships.

Interpreters may be required for patients who are hearing impaired, those not fluent in English or whose preferred language is a language other than English.

Document partnering with patients and carers in the medical record when developing care/management plans and have open disclosure when a pressure injury develops during an episode of care.

Information to support the ongoing management of risk factors is to be provided on transition of care/discharge.[5]

4 CLINICAL PRACTICE REQUIREMENTS

4.1 Conduct screening

Health services are to have systems and processes appropriate for their patient populations, which identify risk factors and support care planning and shared decision making.

Patients are to be screened for pressure injury risk as early as possible on presentation/admission:

- Within 8 hours of presentation to a health facility for inpatient and Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities
- At the first home visit or presentation for non-inpatient (community services, ambulatory facilities or clinics with clients at high risk) services.

Risk screening must consider the three primary predictors of pressure injury development:

1) Mobility/activity and neurological status - which can be restricted by the following but is not limited to physical limitations, over/under weight, sensory deficits, impaired cognition, low affect, demotivation, medication/anaesthetic or pain.
2) Perfusion – related to diabetes, peripheral artery disease, venous insufficiency, respiratory disease, organ failure, medication.
3) Skin status (as reported by the patient or the carer):
   a) General skin status relating to factors which may make the skin more vulnerable to pressure injury, e.g., redness, moisture, dryness, oedema
   b) Skin integrity including current and previous pressure injuries.[9]

Patients with a history of or if a current pressure injury exists may be at risk of developing further pressure injuries.

4.2 Conduct skin assessment

When pressure injury risk factor/s are identified through the initial screening process, the patient is to have a documented skin assessment. Where skin assessment is outside the clinician's scope of practice, referral for skin assessment may be required. Ongoing, regular skin assessment appropriate to the care setting is required. See table 1 below.

In some situations, the patient may not give consent or is unsuitable to undergo a full skin assessment. The clinician must record in the medical record the reason why the skin assessment was not undertaken. In clinical situations when the risk of doing a skin assessment is outweighed by other risks to the patient or staff, the assessment is to take place as soon as practical after the risk is mitigated. Risks include:

- Clinical instability e.g. acute spinal cord injury, unstable fractures, active bleeding
- Medical device patency e.g. extracorporeal membrane oxygenation (ECMO), intraarterial lines/sheaths
- Dressing wear time e.g. severe burn injury, negative pressure wound therapy
- Potential for physical harm to the patient or staff e.g. delirium, behavioural disturbance, psychological trauma e.g. sexual assault, cultural sensitivity, trauma history, mental illness
- Imminent death.

The skin assessment is to include a comprehensive head to toe assessment, focusing on skin overlying bony prominences including the occiput, sacrum, buttocks, heels, hips, pubis, thighs and torso. When the patient has a medical device the skin assessment is to include the skin under and around the device. For neonates, young children and critically unwell patients, the occiput requires careful attention.[3,10]

Patients are to be reviewed if there is a change to a patient's health status or mobility, pre-operatively, as soon as feasible after surgery, postnatally prior to leaving the birthing setting, at transition of care, prior to discharge and if a pressure injury develops. If risks are identified, the plan of care is to be reviewed and ongoing skin assessment is required. If pressure injury risk factors are no longer present regular skin assessment is not required.

Table 1: Identification of risk factors, skin assessment and care plan review requirements based on the care setting1.

	Inpatients	Multi-Purpose Service (MPS) long stay facility residents and NSW Health Residential Aged Care (RAC) facility residents.	Non-inpatients (community services, ambulatory care or clinics with clients at high risk)
First pressure injury screening and skin assessment to guide clinical decision making	1. Screened as soon as possible - no later than 8 hours of presentation 2. Skin assessment on identification of risk factors	1. Screened within 8 hours of presentation 2. Skin assessment on identification of risk factors	1. Screened at the first home visit or presentation 2. Skin assessment (if practicable) on identification of risk factors
Identified risk factor/s	Skin assessment and plan of care reviewed daily, and: • Change in health status or mobility • Pre-operatively, and as soon as feasible after surgery • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement	Skin assessment daily and plan of care reviewed regularly (on agreed review date), and: • Change in health status or mobility • Clinical change impacts on the needs, goals or preferences of the consumer • Transition of care • If a pressure injury develops • Based on clinical judgement	Skin assessment and review of plan of care monthly (as a minimum) and: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
No identified risk factor/s	Reassess: • Change in health status or mobility • Post operatively • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement	Reassess: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement	Reassess: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
Pressure injury/ies - skin assessment and pain assessment completed and documented	During each shift as a minimum	During each shift as a minimum	At each home visit/appointment

[1] NB. Community services who are not the primary care provider for clients/consumers identified at risk for pressure injury are to provide education to the client/consumer and/or carer and primary provider. This will increase awareness and understanding of risk factors and their role in ongoing monitoring of skin integrity and the plan of care. People with spinal cord injury and other neurological disorders are at life-long high risk for pressure injuries. The plan of care is to be reviewed regularly, particularly if there is a change in health status or mobility.

4.3 Develop a prevention plan

For patients/clients who are at risk of, or have an existing pressure injury, the plan of care needs to:

- Be developed with the person, and/or their carer (when able) and documented in their medical record
- Include strategies aimed at preventing pressure injury/injuries and optimising healing and preventing complications of current pressure injury/injuries
- Document how the patient and/or carer are involved in the pressure injury prevention and management care planning process
- Have input from the interdisciplinary team about additional assessment, recommendations and treatment
- Be communicated via documentation in the medical record
- Be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and within twenty-four hours of initial home visit for community services
- Have risk communicated, e.g. through the use of patient journey boards and care boards
- Be verbally communicated during bedside handover, intentional-rounding, safety huddles, journey board meetings and at transition of care.

4.4 Prevention Strategies

Patients with risk factors for pressure injury, either with or without pressure injury, are to have:

- Evidence based prevention strategies implemented as a priority within two hours of risk identification
- Targeted interventions/strategies based on the risk factor(s) identified and reviewed regularly for their effectiveness.

Repositioning and/or early mobilisation schedule to prompt or assist repositioning as clinically indicated and using appropriate manual handling techniques and equipment. Patients are to be educated and encouraged to perform independent, pressure relieving manoeuvres when able.

- A 30-degree side lying position is to be used when repositioning individuals in bed. Keep the head of the bed as flat as possible at no greater than 30-degrees elevation unless clinically necessary to facilitate breathing and/or prevent aspiration and ventilator-associated pneumonia.3

The knee break function is to be used to prevent the patient from sliding down the bed to reduce shear forces. The torso to thigh angle is to be no greater than 30-degrees.[3]

Pressure redistribution

- Mattress support surfaces which meet individualised requirements (i.e. weight, moisture, temperature, width, static or active surface types) are to be considered and regularly reviewed.
- Support surfaces (such as active and reactive) are to be used during care, including emergency departments, operating room, intensive care, dialysis units, and during transportation when clinically indicated and appropriate.

NB: In unstable spinal or pelvic fracture, active support surfaces are contra-indicated.
This is regardless of the patient having identified risk factors for pressure injury or an existing pressure injury. Patients with unstable spinal or pelvic fracture are to stay on the appropriate non-powered support surface and receive regular pressure relief through lifting, as per spinal and pelvic fracture protocols.

- Seating support surfaces which meet the individualised requirements are to be considered and regularly reviewed.
- Other pressure redistribution and offloading equipment (e.g. repositioning devices or aids) are to be used according to individualised requirements and goals of care.
- Heels, Achilles tendon and popliteal vein are to be offloaded completely to distribute the weight of the leg along the calf.[3]

Medical devices
- Devices/orthoses, compression therapy/stockings, casts/splint and other devices are to be correctly fitted, repositioned or removed regularly to have underlying skin inspected. Devices and orthosis need to be checked within 1-2 hours of first application to ensure there is no pressure.10 The paediatric population is at increased risk of device related pressure injury.

Reduction of shear and friction:
- Prophylactic dressings - note dressing products do not reduce pressure
- Appropriate manual handling techniques and equipment

Pain Management ensures patients have adequate pain management to support early mobilisation and repositioning.

Education of patients/carers on the importance of regular repositioning and other prevention strategies which address risk factors.

Skin protection and moisture balance:
- Skin is cleaned and hydrated
- Skin is protected from excessive moisture with a barrier product
- Vigorous massage or rubbing of the skin is to be avoided as this can cause damage from shear and friction.

Continence management for persons with incontinence
- A continence management plan is to be developed that facilitates individualised toileting, change of continence aids, and regular skin care.
- Highly absorbent continence products to protect the skin in individuals with or at risk of pressure injuries who have urinary and/or faecal incontinence. These need to be checked and changed regularly.
- Skin is to be cleansed after each episode of incontinence.

Adequate nutrition and hydration, is to be provided, including:
- Consideration of adequacy of total energy (calorie), protein, fluid, vitamin and mineral intake
- Screening for nutritional deficiencies
- Nutrition assessment by a Dietitian (where available) if with or at risk of malnutrition or for those with severe pressure injuries (stage 3, stage 4, Unstageable and Suspected Deep Tissue). Risk factors for malnutrition may include unintentional weight loss, poor appetite, reduced oral intake, and increased gastrointestinal losses (e.g. diarrhoea, vomiting)
- Consideration of high energy high protein supplements, and/or arginine if recommended by a Dietitian or Medical Officer
- Feeding assistance, if required.

Referral to health disciplines are to be made as clinically indicated for additional assessment and treatment.

4.5 Assess existing pressure injuries

Classification and assessment of pressure injuries is to occur when a pressure injury is identified, during serial wound management and on transfer of care (at the next dressing change). Pressure injuries are classified using the EPUAP/NPUAP 2009/2014 classification system.

Pain assessments are to be conducted to include pain management in the plan of care.

4.6 Managing existing pressure injuries

Plan of care that addresses risk factors and includes wound and pain assessment and management. The plan of care is to be reviewed by the multidisciplinary team within twenty-four hours of pressure injury identification wherever possible. If a pressure injury develops or an existing pressure injury significantly deteriorates (progresses to a more severe stage) the patient is to be reviewed.

Wound Management is to be provided or supervised by clinicians with knowledge, skills, and resources to provide treatment in accordance with best practice.

4.7 Monitor and document

Document in the medical record and complete wound chart(s) for pressure injuries, including if they were present on presentation or developed during the episode of care.

Pressure injuries are to be notified through the incident management system if the injury was acquired during the current episode of care. Documentation is to include a pressure injury classification, anatomical location and dimensions. Capture and upload an image of the pressure injury as part of the documentation to monitor outcomes.

Wound reassessment is to occur as frequently as required, but at least weekly. Severe or a pressure injury that is not healing as anticipated, i.e. 25% reduction in four weeks3 are to be reviewed by a clinician with expertise in wounds.

Consultations are to occur in a timely fashion with clinicians with expertise in wounds, medical or other health disciplines for their assessment, management and interventions. The use of virtual health to facilitate the consultation and reduce the need for patient or clinicians to travel is to be considered.

Pain is to be assessed and managed using best practice guidelines (using a validated pain tool) and documented.

Nutritional support is to be provided in accordance with NSW Health Nutrition Care Policy.

Prevention of additional pressure injuries as patients with a pressure injury are at a high risk of the injury worsening or developing other pressure injuries. See section 4.4 on prevention strategies.

4.8 Transition of Care

Transition of care for a patient at risk or with a pressure injury requires timely communication with health care providers taking over/resuming care, the patient and/or their carers, other community or residential services, equipment suppliers, and allied health clinicians.

Communication is to include:

- Goals of care (healing, maintenance, or palliation)
- Classification, anatomical location and dimensions of the pressure injury
- Wound management
- Ongoing prevention/management strategies
- Follow-up care.

Prevention strategies are to be used during transportation or transition of care for patients at risk or with an existing pressure injury.[3]

5 RESOURCES

All health services are to have systems in place so that adequate expertise and resources, including equipment, devices and products, are available and accessible to provide best practice in pressure injury prevention and management.

Pressure injury prevention products, devices and equipment are to be purchased in accordance with NSW Health Procurement Guidelines and used in accordance with:

- The manufacturers' instructions
- NSW Health Infection Control Policies
- NSW Health Workplace Health & Safety Policy.

6 EDUCATION AND TRAINING

Clinical staff providing care to patients at risk of or with pressure injuries are to undertake training in pressure injury prevention and management, modules are available on My Health Learning.

Health services are to have:

- Orientation and ongoing training programs related to pressure injury prevention and management available to ensure staff have the knowledge, skills and resources to deliver quality care
- Health professionals with expertise are available to provide clinical education for pressure injury prevention and management for staff caring for patients with complex needs
- Targeted education available for:
    - Clinical coders on pressure injury classification and condition onset
    - Auditors who conduct audits related to pressure injuries
- Systems in place to monitor education and records of training for staff on preventing and managing pressure injuries.

7 REPORTING

7.1 Pressure injury incidents

Hospital/health service-acquired pressure injuries, which have developed after eight hours of presentation, are to be notified in the incident management system and communicated to the admitting medical team or primary care provider. Notification is also a requirement for pressure injuries that have deteriorated (progressed to a more severe pressure injury) since admission. Unstageable pressure injuries and suspected deep tissue injuries require review for definitive staging.[13] Where definitive staging is likely to occur after the transition of care, the health service is to communicate with the ongoing care provider to confirm staging. Definitive staging is to be entered into the medical record and the incident management system particularly for unstageable pressure injuries or suspected deep tissue injuries that are staged as a stage 3 or stage 4.

Hospital/Health Service-acquired pressure injuries are reviewed and recommendations reported and monitored in accordance with the NSW Health Policy Directive *Incident Management* (PD2020_047). When a pressure injury occurs or deteriorates to a more severe injury during an episode of care, the patient and/or carer are informed in accordance with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028).

Stage 3, stage 4, unstageable and suspected deep tissue pressure injuries which are hospital/health service-acquired are to have a clinician with expertise in wound management on the Incident Review Team, where possible.

Pre-existing pressure injuries do not require notification in the incident management system. These are to be documented in the medical record and wound chart.

7.2 Monitoring

Health services are to have systems in place to:

- Identify pressure injuries that develop during the episode of care
- Review pressure injury data regularly, at a minimum quarterly
- Ensure pressure injury data is communicated to the health service executive and those responsible for governance of clinical care
- Analyse pressure injury data to inform care, quality improvement activities and monitor progress.

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9 RELATED LITERATURE, DOCUMENTS AND RESOURCES

- NSW Procurement Guidelines
- NSW Health polices and guideline (i.e. incident management, nutrition care, open disclosure, infection control and workplace health and safety) can be found at: https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx
- Leading Better Value Care Standards for Wound Management September 2019 http://eih.health.nsw.gov.au/__data/assets/pdf_file/0010/558352/NSWHealth_Wound-Standards_September-2019.PDF
- Australian Commission on Safety and Quality in Health Care March 2018 https://www.safetyandquality.gov.au/sites/default/files/migrated/Pressure-injuryshort-clinician-fact-sheet.pdf

CARE TYPE POLICY FOR ACUTE, SUB-ACUTE AND NON-ACUTE AND MENTAL HEALTH ADMITTED PATIENT CARE (PD2016_039)

PD2016_039 rescinds PD2014_010

PURPOSE

'Care type' refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding. This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded:

- Acute care is classified using the Australian Diagnosis Related Groups (AR-DRGs)
- Sub-Acute and Non-Acute care is classified using Australian National Subacute and Non-Acute (AN-SNAP) classification
- Mental health care is classified using the Australian Mental Health Care Classification.

This version of the Policy Directive introduces the mental health care type.

MANDATORY REQUIREMENTS

Local Health Districts (LHD) and Specialty Health Networks (SHN) are responsible for accurately reporting the clinical activity within their facilities to the NSW Ministry of Health in order to meet State and Commonwealth reporting requirements.

In order to do so, clinical services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided.

When the clinical purpose or treatment goal changes so must the care type.

The care type to which the episode is allocated must always be evidenced by documentation in the patient health record.

IMPLEMENTATION

Chief Executives are required to ensure that:

- Staff responsible for entering care type changes are made aware of and gain an understanding of the provisions of this policy directive, and
- Relevant staff comply with this Policy Directive.

1 BACKGROUND

1.1 About this document

NSW Health Services have an obligation to count and classify activity in a meaningful and consistent manner. The Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care provides a framework to ensure assignment to and changes in care type occur appropriately and correctly. Implementation of this policy will contribute to ensuring that information reflecting the patient's episode of care is accurate and reflects the type of care provided to the patient.

In 2013 the Australian Institute of Health and Welfare (AIHW) developed a revised set of National care type definitions. This work was commissioned by the Independent Hospital Pricing Authority in order to achieve consistency in classification of admitted patient activity.

There are currently eleven (11) care types in use in New South Wales, they are:

- Acute Care
- Rehabilitation
- Palliative Care
- Maintenance Care
- Newborn Care
- Other Care (note: this category is included for completeness, but is not applicable for admitted patients in NSW. This care type generally applies to residential aged care patients only)
- Geriatric Evaluation and Management (GEM)
- Psycho-geriatric
- Organ Procurement
- Hospital Boarder
- Mental Health.

1.2 Key definitions

Care Type (previously known as 'service category')

Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care.

Care Type Change

An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient. For example, a patient who is receiving acute intervention for a stroke will have a care type change to rehabilitation if and when the main focus of care changes from acute management to functional improvement.

When the intensity of treatment or resource utilisation changes but the primary clinical purpose or treatment goal does not change, a care type change is *not* warranted.

A reduction in the intensity of acute care does not trigger a change to a sub-acute care type if the patient is not receiving care that meets the definition of a sub-acute care type. It is therefore essential that any care type change reflects a *clear change* in the primary clinical purpose or treatment goal of care provide.

With respect to the mental health care type, for 2016/17 a type change is to occur when a patient is transferred into or out of a specialist mental health unit. Transfers between specialist mental health units will not trigger a care type change.

All care type changes must be clearly documented.

The 11 Care Types are defined below. A full list of definitions is also provided at Appendix 2.

2 PURPOSE

'Care type' refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care.

Admitted patient care is provided in a variety of settings. The care type allocated to an episode of care is independent of the location of the patient, and reflects the primary clinical purpose of the care provided.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding (ABF). This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded:

- Acute care is classified using AR-DRGs
- Sub and Non-Acute care is classified using AN-SNAP.
- Mental Health care is classified using AR-DRGs(for 2016/17).

The care type to which the episode is allocated must be evidenced by documentation in the patient health record, i.e. if an episode is allocated to a rehabilitation care type, there must be evidence in the medical record that rehabilitation care, meeting the National Definition (refer below) is occurring.

The care type allocated *should not* reflect the care that is intended for the patient to receive at some time in the future when, for example, another service takes over care of the patient or when the patient is moved to a different ward.

3 INTENDED AUDIENCE

This policy applies to all staff responsible for the clinical care and / or admission details of patients at all facilities within NSW providing admitted patient care. This includes all medical, nursing, allied health staff and relevant administrative staff such as ward clerks, admission officers, admitted patient data co-ordinators, clinical coders and health information managers.

4 EXPECTED OUTCOMES

The expected outcomes are:

- The care type of all episodes in NSW Health facilities accurately reflects the care provided.
- Statistical information is accurate and timely.
- NSW Health submission requirements for the Admitted Patient Data Collection are met.
- NSW Health submission requirements for the AN-SNAP Data Collection are met.
- NSW Health submission requirements to the Activity Based Funding: Mental Health Care DSS are met.
- Data will be available to assist in ensuring facilities will receive appropriate funding for the care they provide.
- NSW Health submission requirements to the National Hospital Cost Data Collection (NHCDC) are met.

5 PURPOSE

Local Health Districts (LHDs) and Specialty Health Networks (SHNs) are responsible for accurately reporting the clinical activity within their facilities to the NSW Ministry of Health in order to meet State and Commonwealth reporting requirements.

In order to do so, clinical services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided.

When the clinical purpose or treatment goal changes, so must the care type.

6 NATIONAL CARE TYPE DEFINITIONS

6.1 Acute care type

Acute care type

The primary clinical purpose or treatment goal is to:

- Manage labour (obstetric)
- Cure illness or provide definitive treatment of injury
- Perform surgery (other than when the exceptions documented in the included guidelines apply)
- Relieve symptoms of illness or injury (excluding palliative care)
- Reduce severity of an illness or injury
- Perform diagnostic or therapeutic procedures, and / or
- Protect against exacerbation and / or complication of an illness and / or injury which could threaten life or normal function.

6.2 Rehabilitation care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition.

The patient will be capable of actively participating. Rehabilitation is always:

- Delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that includes negotiated goals within specified time frames and formal assessment of functional ability.

6.2.1 Rehabilitation care guidelines

- When an acute patient is waiting for Rehabilitation, but Rehabilitation care has not yet commenced, a care type change to Rehabilitation cannot occur. The patient must remain in an acute care type until rehabilitation care begins. In some instances a care type change to maintenance may be warranted.
- If Rehabilitation is occurring on an acute ward, the Rehabilitation care type should be used, as care type is independent of patient location.
- The period of recovery at the end of an acute episode prior to separation (for example, the final 1-2 days after a joint replacement) is not necessarily a separate episode and should not trigger a care type change to rehabilitation. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of Rehabilitation (as stated above) is met, the care type remains acute.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- Patients who receive acute same day interventions, such as dialysis, during the course of a Rehabilitation episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the Rehabilitation episode of care.

6.3 Palliative care

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and / or spiritual needs. Palliative care is always:

- Delivered under the management of, or informed by a clinician with specialised expertise in palliative care, and
- Evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, which covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

6.3.1 Palliative care guidelines

- Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptom relief.
- Patients referred to the Emergency Department (ED) by a clinician for palliative care should have a care type of Palliative Care assigned from the ED time of admission.

6.4 Maintenance care

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition.
Following assessment or treatment, the patient does not require further complex assessment or stabilisation. Patients with a care type of 'maintenance care' often require care over an indefinite period.

6.4.1 Maintenance care guidelines

- Care provided to a patient, who would normally not require hospital treatment and would be more appropriately treated in another setting, which is unavailable in the short term, or where there are factors in the home environment making it inappropriate to discharge the patient in the short term. For example:
    - A patient requires home modifications in order to be safely discharged home. The modifications are not yet complete and therefore, although ready for discharge the patient cannot safely return home.
    - A patient requires nursing home placement and although ready for discharge a place is not yet available. The patient has a current acute care certificate.
- Nursing Home Type patients for whom there is no acute care certificate.
- Patients in receipt of care where the primary reason for admission is respite.

6.5 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the patient is separated.

6.5.1 Newborn care guidelines

- Patients who turn 10 days of age and require clinical care must continue in the newborn episode of care (that is "5 – Newborn") until separated. A type change to care type "1 – Acute" must not be performed.
- Patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders.
- Patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type.
- Patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type.
- Within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- A newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status, see Appendix 2 for details
- Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such
- This care type can only ever be allocated at the time of admission. As a result, there can never be a care type change to 'Newborn'.

6.6 Other care

Other admitted patient care is care that does not meet the definitions above.

6.6.1 Other care guidelines

- This care type is included for completeness only; it is not applicable to admitted patients in NSW.
- The purpose of care type of 'Other' is to collect non-admitted activity reported via a patient administration system (PAS). This activity may include community residential care, and residential aged care covered by Commonwealth Block funding.
- Activity collected using this care type is excluded from any reporting of admitted patient care in NSW. This activity is used in cost allocation of residential services in the DNR (District and Network Return)

6.7 Geriatric Evaluation and Management (GEM)

Geriatric Evaluation and Management care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as a tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems. Geriatric Evaluation and Management is always:

- Delivered under the management of, or informed by a clinician with specialised expertise in geriatric evaluation and management, and
- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability

6.7.1 Geriatric Evaluation and Management guidelines

- When an acute patient is waiting for GEM, but GEM care has not yet commenced, a care type change to GEM cannot occur. The patient must remain in an acute care type until GEM care begins. In some instances a care type change to maintenance may be warranted.
- If GEM is occurring on an acute ward, the GEM care type should be used, as the care type is independent of patient location.
- The period of recovery at the end of an acute episode prior to separation (for example the final 1-2 days after a joint replacement), is not necessarily a separate episode and should not trigger a care type change to GEM. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of 'GEM' (as stated above) is met, the care type remains acute.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- Patients who receive acute same day intervention(s) during the course of a GEM episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the GEM episode of care.

6.8 Psycho-geriatric

Psycho-geriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and / or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related brain impairment or a physical condition.

Psycho-geriatric care is always:

- Delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.
- Psycho-geriatric care is not applicable if the primary focus of care is acute symptom control.

6.9 Organ procurement – posthumous

Posthumous organ procurement is the procurement of human organ or tissue for the purpose of transplantation from a donor who has been declared brain dead.

6.9.1 Organ procurement care type guidelines

- Once clinical staff confirm and document brain death of the patient, a care type change to "Organ procurement – posthumous" must be performed. Date and time of the type change should be recorded as the date and time of documented death, not the date and time the organ or tissue harvest has been completed.
- The posthumous organ procurement care type is to be used for all posthumous organ procurement, irrespective of whether the deceased patient is kept in ICU for the preservation of organs that require oxygen (e.g., heart or lungs, etc.), or whether the deceased patient is transferred to the morgue to await the removal of other tissue (such as corneas, etc.).
- Patients in an Emergency Department (ED) who die in the ED or are dead on arrival do not meet the criteria for admission. However, such patients whose organs are to be procured are to be registered on PAS and be assigned an 'Organ procurement – posthumous' care type.
- All 'Organ procurement – posthumous' care type episodes are in scope of reporting to the Admitted Patient Data Collection, though the posthumous organ procurement component of the admitted patient stay may be excluded from the calculation of specific KPIs and other activity measures
- Diagnoses and procedures undertaken during this activity, including mechanical ventilation and organ procurement should be recorded in accordance with the relevant ICD-10-AM / ACHI Australian Coding Standards.

For more detail refer to the Admitted Patient Data Collection Intranet site.

6.10 Hospital boarder

A hospital boarder is a person who is receiving food and / or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and / or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder.

Babies in hospital at age nine days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified. Unqualified newborn days (and separations consisting entirely of unqualified newborn days) are not to be counted for all other purposes, and they are ineligible for health insurance benefit purposes.

6.11 Mental health care

Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and / or psychosocial, environmental and physical functioning related to a patient's mental disorder.

Mental health care:

- Is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health
- Is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan and
- May include significant psychosocial components, including family and carer support.

6.11.1 Mental health care guidelines

- This care type is to be initially used for patients treated within a specialised mental health inpatient unit only. Other factors such as diagnosis, DRG assignment or treating specialist (where the patient is not in a specialised mental health unit are not to be used as criteria in assigning this care type.
- This care type is to be introduced across all LHDs and SHNs by 30 June 2017. For the 2016/17 reporting year, it will be used at a point as negotiated by the LHD or SHN and the NSW Ministry of Health during the 2016/17 reporting year.
- Assignment of this care type occurs when a patient is admitted or transferred into a specialised mental health unit. Movements into or out of a specialised mental health unit from other inpatient units, where it reflects a change in the primary clinical purpose or treatment goal of the inpatient episode, will trigger a type change, **with the following exceptions**:
    - Patients within non-mental health units who are transferred into ECT suites for regular ECT and then returned to the non-mental health unit following the ECT procedure are not to be type changed to the mental health care type for the provision of the ECT.
    - Patients within specialised mental health units who are transferred for regular procedures like chemotherapy or renal dialysis, or who go to an operating theatre, and who are returned to the specialised mental health unit following the procedure are not to be type changed from the mental health care type for the provision of the procedure.
- At the point of introduction by the LHD, all existing patients within specialised mental health units are to be type changed to this care type. The date for the type change can be either:
    - The date of the introduction of the care type by the LHD, or
    - The date when the patient was admitted or transferred into the specialist mental health unit. Under this criterion, long standing patients who were in the mental health unit prior to 1 July 2016 are to be backdated to 1 July 2016 only.
    - Note that the decision of which date to use is to be made by the LHD / SHN, and must be applied consistently across the entire LHD / SHN, and not on a facility by facility basis.
- Movements between acute mental health units and non-acute mental health units (rehabilitation or extended care mental health units) do not trigger type changes. They are all to be categorised within this single care type.

7 PROCEDURE FOR ASSIGNING CARE TYPES

7.1 Care type assignment upon admission

Only one care type can be assigned at a time. In cases where a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. For example if a patient is primarily receiving acute care and an in-reach rehabilitation team is also involved with the patient, the care type will be acute. When the focus of care provided to the patient shifts to functional improvement, the care type should be changed to rehabilitation at the point this shift in focus occurs.

The care type is assigned by the clinician responsible for the management of the care, based on clinical judgements as to the primary clinical purpose of the care provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for the management of the care.

For the mental health care type, the clinical judgement as to the primary purpose of the care forms part of the clinician's decision to admit a patient into the specialised mental health inpatient unit.

At the time of sub-acute care type assignment, a multidisciplinary management plan may not be in place but the intention to prepare one should be known by the clinician assigning the care type.

The clinician determining the appropriate care type to be assigned must ensure that clear documentation of the care type is recorded in the medical record. The clinician determining the appropriate care type to be assigned (or other authorised clinician) must ensure that the ward clerk (or staff member responsible for updating the Patient Administration System (PAS)) is informed of the care type decision.

The ward clerk (or staff member responsible for updating PAS) ensures the correct care type is assigned within the PAS.

7.2 Care type change during the admission event

During an admission or stay the primary clinical purpose or treatment goal of care may change. When this occurs, the care type also changes. It is essential that any change in care type is supported by documentation reflecting the change in purpose and goal of care.
Responsibility for the decision to change care type ultimately rests with the senior medical officer but may be delegated to other senior members of the clinical team. The process of care type change generally occurs as follows:

- Clinical staff assesses the patient, their clinical status and treatment needs and then determine the clinical purpose and goals of treatment. If the current care type accurately reflects the treatment goals and focus of care, no further action is required.
- If the current care type for the episode no longer reflects the clinical purpose and goals of treatment and the care provided fits the definition of another care type, then a care type change is warranted.
- The new care type is determined by the clinician who is taking over responsibility for the management of the care of the patient at the time of transfer. (Note, in some circumstances the patient may continue to be under the management of the same clinician).
- Two methods of initiating and informing the change to be made on the PAS are suggested, either:
    - On a form, or
    - In the healthcare record as a handwritten entry / label / stamp.

  Local processes will determine which method is most suitable. Regardless of the method used, the medical officer must ensure that clear documentation of the care type is recorded in the medical record.
  Documentation must include the following information:
    - When a separate form rather than a notation or sticker in the record is used, the MRN and patient name must be noted on the form
    - Date Effective: indicate the actual date the care type change is effective
    - Time Effective: indicate the actual time the care type change is effective
    - Indicate the new care type
    - If there is an AMO change, document the new AMO and their specialty.
- The receiving or primary clinician must authorise the care type change by signing the documentation.
- The receiving or primary clinician must ensure that the ward clerk (or staff member responsible for updating PAS) is informed that the care type change has occurred.

- The ward clerk (or staff member responsible for updating the PAS), updates the care type in PAS, along with any other relevant information that may have changed such as ward or AMO. It is important that the date of change recorded in PAS matches the actual date and time of the care type change.

7.2.1 Additional guidelines for care type change during admission

- A care type change or admission under a sub-acute or non-acute care type may trigger collection of the AN-SNAP data variables.
- Where AN-SNAP data is collected, care must be taken to ensure reconciliation of care type and care type change dates between SYNAPTIX and the PAS.
- The clinician responsible for the management of care may not necessarily be located in the same facility as the patient. This may be the case when a 'hub and spoke' model of care is in place. In these circumstances, a clinician at the patient's location may also have a role in the care of the patient; the expertise of this clinician does not affect the assignment of care type.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- It is highly unlikely that, for care type changes involving sub-acute care types, more than one change in care type will take place within a 24 hour period. Changes involving sub-acute care types are unlikely to occur on the date of formal separation.
- Patients who receive acute same day intervention(s) during the course of a sub-acute or non-acute episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the sub-acute or non-acute episode of care.
- Palliative care episodes can include grief and bereavement support for the family and carers of the patient where it is documented in the patient's medical record.
- All care type changes must be updated on the PAS at the time of (or as close to) the care type change.
- An Acute Care Certificate should not influence the classification of a patient to a particular care type. Patients may have an Acute Care Certificate and be classified as other than "1 – Acute".
- The completion of an Aged Care Client Record (ACCR) form should not influence the classification of a patient. For example patients may not have an ACCR form completed but the episode can still be care type 'Maintenance'
- Regular training sessions for ward and clinical staff should be conducted to ensure that reviewing patient care types becomes part of daily ward routine.

7.3 Retrospective care type changes not identified during the admission event

The care type should not be retrospectively changed unless it is:

- For the correction of a data recording error, or
- The reason for change is clearly documented in the patient's medical record and it has been approved by the hospital's director of clinical services or delegated officer, or
- As a result of the introduction of a new care type which can apply retrospectively.

It is the responsibility of the staff member identifying the retrospective care type change to ensure that the care type change details have been updated in the patient administration system and to notify staff responsible for patient movement reconciliation processes.

Appendix 1 contains a number of care type change scenarios.

8 REFERENCES AND RELATED POLICIES

- Inter-Government and Funding Strategies Branch (2008), *PD2008_063 Episode Funding Policy 2008/2009 – NSW*, NSW Health
- Admitted Patient Data Dictionary (2009), *Service Category*, NSW Health
- Casemix Policy Unit (2005), NSW SNAP Data Collection: Data Dictionary v 3.0, NSW Health
- Corporate Governance & Risk Management Branch (2007), *Section 5: Nursing Home Type - Fees Procedure Manual for Public Health Organisations*, NSW Health
- Finance Branch (2016), PD2016_011 Nursing Home Type Patients and the National Acute Care Certificate, NSW Health
- *Inter-Government and Funding Strategies Branch (2008), PD2008_028 SNAP Data Collection – Australian National Sub-Acute and Non-Acute Patient (AN_SNAP) Classification, NSW Health*
- Fees Procedure Manual for Public Health Organisations PD2007_050, NSW Health
- National care type definitions: http://meteor.aihw.gov.au/content/index.phtml/itemId/491557

9 LIST OF ATTACHMENTS

1. Appendix 1: Care type change scenarios

2. Appendix 2: Definitions of terms

Appendix 1: Care Type Change Scenarios

Temporary Care Type Escalation

(a) Overnight

***Example**: A patient is admitted to Rehabilitation on 01/01/11 for management of a brain injury. On 10/01/11, he falls out of bed and sustains a fractured neck of femur. The patient is transferred to Orthopaedic surgery for surgical management of the fracture. He remains in the Orthopaedics unit for two days and is transferred back to Rehabilitation on 13/01/11. The patient is discharged from hospital on 30/01/11.*

The care type should be updated on the PAS to reflect the change in the primary clinical purpose of care provided to the patient from rehabilitation to acute care.

The care type was changed in this scenario because the patient had a clear change in primary clinical purpose or treatment goal.

Episode Date Range	Care Type
01/01/11 – 10/01/11	Rehabilitation
10/01/11 – 13/01/11	Acute
13/01/11 – 30/01/11	Rehabilitation

(b) Same Day

***Example**: A patient is admitted to Rehabilitation on 01/01/11 for management of a brain injury. On 10/01/11, the patient is admitted to Neurosurgery for a burr hole procedure, and is transferred back to Rehabilitation on the same day. The patient is discharged on 30/01/11.* The care type is not changed, however the procedure is coded at the conclusion of the episode.

Episode Date Range	Care Type
01/01/11 – 30/01/11	Rehabilitation

(c) Surgical Interventions for a Palliative Care Patient

***Example**: A patient commences palliative care on 01/02/12. In order to better manage her pain, the patient is taken to theatres for insertion of an intrathecal catheter on 10/02/12. The patient is transferred back to palliative care on the same day. The patient dies on 03/03/12.*

The care type is not changed, however the procedure is coded at the conclusion of the episode.

Episode Date Range	Care Type
01/02/12 – 03/03/12	Palliative Care

(d) Surgical Interventions for a Palliative Care Patient

***Example**: A patient commences palliative care on 10/04/12. During the course of the palliative episode exacerbation of acute renal failure necessitated immediate transfer to the surgical ward. To provide acute care for the management of the renal failure ureteral stenting is performed on 10/05/12 with the patient remaining in acute post surgical care overnight. As the need for acute management subsides the patient is transferred back to the palliative care unit on 11/05/12 for ongoing palliative care management. The patient is discharged on 03/06/12.*

In this example, the care type is changed as the focus of care in the surgical ward was to deal with the management of an acute condition.

Episode Date Range	Care Type
10/04/12 – 10/05/12	Palliative Care
10/05/12 – 11/05/12	Acute care
11/05/12 – 03/06/12	Palliative Care

9.1 Change in Intensity of Care

(a) Post-surgical allied health intervention

***Example**: A 70 year-old female patient is admitted to the acute cardiothoracic surgery inpatient unit on 01/01/11 for Coronary Artery Bypass Graft. Following surgery, the patient goes to HDU for five days for monitoring due to her rapid atrial fibrillation and hypertension. The patient then returns to the cardiothoracic surgery ward for ongoing management, concurrently she receives physiotherapy in preparation for discharge, due to post-acute de-conditioning. The patient is discharged on 07/01/11.*

The provision of physiotherapy does not on its own meet the definition of Rehabilitation. Therefore, the patient remains in the Acute care type as there has not been a clear documented change in the primary clinical purpose or treatment goal.

The care type was not changed in this scenario because the primary clinical purpose tor treatment goal of the episode did not change.

Episode Date Range	Care Type
01/01/11 – 07/01/11	Acute

9.2 Care Type Change due to Change in Focus of Care

(a) GEM

***Example**: An 80 year-old female patient is admitted to Neurosurgery on 01/01/11 for management of a cerebral aneurysm. Following surgery, the patient experiences left-sided weakness and moderate cognitive difficulties. The patient is referred for an Aged Care consult on 05/01/11. The Aged Care consult is completed on 06/01/11. The patient is accepted for Aged Care, however no beds are*

currently available and no intervention to facilitate functional improvement is provided. On 10/01/11 an Aged Care bed becomes available and the patient is transferred. Whilst in the Aged Care Unit, the patient receives interventions to increase her functional independence, ongoing monitoring of her medical condition and assistance to find supported accommodation. These interventions constitute a change of focus of care to GEM. The patient is discharged from Aged Care on 30/01/11.

The care type was changed in this scenario on 10/01/11 because this is when GEM care commenced. Although the patient was identified as an appropriate GEM candidate on the 06/01/11 the care received did not change until the 10/01/11.The patient should remain as an acute patient for the period of time during which they are waiting

Episode Date Range	Care Type
01/01/11 – 10/01/11 10/01/11 – 30/01/11	Acute Geriatric Evaluation and Management (GEM)

(b) Maintenance

Example*: A 95 year-old female patient is admitted via ED on 26/02/11 for treatment of fractured vertebrae. The patient is transferred to the Aged Care ward on 28/02/11. The patient has a history of falls, lower limb weakness, hypertension and diabetes. During the admission, the patient receives a bone scan, CT scan head and pelvis, and lower limb Doppler ultrasound. During this period of evaluation the patient concurrently receives multidisciplinary interventions aimed at improving her functional status and preparing her for discharge. On 14/03/11 the team determine that the patient will not benefit from Rehabilitation, is unable to return home and will require placement. Interventions are provided to maintain the patient's current functional status whist placement is organised. The patient is discharged to a nursing home on 21/03/11.*

The maintenance care type was used in this example as the patient was no longer receiving acute interventions and was awaiting placement.

Episode Date Range	Care Type
26/02/11 – 14/03/11 14/03/11 – 21/03/11	Acute Maintenance

(c) Rural patient

Example*: A 75 year-old patient is admitted by their GP to a small rural hospital on 1/9/12 with severe influenza. The patient has co-morbidities of diabetes and cardiovascular disease. The patient receives acute interventions to manage their illness. As they recover, it is evident that they are significantly de-conditioned and are unable to be discharged at their current functional level. The nursing staff request a consult by a visiting Physiotherapist and Occupational Therapist. The allied health staff complete their assessments on 18/9/12, including a formal functional assessment. In conjunction with the patient's GP, a clinician with extensive experience caring for older people with functional impairments, the therapists prescribe a rehabilitation plan that will be carried out jointly by the nursing staff and the therapists on the days that they attend the hospital. This rehabilitation plan includes treatment goals. Regular review of the plan and the patient's functional status is carried out. The patient is discharged home on 5/10/12*

Episode Date Range	Care Type
01/09/12 – 18/09/12 18/09/12 – 05/10/12	Acute Rehabilitation

Mental Health

(a) Patients treated only within one or more specialised mental health unit(s) for the entire stay

Example*: A patient is transferred from the ED to an associated PECC unit on 01/07/2016. On 03/07/2016, the patient is transferred to an acute mental health specialist unit. They remain there until 17/07/2016 when they are transferred to a mental health rehabilitation unit. They remain there until their discharge on 31/08/2016.*

All care delivered within specialised mental health units, regardless of the intended clinical focus of the unit, is to be categorised under one care type, and thus treated as a single admission.

Episode Date Range	Care Type
01/07/16 – 31/08/16	Mental Health

(b) Patients treated across a number of units, including a specialised mental health unit

Example 1*: A patient is admitted on 21/07/2016 to an orthopaedic unit for a planned total hip replacement. After surgery on 22/07/2016, the patient returns to the orthopaedic unit. On 30/07/2016, the patient's co-morbid schizophrenia deteriorates and a decision is made to transfer the patient to the acute mental health unit. The patient remains there until 16/08/2016 when they develop pneumonia. The patient is transferred to a respiratory unit to manage the pneumonia. They remain there until 27/09/2016 when they are discharged.*

Any ongoing or continuous care that is delivered within a specialised mental health unit triggers a type change if they are transferred from another inpatient unit. Likewise, if the patient is transferred from a specialised mental health unit to another unit for ongoing or continuous care, this will also trigger a type change.

Episode Date Range	Care Type
21/07/16 – 30/07/16	Acute
30/07/16 – 16/08/16	Mental Health
16/08/16 – 27/09/16	Acute

Example 2*: A patient is admitted to a specialist acute mental health inpatient unit on 01/08/2016. On 29/09/2016, the patient is treated for their planned cataract surgery. The patient is transferred to the ophthalmology unit after the surgery, where they remain until the 30/09/2016. They are then transferred back to the mental health rehabilitation unit and remain there until their discharge on 22/03/2017.*

Any ongoing or continuous care that is delivered outside a specialised mental health unit triggers a type change if they are transferred from a specialised mental health unit and they are not returned directly back to the specialised mental health unit following treatment.

Episode Date Range	Care Type
01/08/16 – 29/09/16	Mental Health
29/09/16 – 30/09/16	Acute
30/09/16 – 22/03/17	Mental Health

(c) Patients treated for ongoing chronic conditions whilst admitted within a specialised mental health unit

Example*: A patient is admitted on 31/07/2016 to an acute mental health inpatient unit, and they are discharged on 17/11/2016. During the period of treatment within the specialised mental health unit, they receive twice weekly dialysis, for which the patient is moved to the renal dialysis unit to receive the treatment, following which they are returned to the specialised mental health unit.*

Any non-mental health procedure that is provided to a patient who is currently in a specialised mental health unit will not trigger a type change if the patient is returned directly to the specialised mental health unit after the procedure is complete.

Episode Date Range	Care Type
31/07/16 – 17/11/16	Mental Health

(d) Patients with mental health conditions but not treated within a specialised mental health unit

Example 1*: A patient is admitted on 03/08/2016 for a delivery of a newborn. On 07/08/2016, she develops post-natal depression for which she is treated in the maternity ward by a specialist mental health team via consultation liaison. She is discharged on 15/08/2016.*

Any mental health care that is not delivered within a specialised mental health unit, regardless of the diagnosis or the treating specialty, is not to be categorised under the mental health care type.

Episode Date Range	Care Type
03/08/16 – 15/08/16	Acute

Example 2*: A patient is admitted on 05/10/2016 for treatment of a perforated gastric ulcer, and is discharged on 01/11/2016. During the admission, the patient continues to receive weekly ECT treatment, which is conducted in the ECT suite. After each ECT procedure is completed, the patient is returned to the gastroenterology unit.*

Any care that does not result in a continuous period of treatment in a specialised mental health unit is not to be type changed and categorised under the mental health care type. This includes where a patient is receiving individual courses of treatment in a specialised mental health treatment facility that sees them return directly to the non-mental health inpatient unit once the treatment or procedure is completed.

Episode Date Range	Care Type
05/10/16 – 01/11/16	Acute

(e) Existing patients treated within a specialised mental health unit

Example*: A patient is admitted to a specialist acute mental health unit on 12/02/2016. On 16/03/2016, the patient is transferred to a specialist rehabilitation mental health unit. On 15/06/16 the patient is transferred to a respiratory unit for treatment of the patient's acute exacerbation of their COPD. They return to the specialist mental health rehabilitation unit on 19/07/16. On 15/08/2016, the facility introduces the mental health care type, and decides to backdate the care type introduction to the beginning of the financial year. The patient is discharged from the facility on 12/12/2016.*

For 2016/17, the assignment of the mental health care type for existing patients can be dated to either the date the care type is introduced, or if the LHD wishes to backdate the introduction of the care type, the date is to be either the date the patient was last transferred into the specialist mental health unit, or to the 1st of July 2016 if the continuous period in the specialist mental health unit began before 01/07/2016.

Episode Date Range	Care Type
12/02/16 – 16/03/16	Acute
16/03/16 – 15/06/16	Rehabilitation
15/06/16 – 19/07/16	Acute
19/07/16 – 12/12/16	Mental Health

Same Day Acute Procedures in Sub Acute Care

(a) Dialysis

Example*: A rehabilitation patient (from 01/03/11 to 13/03/11) receives haemodialysis twice a week. They receive haemodialysis and return to the rehabilitation ward on the same day.*

Although dialysis is a high cost and high volume service, national care type definitions state that same day acute interventions or procedures provided to an admitted patient in a sub or non-acute care type do not warrant a change in care type. The provision of dialysis should be captured as a procedure code during coding.

Episode Date Range	Care Type
01/03/11 – 13/03/11	Rehabilitation

(b) Chemotherapy/radiotherapy during a Palliative Care Episode

Example*: A Palliative Care patient (from 01/03/11 to 10/03/11) receives radiotherapy to assist with symptom management.*

There is no care type change in this scenario as the provision of radiotherapy or chemotherapy for symptom management meets the definition of palliative care and does not constitute a change in the focus of care.

Episode Date Range	Care Type
01/03/11 – 31/03/11	Palliative Care

(c) Non Weight Bearing Scenarios

Example 1*: A patient is admitted to hospital following a fall on 31/07/12 and has hip surgery on 01/08/12. After the surgery, the patient is transferred to the orthopaedic ward. The patient experiences post-surgical complications and on 05/08/12 the orthopaedic surgeon advises that the patient is to be non-weight bearing for a period of 6 weeks.*

The patient is medically stable, their wound is healing well and they do not require any ongoing acute interventions. The patient is referred to the rehabilitation service on 10/08/12, where the patient is assessed. The rehab team determine that the patient would benefit from interventions to increase their independence in sliding transfers, wheelchair mobility and self care. The patient participates in a modified rehabilitation programme until they are cleared for weight bearing by the orthopaedic surgeon. Once able to resume weight bearing the patient receives ongoing rehab for a further 3 weeks. They are discharged home on 17/10/12.

Episode Date Range	Care Type
31/07/12 – 10/08/12	Acute Care
10/08/12 – 17/10/12	Rehabilitation

Example 2*: A patient is admitted to hospital following a fall on 31/07/12 and has hip surgery on 01/08/12. After the surgery, the patient is transferred to the orthopaedic ward. The patient experiences post-surgical complications and on 05/08/12 the orthopaedic surgeon advises that the patient is to be non-weight bearing for a period of 6 weeks.*

The patient is medically unstable, experiencing intermittent chest pain and issues related to wound healing. They receive ongoing monitoring and care related to these medical issues. The patient is referred to the rehab service for assessment. The rehab team determine that the patient is not currently suitable for a rehabilitation program. On 12/09/12 the orthopaedic surgeon reviews the patient and clears them for weight bearing. The rehab team reviews the patient on 13/09/12 and determines that they are appropriate for rehab. The patient commences rehab on 14/09/12. They are discharged home on 17/10/12.

Episode Date Range	Care type
31/07/12 – 14/09/12	Acute Care
14/09/12 – 07/10/12	Rehabilitation

***Example 3**: A patient is admitted to hospital following a fall on 31/7/2012 and has hip surgery on 1/8/2012. After the surgery the patient is transferred to the orthopaedic ward. The patient experiences post surgical complications and on 5/8/2012 the orthopaedic surgeon advises that the patient is to be non weight bearing for a period of 6 weeks.*

The patient is medically stable. The patient is referred to the rehab service for assessment. On 06/08/12 the rehab team determine that the patient is not currently suitable for a rehab program. The patient is unable to be discharged home due to access and safety issues. The patient is transferred to a medical ward and receives ongoing minimal nursing care and occasional physiotherapy to maintain current physical status. On 12/09/12 the orthopaedic surgeon reviews the patient and clears them for weight bearing. The rehab team reviews the patient on 13/09/12 and determines that they are now an appropriate candidate for rehab. The patient commences rehab on 14/09/12. They are discharged home on 17/10/12.

Episode Date Range	Care type
31/07/12 – 06/08/12	Acute Care
06/08/12 – 14/09/12	Maintenance
14/09/12 – 17/10/12	Rehabilitation

Appendix 2: Definitions of Terms

Acute Care Certificate	After 35 days of hospitalisation, private and DVA patients in need of ongoing acute or sub-acute care must have an Acute Care Certificate completed by the registered doctor caring for them. The Acute Care Certificate is valid for a period of up to 30 days, after which a new certificate will need to be issued if the patient is still undergoing acute / subacute care in hospital. If an Acute Care Certificate cannot be issued by the treating doctor, a type change to Maintenance Care is required. The financial class must be reclassified to nursing home type and the appropriate charges to the patient must be organised. Note: For policy details regarding Acute Care Certificates see the *Public Fees Procedures Manual for Public Health Organisations* (Sections 2.56 to 2.67, as amended from time to time) and Policy Directive PD2016_011 *Nursing Home Type Patients and the National Acute Care Certificate*
AMO	Attending Medical Officer: the medical officer / senior clinician (a visiting medical practitioner, staff specialist or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted. May also be referred to as *Admitting Medical Officer*.
Other Authorised Clinician	Clinical staff authorised by the AMO to be responsible for care type changes e.g. Registrar, Resident Medical Officer, Junior Medical Officer, Nursing Unit Manager or senior nursing staff.
APDC	Admitted Patient Data Collection: the framework for mandatory data reporting for all admitted patients within New South Wales.
Clinical Coding	Clinical Coding involves abstracting disease and procedure information from the medical record and then assigning codes using the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI). The process of Clinical Coding is performed by Clinical Coders.
Clinician	Medical, nursing and allied health staff involved in patient care

AR-DRGs	Australian Refined-Diagnosis Related Groups are the classification tool allocated to acute inpatients. DRGs are used to fund inpatient episodes of care for acute care.
Episode of Care	The period of admitted patient care between a formal or statistical admission and a formal or statistical discharge, characterised by one care type. (Refer *National Health Data Dictionary*)
Nursing Home Type Patient (NHTP)	A nursing home type patient is a patient who has been in one or more approved hospitals (public or private) for a continuous period of more than 35 days, without a break of seven days, and who is not deemed to be receiving acute care. After 35 days, the patient will be reclassified as a NHTP unless an Acute Care Certificate is issued by a medical practitioner to certify that the patient requires acute care. An Acute Care Certificate may be reissued every 30 days thereafter, for as long as the patient requires acute care. In the event of readmission to a hospital within 7 days (or transfer between hospital), the previous related inpatient periods will be regarded as contributing towards the period of 35 days hospitalisation. The periods of leave themselves are not counted towards the 35 day qualifying period. Hence, a patient who has been in hospital for 20 days and then leaves the hospital for 3 days, will start at day 21 when returning to hospital. However, where a patient is discharged and a period of more than 7 days elapses before readmission, the previous stay in hospital will not be counted. The date of discharge is not to be counted as one of the 7 days; seven days commences from the day after discharge or on leave. The nursing home type patient arrangement does not apply to Third Party, Workers' Compensation and other compensable patients, or patients who are ineligible under Medicare. For compensable patients, Acute Care Certificates should be issued where appropriate in case the patient's compensation claim is rejected.
PAS	Patient Administration System
Care Type (Previously known as 'service category')	Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care. Reference:http://meteor.aihw.gov.au/content/index.phtml/itemId/491557
Care Type Change	An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient
AN-SNAP	Australian National Sub-Acute and Non-Acute Patient Classification: the framework for mandatory data reporting for all sub-acute and non-acute episodes within New South Wales designated services.
Stay	The period of admitted patient care between a formal admission and a formal discharge which comprises one or more episodes of care. Refer also 'Care Type Change'
Type Change	See 'Care Type Change'. This terminology is interchangeable with the term Care Type Change.

Newborn Qualification Status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is 'qualified' if the infant meets at least one of the following criteria: • Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient, or • Is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care, or • Is admitted to, or remains in hospital without its mother. A newborn patient day is 'unqualified' if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day. Reference: http://meteor.aihw.gov.au/content/index.phtml/itemId/327254

NSW PATIENT SAFETY AND CLINICAL QUALITY PROGRAM (PD2005_608)

New South Wales is recognised nationally and internationally, as a leader in improving the quality and safety of clinical services provided to patients.

The NSW Patient Safety and Clinical Quality Program provides the framework for significant improvements to clinical quality in our public health system. Success depends on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

In a system as large and complex as the NSW public health system, it is unrealistic to expect that no mistakes will occur, and our aim is to develop a system that continually strives for ongoing improvement - where lessons are learnt from mistakes and are communicated to other health services.

The Government has invested $55 million in improving frontline clinical care through the NSW Patient Safety and Clinical Quality Program. The Program is ambitious and sets the agenda for one of Australia's most comprehensive clinical quality programs, ensuring patient safety and excellence in healthcare is the top priority for the NSW health system.

The key components of the program are:
- Systematic management of incidents and risks
- A new Incident Information Management System
- Clinical Governance Units in each Area Health Service
- A Quality Assessment Program for all public health organisations
- The establishment of the Clinical Excellence Commission.

These initiatives are designed to support clinicians and managers with improving quality and safety for patients and will focus on promoting and providing the delivery of the best care in health services. Key to the success of the program is the active involvement of doctors, nurses, allied health professionals, health managers and our community.

With this level of commitment, the result will be a more consistent approach to high quality patient care and people in NSW will continue to enjoy access to one of the best health systems in the world.

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Diagram 1:
NSW Patient Safety and Clinical Quality Program flowchart

1. Introduction

There is a growing body of international and Australian knowledge that has contributed to the evolving concept of quality improvement in healthcare.

Borrowing from other high-risk industries where safety is paramount, the health industry is developing techniques to better identify risks, investigate and analyse incidents and to improve practice. These techniques allow health services to manage known risks actively and to develop systems to identify new or emerging risks.

In healthcare, as in any industry, sometimes things go wrong. Equipment can fail, systems can prove inadequate and errors of judgment are made. In relatively few cases, serious incidents occur that might have been prevented and some of these result in serious harm to patients. The majority of these incidents are not the result of a single action by an individual but, more commonly, are generated by a chain of events.

Preventing error depends on identifying the deficiencies in the sequence of events and fixing any identified problems. It is crucial to capture all the relevant information about an incident, investigate all known causes and to take decisive action to protect patients from a recurrence of that kind of event.

The aim of the NSW Patient Safety and Clinical Quality Program is that all significant adverse incidents are reported and reviewed so that education and remedial action can be applied across the whole health system. This shift in thinking about how we deal with error, combined with the rollout of a new system for electronic reporting of incidents, will lead to an increasing number of events being reported. Somewhat paradoxically, a rising number of events reported will be one measure of success for the program.

This first year of the program lays the groundwork for what is potentially one of the greatest ever systemic improvements to clinical quality in our public health system. Future success will depend on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

Everyone working in the health system is encouraged to contribute their knowledge of how and when mistakes are made in this constructive spirit, free of anxiety that the response will be unnecessarily punitive. The lessons from each localised incident can then be used to inform safety improvements in every health facility throughout NSW.

2. Key Components

The NSW Patient Safety and Clinical Quality Program has five key components:

1. The systematic management of incidents and risks both locally and statewide to identify remedial action and systemic reforms.
2. The Incident Information Management System (IIMS) to facilitate the timely notification of incidents, track the investigation and analysis of health care incidents, enable the reporting about incidents, particularly the provision of trended information by incident type, and to understand the lessons learned.
3. The establishment of Clinical Governance Units (CGU) in each Area Health Service (AHS) to implement the NSW Patient Safety and Clinical Quality Program.

4. The development of a Quality Systems Assessment (QSA) Program for all public health organisations undertaken by an external agency, to determine whether the above components are in place and working well. The focus of the assessments is on AHS patient safety and clinical quality systems.

5. A Clinical Excellence Commission (CEC) to promote and support better clinical quality and to advise the Minister for Health on where systemic improvements can be made.

3. Guiding Principles

The NSW Patient Safety and Clinical Quality Program is underpinned by guiding principles:

1. **Openness about failures** - errors are reported and acknowledged without fear of inappropriate blame, and patients and their families are told what went wrong and why.
2. **Emphasis on learning** - the system is oriented towards learning from its mistakes and extensively employs improvement methods for this.
3. **Obligation to act** - the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit.
4. **Accountability** - the limits of individual accountability are clear. Individuals understand when they may be held accountable for their actions.
5. **Just culture** - individuals are treated fairly and are not blamed for the failures of the system.
6. **Appropriate prioritisation of action** - action to address problems is prioritised according to the available resources and directed to those areas where the greatest improvements are possible.
7. **Teamwork** - teamwork is recognised as the best defence against system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

4. Patient Expectations

As a patient admitted to a hospital or requiring treatment from a health service what might you reasonably expect?

1. Appropriate treatment for my condition when I need it.
2. The best possible care at all times, based on the latest evidence.
3. To be treated with respect and have easy and honest communication with the doctors, nurses and other health care professionals who are providing care to me.
4. To be looked after by clinicians who have the necessary clinical skills for the work that they do.
5. Those who provide care to me are well-supported and part of effective teams, and have access to the resources (including equipment and information) they need to do their work.
6. Systems are designed to prevent inadvertent or accidental harm to me while in hospital.
7. If I have concerns, I will be able to talk to someone immediately and have my concerns addressed to my satisfaction.
8. If something goes wrong with my care, that there is a system in place to openly report, investigate and fix the underlying problems so that others are not harmed. In addition, I will be told openly and honestly what went wrong and receive an apology.
9. Reassurance that there is an external body evaluating the safety of care in hospitals and working to improve quality and safety in the NSW health system.

Patient expectations have been incorporated into standards and performance measures developed to monitor the effectiveness of the implementation of the NSW Patient Safety and Clinical Quality Program.

5. Roles and Responsibilities

NSW Department of Health

The NSW Department of Health is established under section 6 of the *Health Administration Act 1982* and supports the Minister in performing his statutory functions including responsibility for patient safety and clinical quality in the NSW health system. The Quality and Safety Branch is responsible for the development of the essential components of the NSW Patient Safety and Clinical Quality Program with lead responsibility for:

- Setting standards for Area Health Service Quality Systems
- Developing policies on quality and safety that need statewide implementation
- Developing and reporting on system wide quality indicators
- Monitoring and analysing serious clinical incidents, and taking appropriate action such as advice and warnings to the health system
- Overseeing statewide clinical governance issues
- Overseeing consistent implementation of the NSW Patient Safety and Clinical Quality Program.

Area Health Services

Area Health Services (AHS) and all Public Health Organisations (PHO) are responsible for the quality and safety of the services provided by their facilities, staff and contractors. With the recent implementation of the health reforms, clinical governance has been embedded in the new AHS through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) directly reporting to the Chief Executive (CE). These Units are responsible for the rollout of the NSW Patient Safety and Clinical Quality Program within their AHS.

Clinical Governance Units

The Clinical Governance Units (CGU) have the roles of support, performance and conformance to develop and monitor policies and procedures for improving systems of care. The CGU will contribute to the program by ensuring it is uniformly implemented across the state and for overseeing the risk management of patient safety and clinical quality by building upon existing incident management and investigation systems.

The Clinical Excellence Commission

The Clinical Excellence Commission (CEC) is a statutory health corporation established under the *Health Services Act* by the NSW Minister for Health as part of the NSW Patient Safety and Clinical Quality Program, and builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001. The core mission of the CEC is to identify issues of a systemic nature that affect patient safety and clinical quality in the NSW health system and to develop and advise on implementation strategies to address these issues. Part of the role of the CEC is to acquire and share information about how well the NSW health system is performing and to use this information to improve the performance of the system.

The CEC has a statewide research oversight, monitoring, education and advisory role. It is not directly responsible for the implementation of the NSW Patient Safety and Clinical Quality Program.

6. Policy and standards

The NSW Patient Safety and Clinical Quality Program lists standards that Area Health Services are required to comply with. This builds upon existing frameworks, programs and initiatives currently well established in all Area Health Services. The Program is based on standards against which a health service's quality system will be assessed.

These standards are derived from existing Departmental policies and guidelines that are familiar to health service staff, administrators and clinicians.

Governance responsibility for identifying patient safety risks and undertaking remedial action is vested in Area Health Services and public health organisations and it is their responsibility to undertake activity to address the standards mandated by the Department.

Standards

Standard 1
Health services have systems in place to monitor and review patient safety.

Standard 2
Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Standard 3
An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Standard 4
Complaints management systems are in place and complaint information is used to improve patient care.

Standard 5
Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

Standard 6
Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Standard 7
Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

STANDARD 1

Health services have systems in place to monitor and review patient safety.

Components

Committee Structure

The Area Heath Service has clearly articulated its commitment to quality improvement and patient safety and has an effective committee structure that oversees quality improvement and patient safety.

Clinical Governance Unit

The Area Health Service has established a Clinical Governance Unit responsible for managing patient safety and clinical quality and has developed an operational plan consistent with Departmental directives. NSW Clinical Governance Directions Statement, issued 2005.

Establishing Clinical Indicators and Performance Information

The Area Heath Service monitors and analyses performance information on quality and patient safety using performance measures and clinical indicators included in strategic planning and business documents.

Monitoring and Reporting Performance Information

The Area Heath Service monitors, analyses and compares performance information on quality and patient safety reported to Area executive and Advisory Council and strives to compete with the best performing facilities. PD2014_004 Incident Management Policy.

Using Performance Information to Improve Patient Care

Performance information is used by Area executive to evaluate and improve safety and patient care and to develop strategies to reduce clinical and patient safety risks. PD2014_004 Incident Management Policy.

Public Awareness of Quality and Safety

The Area Health Service publicly reports information on patient safety activities and outcomes.

Patient Safety Performance

Health services perform to desired levels against targets for patient safety and performance is improving.

STANDARD 2

Health services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Components

Minimum Requirements

The Area Health Services develop, implement and review patient safety policies and protocols for incident management, complaint management, complaints or concerns about clinicians, new interventions and correct patient/site/procedure.

Implementation

Systems are in place to effectively disseminate, implement, review and update new policies and procedures on patient safety to health facilities in the Area, including Departmental directives and safety alerts. NSW Clinical Governance Directions Statement, 2005.

Detailed Policy Review - New Interventions

The Area policy on new interventions is consistent with Departmental guidelines and risk assessments are undertaken before new procedures are introduced. An implementation plan is prepared for each new procedure introduced by the Area.

Detailed policy review - correct patient/site/procedure (Note: does not apply to the Ambulance Service)

Health Services have developed an implementation plan to ensure all procedural teams comply with PD2014_036 Clinical Procedure Safety.

Policy Directives and Related Documents

PD2006_007 - Complaint or Concern about a Clinician - Principles for Action
PD2006_073 - Complaint Management Policy
GL2006_002 - Complaint or Concern about a Clinician - Management Guidelines
GL2006_023 - Complaint Management Guidelines
PD2014_004 - Incident Management Policy
PD2014_036 – Clinical Procedure Safety.

STANDARD 3

An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Components

Notifying and Assessing Incidents

The Area Health Service supports a culture that facilitates incident reporting, the use of systems to notify and record incidents using the Severity Assessment Code (SAC) matrix to identify matters requiring investigation, and ensures incident reports are forwarded to relevant authorities within the required timeframe.

Investigating Incidents

High-risk incidents are investigated in accordance with Departmental guidelines by a multidisciplinary team nominated by the Area executive in a timely manner to analyse the incident, and to recommend key actions to minimise the risk of recurrence.

Implementing Recommendations

Recommendations arising from investigations are implemented in health facilities to improve patient safety. Incident data is monitored and analysed to detect trends and determine whether system-wide improvements are needed. Feedback on the outcome of investigations is provided to the Root Cause Analysis (RCA) team and the person who reported the incident (where identified) and feedback is provided to staff on policy and procedural changes.

Incidents Involving the Death of a Patient

Systems are in place to monitor deaths and determine whether changes in practice are needed to improve patient care. PD2014_004 Incident Management Policy.

STANDARD 4

Complaints management systems are in place and complaint information is used to improve patient care.

Components

Complaint Monitoring and Review

Responsibility for the timely management of complaints and feedback on the outcome of investigations to complainants is assigned appropriately and systems are in place to record, monitor and review complaints.

Systems Improvement

Complaint data are monitored, analysed to identify trends and to determine whether system-wide improvement is needed to prevent recurrence. Processes are in place to address the systems issues identified by complaints, to implement recommendations by health facilities and to ensure complaints information is reported to Departmental and other relevant authorities.

Management of Complaints or Concerns About Individuals

Complaints or concerns against individuals are dealt with according to Departmental policy and within relevant timeframes. PD2006_073 Complaint Management Policy and GL2006_023 Complaint Management Guidelines. PD2006_007 - Complaint or Concern about a Clinician - Principles for Action. GL2006_002 - Complaint or Concern about a Clinician - Management Guidelines

STANDARD 5

Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

Components

Health services have developed an appropriate system of chart review.

Systems Improvement

The results and recommendations of chart reviews and investigations are reported to management/ Area executive and staff, and the recommendations are implemented to effect system improvement.

STANDARD 6

Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Components

Performance Review Process

Health services have developed an appropriate system of performance review and meetings where clinical management issues are adequately discussed and improvement action identified and documented.

PD2012_028 - Recruitment & Selection of Staff of the NSW Health Service.
PD2015_023 - Appointment of Visiting Practitioners in the NSW Public Health System
PD2005_497 - Visiting practitioners and staff specialists Delineation of clinical privileges
PD2011_010 - Visiting Medical Officer (VMO) Performance Review Arrangements.

Systems/Performance Improvement

Performance review reports are forwarded to an appropriate delegate within the Area for action, matters requiring further review are investigated, and feedback is provided to staff on any policy and procedural changes to effect system improvement.

STANDARD 7

Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

Components

Topic Selection

Health services have developed a program of clinical practice audits that targets major care processes or practices considered to be high risk.

Review Process

People with relevant skills and knowledge conduct the audits. Audits are conducted in an efficient and effective manner against pre-determined components or performance standards.

Systems Improvement

The audits identify clinical management issues that need to be addressed to improve patient safety and quality care. Audit results are reported to management/Area executive and feedback is provided to staff on policy and procedural changes and ongoing monitoring of the effectiveness of systems changes is in place.

7. Clinical Governance Units[18]

The developing focus on the integrity and accountability of health systems through clinical governance is integral to improving the performance of health systems and the enhancement of clinical care through analysis and feedback. The concept of clinical governance integrates clinical decision-making within an organisational framework and requires clinicians and administrators to take joint responsibility for the quality of clinical care delivered by the organisation.

With the recent implementation of the health reforms, clinical governance has been embedded in the new Area Health Services (AHS) through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) as a direct report to the Chief Executive (CE).

Core Functions

The primary focus of the CGU can be summarised as the risk management of patient safety and clinical quality through implementation of the NSW Patient Safety and Clinical Quality Program. The Program will be implemented in collaboration with the Clinical Excellence Commission (CEC), the Department and the CGU.

The CGU will build upon existing incident reporting and investigation systems enhanced through the implementation of the Incident Information Management System (IIMS). Functions that will guide the role of the CGU in 2004/05 are:

1. Structural establishment
2. Incident management
3. IIMS implementation
4. Complaints management
5. Death review
6. Continuous Quality Improvement (CQI) support
7. Communication training
8. Policy development
9. Clinician performance review
10. Reporting
11. External reports.

[18] Draft NSW Clinical Governance Units Implementation Framework, 2004

Other Functions

- Management of individual performance issues. The establishment of clinician performance review is a key part of the NSW Patient Safety and Clinical Quality Program. The role of the CGU will be to determine an appropriate performance management framework for the health service, in collaboration with the CEC, and be a source of advice and expertise regarding due process for those line managers.

- Complaints management. The CGU will ensure a single point of access for staff and the public to register complaints and to take responsibility for the management of serious complaints. The CGU will lead the process of complaints management but should not take over this function on behalf of the health service.

- Integrated risk management. Clinical risk management is an integrated responsibility for clinical operations and for the CGU. The CGU will advise and support clinical operations in the recognition and management of clinical risk. It is not intended that the CGU assume global risk management responsibility for the health service.

8. Incident Management

A quality improvement framework requires routine examination of all incidents that cause patient harm. Most adverse events are not caused by a single, individual action. They usually result from a chain of events where inadequate safeguards and other systemic vulnerabilities erode patient safety. Preventing incidents depends on identifying the deficiencies that allowed the event to occur and fixing those problems.

In the past, information about adverse events was generally derived from single studies and often specific only to a hospital or clinician. Through the NSW Patient Safety and Clinical Quality Program, Area Health Services are now well placed to systematically collect incident information to effect system-wide improvement.

In NSW, all incidents that result in detriment to a patient are 'reportable' - they must be reported to management and, depending on their severity, the AHS and the NSW Department of Health for analysis and remedial action.

The NSW Patient Safety and Clinical Quality Program aims to develop a culture where health care incidents are identified, reported, investigated, analysed and acted upon. The lessons learned locally will be disseminated statewide through a knowledge management strategy.

The Program is supported by an information system, the Incident Information Management System (IIMS), that assists heath care workers to achieve this.

The Incident Information Management System (IIMS)

The Incident Information Management System is an electronic system activated in all AHS in December 2004 to:

- Record all healthcare incidents, both adverse events and incidents that did not result in adverse events, but might have, in four categories:
  1. Clinical
  2. Complaints
  3. Property security and hazards
  4. Staff, visitors and contractors

- Assist managers to deal with incidents in their areas
- Record the results of reviews and investigations of incidents
- Provide reports on all incidents recorded in the system.

There are 100,000 potential users of the IIMS system that includes all NSW health system employees and contractors. A comprehensive training and education program has been developed using 'e-learning modules', a CD-ROM, DVD and video to ensure all potential users have consistent training in the use of the IIMS.

Full deployment was completed in May 2005 across the whole of NSW.

9. Clinical Excellence Commission[19]

The Clinical Excellence Commission (CEC) is a statutory health corporation established under the *Health Services Act* and launched by the NSW Minister for Health as part of the NSW Patient Safety and Clinical Quality Program and builds on the foundation work of the Institute of Clinical Excellence established in 2001. The NSW Department of Health, public health organisations, the Health Care Complaints Commission (HCCC) and professional registration boards are the other principal organisations with major roles in this program.

The CEC will work effectively in partnership with these organisations to:

- Promote and support improvement in clinical quality and safety in public and private health services
- Monitor clinical quality and safety processes and performance of public health organisations and to report on these to the Minister
- Identify, develop and disseminate information about safe practices in health care on a state wide basis, including (but not limited to) developing, providing and promoting training and education programs, and identifying priorities for and promoting the conduct of research about better practices in health care
- Consult broadly with health professionals and members of the community in performing its functions
- Provide advice to the Minister for Health and Director-General of Health on issues arising out of its functions.

Patient Safety Risk Identification

A major role of the CEC will be to analyse information from a range of relevant sources regarding adverse events, to identify trends, causes and preventative strategies and to work with Public Health Organisations (PHO) to facilitate ongoing improvements in the health care system. The CEC will analyse information provided by the Department and PHO. This may include information from the following sources to identify systemic issues that need to be addressed:

- Root Cause Analyses (RCAs)
- Incident Information Management System (IIMS)
- Coroners' findings and recommendations
- Special Committees' and expert committees' reports
- Treasury Managed Fund and medical defence organisations
- Quality System Assessments (QSA)
- Information from the Health Care Complaints Commission
- Literature reviews, research and other sources as appropriate
- Special reviews.

[19] NSW Clinical Excellence Commission Directions Statement, 2004.

10. Quality System Assessments

The effectiveness of the implementation of the NSW Patient Safety and Clinical Quality Program will be routinely monitored through an external review process, the Quality System Assessments (QSA) conducted by the Clinical Excellence Commission (CEC).

The QSA is an annual review of Area Health Services (AHS) to identify, analyse and advise on issues of a systemic nature that affect patient safety and clinical quality in the NSW health system. The CEC will assess AHS and PHO to identify if there has been effective implementation of the Program.

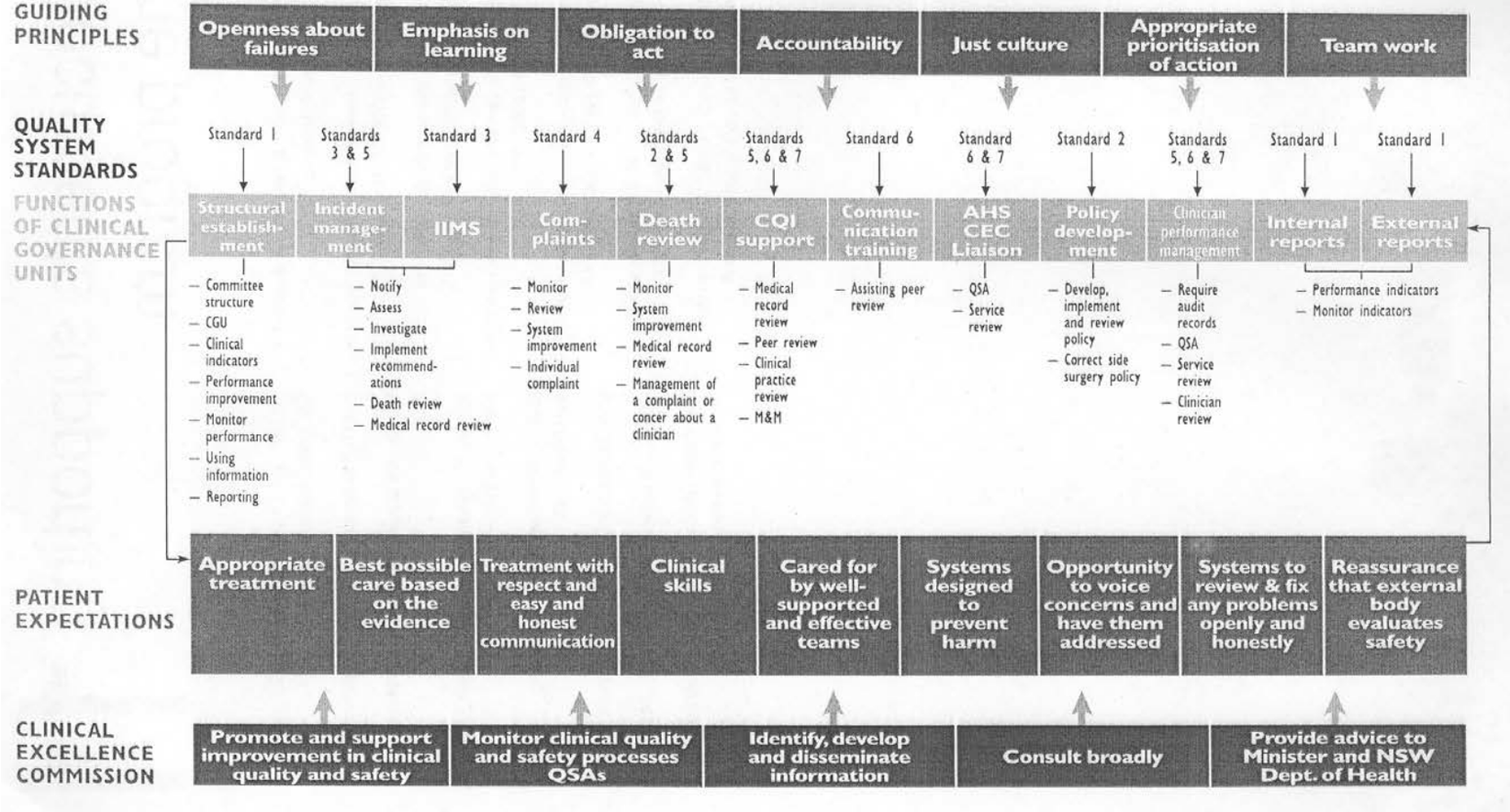
Specifically, the QSA will review patient safety arrangements in AHS focusing on compliance with the standards and policy requirements developed by the Department. The key areas for review are:

- Quality and safety reporting structures
- Safety polices and procedures
- Incident management
- Complaint management
- Medical record reviews
- Audits of clinical practices.

The CEC will provide the QSA Report to the Chief Executive of the AHS and Public Health Organisation, and a copy to the Department of Health. The AHS and PHO will notify the Department of the actions taken to address safety and quality issues contained within the report, and work with the Department to ensure appropriate implementation. It is acknowledged that from time to time significant issues may be identified from a Quality Systems Assessment.

The Department will support AHS and PHO to address risks identified by the CEC, or through its own sources of information and advice. The Areas can also approach the CEC for advice and assistance in improving quality systems.

Patient Safety and Clinical Quality Program



Documents Supporting the Program

PD2015_023 Appointment of Visiting Practitioners in the NSW Public Health System

PD2005_497 Visiting practitioners and staff specialists Delineation of clinical privileges.

PD2006_007 Complaint or Concern about a Clinician - Principles for Action

PD2006_073 Complaint Management Policy.

GL2006_002 Complaint or Concern about a Clinician - Management Guidelines

GL2006_023 Complaint Management Guidelines.

PD2014_004 Incident Management Policy.

PD2014_036 Clinical Procedure Safety.

PD2011_010 Visiting Medical Officer (VMO) Performance Review Arrangements.

PD2012_028 Recruitment & Selection of Staff of the NSW Health Service.

NSW Clinical Governance Directions Statement, 2005.

NSW Patient Safety and Clinical Quality Program Implementation Plan, 2005.

Definition of Terms

Adverse Event

Any event or circumstance leading to avoidable patient harm which results in admission to hospital, prolonged hospital stay, significant disability at discharge or death.

Area Health Advisory Councils (AHAC)

A clinical and community advisory body established in Area Health Services following the health reforms to give clinicians including doctors, nurses and allied health professionals, health consumers and local communities a stronger voice in health decision-making.

Area Health Services (AHS)

Area Health Services provide the operational framework for the provision of Public Health Services in NSW. They are constituted under the *Health Services Act 1997* and are principally concerned with the provision of health services to residents within the geographic area covered by the Area Health Service.

Clinical Excellence Commission (CEC)

A statutory health corporation established under the *Health Services Act* to promote and support improvement in clinical quality and safety in NSW health services.

Incident Information Management System (IIMS)

A state-wide electronic reporting and incident management system designed to underpin the NSW Safety Improvement Program.

Incident[20]

An unplanned event resulting in, or having the potential for, injury, damage or other loss.

Public Health Organisation (PHO)

Means an area health service, a statutory health corporation or an affiliated health organisation in respect of its recognised establishments and recognised services, as defined in section 7 of the *Health Services Act*, and in addition, for the purposes of this document, includes the Ambulance Service of NSW.

Quality System Assessment (QSA)

Criteria for the collection and analysis of information on the quality and safety of health services designed to test the effectiveness of the systems in place to monitor and improve quality and patient safety.

Severity Assessment Code (SAC)

A risk matrix used to stratify the consequence and likelihood of an incident to generate a numerical rating from 1 to 4. SAC 1 events always require investigation and notification to the Area Health Service Executive and the NSW Department of Health. SAC 2 events require notification to the Area Executive and local assessment as to the level of investigation required. Incidents rated 3 or 4 will be managed locally by the Area Health Service.

[20] NSW Health First Report on incident management in the NSW public health system 2003-2004.

KIDNEY HEALTH CHECK: PROMOTING THE EARLY DETECTION AND MANAGEMENT OF CHRONIC KIDNEY DISEASE (PD2010_023)

PURPOSE

This policy directive promotes the early detection and management of chronic kidney disease. It aims to optimise existing contacts with at risk patients in hospital settings in order to prevent progression to end stage kidney disease. The screening tool described is the *Kidney Health Check*. If disease is detected, a primary care referral will be made, highlighting the importance of treating the condition in order to encourage remission and regression of the disease.

MANDATORY REQUIREMENTS

Area Health Services are to develop and implement a framework to screen for chronic kidney disease which consists of three steps:

1. **Identification of High Risk Patients** - risk factors are listed in section 2 step 1 of the attached Kidney Health Check procedures;
2. **Kidney Health Check** - assessment of urinalysis, blood pressure and an estimated measure of glomerular filtration rate (section 2 step 2); and
3. **Follow Up** - a referral is to be made to the patient's General Practitioner or Nurse Practitioner if any one of these tests yields abnormal results (section 3).

IMPLEMENTATION

Chief Executives of Area Health Services are responsible for implementing this Policy Directive and must ensure:

- Local policies and procedures are developed for clinical care establishing standards of practice;
- Staff education and training programs are in place to support the implementation of the Kidney Health Check; and
- An evaluation framework is in place to assess that the Kidney Health Check has been implemented and that the target group has been identified, screened using the Kidney Health Check, and followed up appropriately.

The Clinical Excellence Commission will conduct a longer term evaluation of the Policy Directive at a state level.

BACKGROUND

Chronic kidney disease (CKD) is defined as the occurrence of kidney damage or decreased kidney function (decreased glomerular filtration rate) for a period of three or more months[1].

CKD is responsible for a substantial burden of illness and premature death with:

- 1 in 3 Australians at risk of developing the disease[2];
- 1 in 7 Australians over the age of 25 years having at least one clinical indicator of existing CKD[2];
- the disease being the 7th leading cause of death[2];

- CKD being a preventable and treatable condition. Once the disease is diagnosed and treatment implemented, the progression to end-stage renal failure can be reduced by up to 50%[3]; and
- proteinuria, which is a clinical marker for CKD, also indicative of an increased risk of cardiovascular disease[4].

Early detection of CKD is the key to both the prevention and the slowing of the progression of the disease.

The purpose of this policy directive is to provide a framework to identify those who have or are at high-risk of developing CKD and for the implementation of timely treatment in order to prevent the progression to end-stage kidney disease. In turn, this will raise awareness of CKD for staff and the public and reduce the burden of disease associated with kidney disease in the NSW population. It will be the responsibility of each Area Health Service to develop and implement a framework for the program.

Area Health Services should have in place systems to screen patients in high-risk categories as identified by Kidney Health Australia by conducting the **Kidney Health Check**. This system of screening should, in the first instance, be implemented within all high-risk inpatient units in hospital settings.

The application of this policy to a broader range of clinical settings should be considered subject to evaluation within the hospital setting.

CHRONIC KIDNEY DISEASE SCREENING

The following process is summarised as a simple algorithm in Appendix 1.

Step 1 - Identification of high-risk patients

Patients who have not previously been diagnosed with chronic kidney disease should undergo the Kidney Health Check if they have one or more of the following features:

- cardiovascular disease;
- diabetes;
- Aboriginal and Torres Strait Islander peoples;
- tobacco smokers.
- obesity;
- hypertension;
- aged over 50 years; and
- a family history of kidney disease;

Step 2 - Kidney Health Check

Area Health Services will implement the Kidney Health Check in high-risk inpatient groups such as cardiology, cardiovascular, general medicine, endocrine, stroke, rehabilitation, geriatric medicine and maternity units, and include patients undergoing cardiac surgery and vascular surgery. Over time, it would be expected that the practice is expanded to other areas of the health service including high-risk outpatient clinics and Emergency Departments.

Patients identified as being at high risk for CKD should undergo the Kidney Health Check, as described below. All three tests, that is, assessment of urinalysis, blood pressure and an estimated measure of glomerular filtration rate must be conducted to constitute a Kidney Health Check.

- **Urinalysis ("Dip Stick")**

Proteinuria has been demonstrated to be an independent risk factor for progression of renal disease. Microalbuminuria is a predictor of progressive renal disease in diabetes.

Patient without diabetes	Test for protein	Abnormal > 30mg/dL
Patient with diabetes	Test for albumin	Abnormal > 3mg/dL (albumin specific dipstick)[5]

- **Blood pressure assessment**

Hypertension can contribute to the development of CKD.

Abnormal result	>140/>90 mmHg[6]

- **Estimated Glomerular Filtration Rate (eGFR)**

The eGFR is considered to be an accurate measure of kidney function, although the test is not always accurate in all circumstances (for example, in patients who are obese, elderly or for Aboriginal or Torres Strait Islander peoples).

Abnormal result	< 60 mL/min/1.73m^2

Clinicians should be mindful that proteinuria and haematuria may be clinical indications of a more rapidly deteriorating patient requiring immediate referral to a renal physician.

Step 3 - Follow Up

Should any of these results be abnormal, this suggests the possibility of CKD. A referral for ongoing assessment must be made, highlighting that re-testing is required to confirm a diagnosis.

The Kidney Health Check should be conducted no more frequently than twelve monthly in the absence of abnormal results.

IMPLEMENTATION

Area Health Services should implement the introduction of the Kidney Health Check and appropriate follow up arrangements in accordance with local policies and practices. Efforts to encourage compliance with recommended follow up arrangements should reflect the level of risk associated with non-compliance. This should include, but not be limited to:

- informing the patient of the need for follow up with their GP and/or Nurse Practitioner;
- referral to their GP and/or Nurse Practitioner for follow up; and
- provision of appropriate documentation for their GP and/or Nurse Practitioner and *written information* for the patient.

Sample letters for both the patient and the patient's GP and/or Nurse Practitioner are contained in Appendix 2 and 3.

It is anticipated that Area Health Services will develop an education program to support clinical staff to implement the Kidney Health Check. This could include an education program through Nurse Educators and Clinical Nurse Educators (so that education can be provided to staff of inpatient wards), through the established training/education sessions for junior medical staff and registrars, and through nurse practitioners in transitional positions.

Area Health Services must implement an evaluation framework to assess that the Kidney Health Check has been implemented and patient care improved. The Clinical Excellence Commission will be undertaking a longer term evaluation of the outcome of the Policy Directive at a state level.

REFERENCES

1 Levey AS, Coresh J, Balk E, et al. National Kidney Foundation Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification. *Annals of Internal Medicine.* 2003; 139:137-149.

2 *National Chronic Kidney Disease Strategy.* Kidney Health Australia. Melbourne, 2006.

3 Hoy WE, Wang Z, Baker PR & Kelly AM. Reduction in natural death and renal failure from a systematic screening and treatment program in an Australian Aboriginal community. *Kidney International Suppl.* 2003; 83:S66–73.

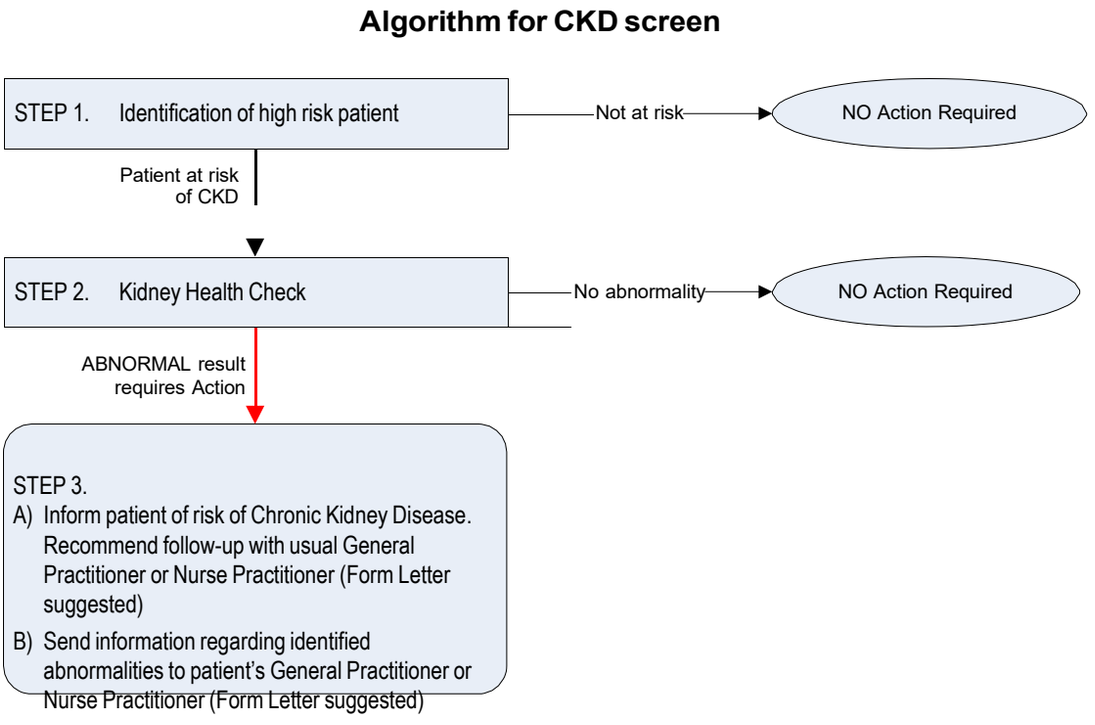
4 Perkovic V, Verdon C, Ninomiya T, Barzi F, Cass A, et al. The relationship between proteinuria and coronary risk: A systematic review and meta-analysis. *PLoS Med.* 2008; 5(10): e207. doi:10.1371/journal.pmed.0050207

5 *Testing for Proteinuria.* The CARI Guidelines – Caring for Australians with Renal Impairment. Published October 2004.

6 National Heart Foundation of Australia (National Blood Pressure and Vascular Disease Advisory Committee). *Guide to Management of Hypertension 2008: Assessing and managing raised blood pressure.* Updated August 2009.
http://www.heartfoundation.org.au/Professional_Information/Clinical_____Practice/Hypertension/Pages/default.aspx

7 *Chronic Kidney Disease (CKD) Management in General Practice.* Kidney Health Australia. Melbourne, 2007.

APPENDIX 1: Algorithm for CKD screen



STEP 1:	STEP 2:
High risk patients have 1 or more of the following risk factors: 1. Cardiovascular Disease 2. Diabetes 3. Aboriginal and Torres Strait Islander peoples 4. Tobacco Smokers 5. Obesity 6. Hypertension 7. Age over 50 years 8. Family history of Kidney Disease	**Kidney Health Check comprises:** I. Dipstick analysis for protein. II. > 30 mg/dL is abnormal III. Check Blood pressure. IV. >140/>90 mmHg is abnormal V. Check eGFR (estimated from serum creatinine). < 60 mL/min/1.73m^2 is abnormal

APPENDIX 2: Sample Letter Patients

APPENDIX 2: SAMPLE LETTER PATIENTS (Copy to GP or Nurse Practitioner)

Letter Head

[Name]
[Address]
[Suburb] [State] [Post Code]

Dear [Name]

During your hospital stay, routine screening showed that you may be at risk of developing early kidney disease. It is important that you are seen by your GP or nurse practitioner within 3 months so that a few simple tests can be redone to confirm if the condition is ongoing.

Chronic kidney disease often has no symptoms so regular screening of high-risk individuals is recommended. You may be at risk if you have one or more of the following features:

- a previous stroke
- heart disease
- high blood pressure
- a family history of kidney disease
- diabetes
- are of Aboriginal and Torres Strait Islander descent
- aged over 50 years
- obesity
- tobacco smokers.

The good news is that if kidney disease is found early, changes can be made to your lifestyle and/or medications can be prescribed to slow or stop the progression of the disease. If the condition is left untreated, the final outcome may be heart disease and/or end-stage kidney failure and premature death.

A letter has also been sent to your GP or Nurse Practitioner recommending that you are re-tested in 3 months and then annually. The testing, known as a Kidney Health Check, involves:

1. testing a urine sample for protein
2. taking your blood pressure to assess if it is within normal limits
3. taking a sample of blood to assess overall kidney function.

If you would like more information, please contact:

Name and position _____
Phone number_____

Please make an appointment with your GP or Nurse Practitioner 3 months after coming home from hospital for further testing.

Yours sincerely

[Name]

APPENDIX 3: Sample Letter to GP or Nurse Practitioner

APPENDIX 3: SAMPLE LETTER TO GP or NURSE PRACTITIONER

Letter Head

[Name]
[Address]
[Suburb] [State] [Post Code]

Dear [Name]

Re: (Insert patient identification sticker)

During (patient's name) recent hospital stay, he/she was screened for kidney disease. Clinical signs of the disease have been detected but diagnosis of the condition cannot be made until it is confirmed by further testing. *If you have already tested for chronic kidney disease within the last 12 months, then please disregard this letter.*

As you are aware, chronic kidney disease often has no symptoms. Regular screening of high-risk individuals through the ***Kidney Health Check*** is therefore recommended. Your patient was considered at-risk as they have one or more of the following features:

- cardiovascular disease
- hypertension
- family history of kidney disease
- Aboriginal and/or Torres Strait Islander origin
- diabetes
- aged over 50 years
- obesity
- tobacco smokers

A letter has been sent to your patient explaining that if chronic kidney disease is left untreated, the final outcome may be end-stage kidney failure whereby individuals require renal dialysis or a kidney transplant to avoid premature death.

What you need to do

Please repeat the ***Kidney Health Check*** within three months of your patient being discharged from hospital. This involves:

Procedure		Abnormal Results
STEP 1	Dipstick analysis for protein	Greater than 30 mg/dL
STEP 2	Check blood pressure	Greater than 140/90
STEP 3	Check eGFR (estimated from serum creatinine)	Less than 60mL/min

Kidney Health Australia's booklet on Chronic Kidney Disease (CKD) Management in General Practice (2007) contains information on screening and treatment protocols, and indications for referral to a Nephrologist. This can be accessed via the Kidney Health Australia website at http:// www.kidney.org.au/HealthProfessionals/PublicationsforHealthProfessionals/tabid/635/Default.aspx

If you would like more information on the contents of this letter, please contact (Name and position) on (contact phone number).

Yours sincerely

[Name]

END-OF-LIFE CARE AND DECISION-MAKING (GL2021_004)

GL2021_004 rescinds GL2005_057

GUIDELINE SUMMARY

Dying patients can be any age and are cared for in many settings including emergency departments, intensive care units, hospital wards, palliative care units, paediatric wards, residential aged care facilities, supported disability accommodation and the home. This Guideline provides useful advice for NSW Health staff about the process for navigating complex end of life decisions wherever that care is delivered.

NSW Health places a high priority on health practitioners working collaboratively with patients, their families and carers, as well as each other, throughout all phases of end of life care. This guideline sets out a process for reaching end of life decisions, in a way that safeguards both patients and health practitioners, through open and compassionate communication, appropriate treatment decisions and fairness.

KEY PRINCIPLES

Building consensus
A large part of this document focuses on building consensus, particularly where patients do not have the capacity to engage in the decision-making process about the role of lifesustaining treatment for themselves.

Respect for life and care in dying
A primary goal of medical care is preservation of life, however when life cannot be preserved, the goal is to provide comfort and dignity to the dying person and to support the person's family and/or carers in doing so.

The right to know and to choose
People relate to death and dying differently, often based on personal experience, culture and history.

Appropriate withholding and withdrawal of life-sustaining treatment
The goals of care shift to ensuring comfort and dignity, whereby withholding or withdrawal of life-sustaining medical interventions are often appropriate in the best interests of the patient or in accordance with a patient's Advance Care Directive (ACD).

A collaborative approach to care
The person responsible, families, carers and health practitioners have an obligation to work together to make compassionate decisions for patients who lack decision-making capacity.

Transparency and accountability
In order to preserve the trust of those receiving health care and to ensure that decisions are fairly made, the decision-making process, the decisions made and likely outcomes should be clear to the participants and accurately documented.

Non-discriminatory care
Everyone in NSW should be able to access quality end of life care when it is needed, regardless of their geographic location, age, condition, disability, socio-economic needs, cultural and religious background, gender identity, sexual orientation or languages spoken.

Rights and obligations of health practitioners
Adults have a right to accept or decline care and health practitioners have a responsibility to practice in accordance with community and professional norms and legal standards.

Continuous improvement
Health practitioners must strive for ongoing improvement in standards of end of life care.

USE OF THE GUIDELINE

This Guideline is designed for use by NSW Health staff who are part of the treating team involved in end of life care.

This Guideline should form the basis of local policy on end of life decision-making, considering local conditions and resources Local policy development is recommended for:

- minimum standards for documentation of decisions about withholding, or withdrawal of, treatment
- providing culturally safe and responsive end of life services
- dispute resolution for patients, person responsible, families, carers and staff.

Local policy may expand on this Guideline by, for example, identifying relevant persons or contacts within the hospital/local health district/specialty health network who may serve certain roles.

The End of Life Care and Decision Making guidelines can be viewed at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_004

336(08/04/21)

RESPONDING TO THE NEEDS OF PEOPLE WITH DISABILITY DURING HOSPITALISATION (PD2017_001)

PD2017_001 rescinds PD2008_010

PURPOSE

This Policy Directive has been updated and replaces PD2008_010 *Disability – People with a Disability: Responding to Needs During Hospitalisation.*

This policy describes the responsibilities of all staff working in hospitals caring for people with disability. The scope of the policy includes: pre-admission planning, admission to hospital, care planning during the hospital stay and planning for the transfer of the patient back to the community; planned and emergency admissions; and in-hospital patient care settings (including Hospital in the Home), hospital emergency departments, and hospital outpatient departments.

MANDATORY REQUIREMENTS

This Policy Directive applies to all NSW Health services, which are required to have local policies, protocols and procedures in place based on the attached Procedures in all hospitals that provide admitted patient services to people with disability.

This policy requires NSW Health organisations and staff to provide services to people with disability that are:

- Inclusive
- Person-centred
- Accessible.

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Health service staff must:

- Make reasonable adjustments according to needs of the individual
- Communicate with and provide information to the person with disability in a way they understand
- Involve the person with disability, and where appropriate, consult their carer, family, guardian and / or disability support staff as outlined in the attached policy directive
- Implement this policy in conjunction with other NSW Health policies relevant to admission to, treatment in, and transfer out of hospital as referenced in this policy.

IMPLEMENTATION

The following NSW Health organisations have responsibilities in relation to this policy:

- Local Health Districts (LHDs)
- Statutory health corporations – network governed (Specialty Health Networks)
- Statutory health corporations – chief executive governed
- Statutory health corporations – board governed
- Affiliated Health Organisations
- Statewide health services.

These organisations and their staff will:

- Treat people with disability, their carers and families equitably, with respect and use a person-centred approach in line with the guiding principles outlined in the attached Procedures
- Aim to keep people with disability healthy and out of hospital
- Allocate responsibility for implementing this policy in hospital facilities to an executive role
- Review their systems for meeting needs of people with disability in line with this Policy Directive, including but not limited to use of the Implementation Checklist in Appendix 3
- Use existing patient safety and quality monitoring processes to identify and address issues in the quality of health care provided to patients with disability and associated outcomes
- Monitor length of stay and unplanned hospital re-admission rate for people with disability and develop mechanisms to determine if there is a difference in outcomes for people with disability when compared to the general population
- Use this policy in the development of LHD / SHN local policies, protocols and procedures related to improving health care provided to people with disability when they are hospitalised (from admission to transfer to care).

Under this Policy Directive the NSW Ministry of Health will:

- Monitor and provide guidance and policy support to relevant health organisations to implement this policy
- Promote awareness of this policy across the NSW Health system
- Encourage LHDs, SHNs and other relevant health organisations to involve people with disability in the development of local policies, protocols and procedures
- Encourage LHDs, SHNs and other relevant health organisations to adopt the principles outlined in this policy.

1. BACKGROUND TO THIS DOCUMENT

This Policy Directive is an update of and replaces PD2008_010 Disability – People with a Disability: Responding to Needs during Hospitalisation.

The purpose of this policy is to improve the experience of people with disability accessing the State Health system, providing a safe and responsive stay during hospitalisation. This policy sets out the requirements of effective communication with the person with disability and where relevant their carer, family, guardian and disability support staff. It also sets out requirements to make reasonable adjustment during the patient journey to ensure people with disability access equitable, effective and safe health care.

Disability for the purpose of this policy is defined as "a long-term physical, psychiatric, intellectual or sensory impairment that, in interaction with various barriers, may hinder the person's full and effective participation in the community on an equal basis with others."[1] Disability itself is not an illness but people with disability may have long-term illnesses, chronic diseases, or co-morbidities that require ongoing attention and management.

People with disability have the right to the highest attainable standard of health. This is achieved through being able to access health services on an equitable basis, receive care that meets individual assessed health needs and through appropriate supports that ensure that high quality health care services are received prior to, during, and after hospitalisation; that barriers are not created due to a person's disability.

The NSW Disability Inclusion Act (2014) commits the NSW Government to making communities more inclusive and accessible for people with disability. This will be achieved by, among other things, promoting the independence of people with disability and enabling choice and control.

This policy, in alignment with the Act, requires staff to provide services that are inclusive, person-centred and accessible.

2. KEY PRINCIPLES

2.1 Inclusion

The NSW Government is committed to supporting the fundamental right of people with disability to "have the same right to choose the way to live their lives, to access the same opportunities and enjoy the benefits of living and working in our society", and that the state and community have a responsibility to facilitate the exercise of those rights.[2]

For more information on how NSW Health is working to improve access and inclusion for people with disability see the *NSW Health Disability Inclusion Action Plan (DIAP) 2016-2019.*

2.2 Person-centred services

A person-centred approach places the person at the centre of decision making, and works with the carer, family, guardian, natural networks of support, and service providers as partners.

For the person to be at the centre of care he or she needs to be well informed about the hospital experience and involved at the centre of decision-making through all the stages of: planning for admission, during hospital stay, and transfer back to the community.

The treating practitioner is responsible for determining the capacity of the person with disability to participate in developing person-centred care plans, or what type of assistance the person needs to support their participation.

[1] NSW Disability Inclusion Act 2014 No 41
http://www.legislation.nsw.gov.au/maintop/view/inforce/act+41+2014+cd+0+N
[2] p.5, NSW Disability Inclusion Action Planning Guidelines 2015,
http://www.facs.nsw.gov.au/__data/assets/file/0004/322366/NSW-DIAP-Guidelines.PDF

2.3 Accessibility

Accessibility includes access to the full range of hospital services and hospital amenities, and information about hospital services including complaints mechanisms. NSW Health organisations should ensure that facilities, services and information are accessible to both the person with disability and those who support them.

Ways to improve access to facilities include:

- Ensuring there is adequate space for wheelchairs and other equipment, and assistance animals
- Ensuring staff are aware that assistance animals are allowed in hospital buildings, including awareness of the Guideline on GL2012_007 - *Animal Visits and Interventions in Public and Private Health Services in NSW*
- Ensuring call systems, diagnostic equipment, toileting facilities, emergency / evacuation procedures and examination tables are fully accessible
- Having an alternative call system in place for patients who are unable to reach or use the call bell
- Providing any information available to patients, and their families, in an accessible format, for example signage, labels, directions and instructions.

Accessibility of information for patients

Health professionals have an obligation to ensure that information is provided to patients in a way that they can understand. This obligation could include the provision of communication aids, including interpreters or translators.

Information should be given in advance of admission to hospital, where possible, to the person, and to their carer and / or their support network as this will enable them to explain the information and prepare the person prior to the hospital stay.

Written information can be made more accessible when it is supported by verbal information given in an explanation. During hospitalisation, from pre-admission to transfer out of hospital, appropriately trained staff should take the time to go through written material with the person with disability, then check whether the person has understood the information, and answer any questions they may have.

2.4 Communication

The most significant factor associated with both a positive and a negative patient experience is the existence and degree of effective communication between health staff and the patient.

It is important there is effective communication between health staff, the person with disability and where relevant their carer, family, guardian and / or disability support staff to understand the person's health and support needs, to understand expectations and feelings, and respective roles and responsibilities.

People with significant and permanent disability living in both residential care and the community are a particularly vulnerable population. Many people often require assistance with activities of daily living, including communication. It is important that the communication support required is identified, documented and used.

All communication should always be addressed in the first instance to the person with disability in matters including treatment, comfort, services, supports, amenities and needs relating to their disability. Health professionals should consult the person with disability for advice on the most effective method of communication.

If the person is unable to advise hospital staff of the most effective method of communication, health professionals should then consult the carer, family, guardian and / or disability support staff for information about what is 'usual behaviour', how the person communicates and whether they use any particular Augmentative and Alternate Communication (AAC) methods.

Information on the person's communication needs and preferences must be documented in communication profiles in care plans, records and the Transfer of Care Referral form. Documentation should include any communication aids used by the patient, interpreting gestures, signs and behaviours which they may use to convey their needs and responses.

Ways to improve communication:

- Recognise that some patients may be unfamiliar with healthcare information and address each person's level of understanding
- Identify methods a person may use to communicate such as signs and gestures and use these methods when communicating with them such as pointing to objects
- Always speak directly to the person and not through the interpreter or the person's carer, family member or companion
- Allow sufficient time and be patient when communicating
- Listen attentively when talking with a person who has difficulty speaking and let them finish
- Keep sentences short, be specific and talk about one step at a time
- If you are not understood, repeat or rephrase the information, reduce the amount of information, use visual supports, or seek help from someone who knows the person well
- Confirm that the person (or carer / family member / disability support staff) has understood all the information provided, encourage questions
- If you do not understand the person, do not pretend to understand, clarify and confirm what the person is saying, ask the person to say it in a different way, ask the person to show you what they mean, check if the person's non-verbal communication supports what they are saying[3]
- People with a cognitive and / or psychiatric disability may require key information to be communicated more than once - using reminders and reassurance can improve communication.

Additional training may be required for health care workers to optimise their ability to effectively communicate with people with disability.

Health professionals may need to access information from other parties to assist in providing appropriate care to a person with disability. The person with disability should be actively involved as much as possible in providing information to health professionals, being informed about their care in hospital, and making decisions about their care.

Health Care Interpreting and Translating Services

The Policy Directive, PD2006_053 - I*nterpreters - Standard Procedures for Working with Health Care Interpreters* is a mandatory policy. This Policy Directive requires the use of professional health care interpreters (Australian Sign Language (Auslan) and / or spoken languages) to facilitate communication between staff and people who are not fluent in English, or people who are deaf.

- Health care interpreters are professionally accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) or similar accreditation agencies
- Staff are not to be used as interpreters unless they are NAATI accredited at least at paraprofessional level
- NAATI accredited interpreters (AUSLAN and spoken languages) must be booked, as necessary and as requested, to communicate with people with disability and/or their carer and family
- Services are available 24 hours per day, 7 days per week. The service is available either face-to-face, by telephone or via videoconference if available.
- Interpreters are also available to provide 'sight translation' of documents such as consent documents. Sight translations should always occur in the presence of health service providers so questions can be addressed

[3] Complex communication needs. Department of Communities (Disability Services), QLD. 2011 https://www.qld.gov.au/disability/documents/community/complex-communication-needs.pdf

- Subject to the requirements of the NSW Health Privacy Manual for Health Information carer, family, guardian, advocates, and / or disability support staff may be consulted using an interpreter for information that may affect the care or treatment of the person with disability
- It should not be assumed that because a person has good spoken language they have equal understanding of written language
- It should not be assumed a person whose first language is Auslan has English literacy skills.

2.5 Reasonable adjustment

In order for health care services to be accessible and safe for people with disability, adjustments need to be made. Making reasonable adjustments means doing things differently to ensure people are not disadvantaged or harmed.

In practice reasonable adjustment means "removing barriers people with disabilities experience in accessing services. This includes changing the ways services are delivered, ensuring that protocols and procedures work equally well for people with disabilities, and ensuring that staff are equipped with the necessary training and resources to deliver effective, timely and quality healthcare to people with disabilities".

In the context of anti-discrimination legislation, a person-centred approach to individualised-planning, the requirements of the *Disability Inclusion Act 2014*, and the National Disability Insurance Scheme (NDIS) there is growing expectation and increasing demand for accommodating the needs of people with disability through mainstream services.

The *Disability Discrimination Act 1992*[4] (Cth) (the Act) recognises the rights of people with disability to equality before the law and makes discrimination based on disability unlawful. The Act defines both direct and indirect disability[5] discrimination. A failure to make reasonable adjustments[6] is an explicit feature of the definitions of direct and indirect discrimination.[7]

Local Health Districts (LHDs) / Specialist Health Networks (SHNs) must make reasonable adjustments to respond to the needs of people with disability during hospitalisation. Health staff should consult with the patient and where relevant their carer, family member, guardian and / or disability support staff and acknowledge and act on the advice provided.

Examples of reasonable adjustment include:

- Adjusting communication methods by taking into account the patient's communication needs
- Addressing the patient's ability to cope with different environments, changes in routines, unfamiliar procedures and unfamiliar staff
- Addressing the patient's need to change the ways in which care or treatment is provided
- Allowing extra time to provide the support that is required
- Including and supporting the patient's carer, family member, guardian or disability support staff as expert care partners
- Providing patient information in alternate formats such as 'easy read' documents.

LHDs / SHNs must consider:

- The barriers a person with disability may experience within their hospital's facilities, processes and systems
- The individual person's specific needs
- Supports the NDIS can or is providing for the patient and how they complement Health interventions.

[4] https://www.comlaw.gov.au/Details/C2015C00252/Html/Text#_Toc422301339
[5] Sections 5 and 6 https://www.comlaw.gov.au/Details/C2015C00252/Html/Text#_Toc422301340
[6] Definition of reasonable adjustment is defined in section 4(1); definition is copied in the Glossary.
[7] See section 5(2) direct discrimination and section 6(2) indirect discrimination.

3. THE PATIENT JOURNEY

Hospital can be a daunting experience for patients, in particular for people with disability due to unfamiliar environments, routines and care arrangements.

A hospital stay can have a significant negative or destabilising effect on people with disability as well as their carer, family, guardian and support networks. It can result in a loss of living skills, depression, and poor adjustment to school, employment and relationships. Some children, young people and adults with disability spend significant amounts of time in hospital.

For people with physical disability, hospitalisation can result in deterioration in their general physical and mental condition such as: loss of joint range, muscle strength and tone, functional independence, and ability in activities of daily living. Similarly, the patient's previous confidence in mobility may deteriorate unless this is noted on admission and reinforced daily within the limits of the patient's presenting diagnosis or condition. The patient's confidence in their ability to perform all functional tasks within the limits of their disability may also deteriorate unless health professionals continue to encourage maintenance of, or improvement on pre-hospitalisation independence.

Where appropriate, Hospital in the Home (HITH) should be considered for people with disability to enable them to receive the hospital care they need in their home environment allowing for the maintenance of routines and care arrangements.

Where hospitalisation is needed, it is important that people with disability receive flexible service delivery, where the health service adapts to meet their particular needs. Ensuring the patient is at the centre of their care, involved in pre-admission planning and supported with information will lead to a good hospital experience for people with disability.

While communication, consultation, consent and planning are essential elements of a good hospital experience for all people, these elements can be particularly important for people with disability.

3.1 Privacy

The collection, use, exchange, or disclosure personal information about the patient must be undertaken in accordance with the *NSW Health Privacy Manual for Health Information* (the Manual) which can be found at: http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx

The NSW Privacy Commission has issued a Direction for permitting an exception to the Health Privacy Principles to enable the exchange of health information to assist in the transition of funded individuals to the NDIS.[8]

The link to the Direction is
http://www.ipc.nsw.gov.au/sites/default/files/file_manager/NDIS_s62_HRIPA_Direction_Approved_by_Min_of_Health.pdf

The direction will enable Family and Community Services (FACS) (and other NSW public sector agencies including Health and Education) to collect, use and disclose personal health information about individuals and their carers, who receive disability supports funded by FACS, Health, NSW public sector agencies or an allied agency for the purposes of transitioning funded individuals to the NDIS.

The National Disability Insurance Authority (NDIA) will use this information to contact those individuals and commence their entry into the NDIS.

Guidance should be sought from LHD / SHN Privacy Contact Officers in relation to any external requests to release patient information under the Direction:
http://www.health.nsw.gov.au/patients/privacy/Pages/privacy-contact.aspx

Resource: Privacy Information Leaflet for Patients
http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-appendix-5.pdf

[8] This Direction has effect until 28/10/2017

3.2 Consent

The NSW Health Policy Directive PD 2005_406 - *Consent to Medical Treatment – Patient Information* sets the legal requirements for obtaining a valid consent from patients and advising patients of material risks associated with any proposed medical or dental treatment.

The policy also outlines how the law is to be applied when obtaining consent from a person who lacks capacity, is a minor, or is a patient who is being treated under the *Mental Health Act*. The Consent Policy can be found at: http://www0.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf

Treating practitioners should assume that an adult patient has capacity to consent unless there is evidence to contradict this assumption. The patient must have capacity to give consent to medical or dental treatment. A person has decision making capacity if they can:

- Understand the facts and choices involved
- Weigh up the consequences, and
- Communicate their decision.

For information on obtaining consent for people who lack capacity see Appendix 2.

3.3 People with disability and their support networks

People with disability may have a range of support needs and may access these supports from a range of sources, and have multiple parties involved in providing care or support to have those needs met.

It is important that health professionals find out if the person with disability has a support network and whether the person will need the support network's involvement during their hospital stay.

Developing a plan for disability support while in hospital should be part of pre-admission planning.

Health staff should communicate with the carer, family, guardian, and / or disability support staff, about ways to provide safe and personalised care for people whose disability could result in significant risk of harm to themselves, the carer or hospital staff e.g. due to fear, anxiety, absconding, challenging behaviours, difficulties with communication.

With the consent of the person with disability, health professionals should ensure that appropriate information is effectively communicated to the relevant members of the person's support network, in both the admission and the transfer of care planning stages.

Refer to section 4.2 Protocols between key agencies on LHD / SHN responsibility for negotiating and establishing frameworks and protocols with local disability support service providers for the provision of disability support services to the person with disability while they are in hospital.

Carers, family members, and disability support staff may assist with basic needs at the request of the person with disability and in consultation with health professionals, but are not obliged to assist with individual or medical care needs.

Carers

A carer[9] provides ongoing, unpaid[10] support to a family member, neighbour, or friend who needs help because of disability, chronic, terminal or mental illness or frail ageing.

The patient, their carers, hospital staff and the health care system all benefit from involving carers as a partner in the health care team. The work carers do is essential to the wellbeing of the person with disability and it is essential that they are listened to and consulted with through all stages of a person's hospitalisation.

The level of carer involvement may vary. Regardless of whether the carer chooses to remain with the person, or not, carers should be consulted at all stages of the patient's hospitalisation.

[9] As defined in the NSW Carers (Recognition) Act 2010, refer to the Glossary for definition.
[10] Carers may receive the Carer Payment or Carer Allowance
http://www.humanservices.gov.au/customer/services/centrelink/carer-allowance

LHDs / SHNs should develop local policies which outline the level of support that is available for the carer while the person with disability is in hospital e.g. bedside accommodation for the carer or family are providing support to the patient.

When a person the disability has a paid carer or disability support worker, due consideration will need to be paid to their status on the wards as an employee of the person with disability. Please refer to section 4.2 for more specific advice.

3.4 Care coordination

Care coordination and transfer of care arrangements for people with disability should be made in accordance with NSW Health Policy Directive PD2011_015 - *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*[11] [12], which sets out five stages of care coordination:

1. Pre Admission / Admission
2. Multidisciplinary Team Meetings
3. Estimated Date of Discharge (EDD)
4. Referrals and Liaison for patient transfer of care
5. Transfer of care out of the hospital.

LHDs / SHNs are responsible for establishing mechanisms to ensure that the essential stages of care coordination are undertaken in each facility and are sustained as part of normal care coordination and transfer of care planning.

Preparing for planned admission

Health services should ensure that as part of their pre-admission screening process, people with disability are offered pre-admission meetings for all planned episodes of hospitalisation. A relatively simple procedure can become unnecessarily complicated if there is insufficient pre-admission planning to ensure optimal supports are in place for the person with disability.

If the person requires multiple tests and / or procedures, consideration should be given to scheduling these in a way to maximise outcomes for the person during their admission to hospital.

Close liaison with the person's General Practitioner (GP) or other community based health professionals will support safe, quality, smooth admission into hospital and subsequent transfer back to the community.

Hospital staff should inform and involve the person's carer, family, guardian and / or disability support staff in planning for the admission as appropriate and with the agreement of the patient.

Should there be an expectation that during the patient's admission their accommodation needs will change, discussing these with the patient and their carer or family as early as possible will facilitate a smoother discharge.

Information about the facility's Patient Representative and consumer feedback mechanisms as well as the Inquiry Service of the Health Care Complaints Commission should be provided as part of pre-admission planning.

[11] http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_015.html

[12] Care Coordination. The following links to three documents that were developed to support staff with implementation of the Policy Directive PD2011_015 *Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals*: http://www.health.nsw.gov.au/pfs/Pages/carecoordination.aspx . The three documents are:

1. Care Coordination Policy Directive Reference Manual
2. Care Coordination Policy Directive Staff Booklet
3. Planning your hospital stay patient brochure

Pre-admission meeting

A pre-admission meeting should be arranged with the person, and when relevant, involve the carer, family, guardian, disability support staff and relevant hospital staff. Reference should be made to GL2013_001 section 4.3.1, Pre admission meeting (pp.10-11), of the *NSW Health and Ageing, Disability and Home Care (ADHC) Joint Guideline: Supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital*, NSW Health.[13]

Staff should be aware that additional time may be needed to develop a pre-admission plan with people who use augmentative and alternative communication methods.

Hospital staff should ensure that information about the hospital admission, hospital routines, and procedures are communicated to the person in the person's preferred communication style.

Transfer of Care Risk Assessment Tool

The person conducting the Transfer of Care Risk Assessment (TCRA) is responsible for communicating any identified risk to the relevant members of the multidisciplinary team. When a transfer of care risk is identified it must be documented and managed.[14]

A TCRA should be conducted at pre-admission and patients with an identified risk should be referred early to the appropriate community teams so planning for transfer back to the community can begin. Completion and actioning of the TCRA within the first contact with the patient, or within 24 hours will expedite this process.

Planned day-only admission

Transfer of care planning must also occur for patients having day-only procedures. Hospital facilities may nominate their own processes to ensure the Transfer of Care Risk Assessment is completed. Ideally this should occur prior to the day of the patient's procedure.

Pre-admission plan

The following issues may need to be addressed in order to complete a pre-admission plan for a person with disability:

- Disclosure of information and the inclusion of others from the person's support networks in the pre-admission and discharge planning process in line with the *NSW Health Privacy Manual for Health Information*
- Identification of whether the person is a participant of the NDISor in the process of making an application to the Scheme
- Procedures for determining informed consent
- Information regarding medical history, social and functional skills
- Clarification of the role of parties involved in care of a person with disability during the hospital stay, including the role of hospital staff, carer / family and disability support staff
- Key community resource contacts, where community or disability service agencies are involved or may be available
- Transportation and mobility requirements
- Physical support needs including appropriate lifting and positioning
- Nutrition and diet requirements; eating and drinking techniques
- Hygiene assistance needs
- The person's specific communication requirements. Hospital staff responsible for planning the admission should ensure that if required a person with disability can bring to hospital their communication resources or equipment such as augmentative communication devices, mobility or functional aids

[13] http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_001.pdf
[14] p. 1, Policy Directive PD2011_015 *Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals*, http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_015.pdf

- Management strategies for difficult or challenging behaviours. Consider involving Dementia Specialists e.g. Clinical Nurse Consultant Aged Care in a suitable management plan
- Consideration of usual care and activity routines to ensure that any medical intervention causes the minimal amount of disruption, confusion and stress to them
- Specific information on equipment that patients must bring to the hospital e.g. for pressure care, respiratory support, should also be discussed. Consider involving Occupational Therapy and Physiotherapy in discussions regarding required equipment
- Hospital staff should ensure that space is provided for comfortable operation and safe storage of equipment, and that the equipment is readily available for use
- Patients who use an assistance animal, such as a guide dog, should not be separated unnecessarily from the animal, and space and care for the animal should be planned and made available
- Conflict resolution mechanisms
- Hospital complaints mechanisms and processes.

Planning for an extended hospital stay may need to include strategies to assist the person to maintain their skills and capacities such as:

- Hospital day passes to access day program and community services can assist in sustaining pre-hospital functional capacity
- Patients, their carer and family, where the patient is an NDIS participant, should be consulted to acquire details of any education, home or day programs that they receive funding for and how those may be accessed.
- Where the patient is not an NDIS participant, they should be consulted to determine whether they are involved in any Information Linkages and Capacity Building (ILC), state / Commonwealth provided education, respite or day supports and how these are accessed
- Where the patient is a long stay resident, the NDIA will need to be informed that the Hospital will temporarily assume the status as the clients' place of residence and that all correspondence should be sent there
- Patients with intellectual disability who underutilise their skills will risk losing those skills. In extended admissions, where possible, hospitals should seek input from their current disability supports and education services for their day-to-day care.
- Where practicable, enable children to continue their school education activities and have access to play therapy.

Engage with the National Disability Insurance Agency (NDIA)

When the person with disability has identified themselves as a participant of the NDIS, identify on what basis their plan is being managed:

- Self-managed – the person with disability will be able to discuss their plan components and, as the coordinator of supports, work with hospital staff to incorporate discharge and ongoing service needs into their budget

- Plan Management Provider – appropriate client consent needs to be gathered and contact made with the plan management provider to ascertain the types of disability supports the client is funded by the NDIS for and discuss their future discharge needs.

Where the person with disability is <u>not an NDIS participant,</u> consideration should be given at the pre-admission stage as to whether they may be eligible for the NDIS. If the person with disability is understood to satisfy the access requirements then they should be supported with an application to the NDIA as early as possible. However this should not delay the planned hospitalisation unnecessarily.

3.5 Admission

When a person with disability is admitted to hospital, health staff should ask the patient, what communication needs they have, whether they are in the NDIS, what existing home support networks they have in place and how their supports and care are coordinated at home. It should always be assumed that the patient is capable of providing consent unless there is evidence (legal or other) otherwise. See Appendix 2: Obtaining consent from a person who lacks capacity.

Planned admission

All planned admission patients should have their Transfer of Care Risk Assessment completed at presentation or before admission to hospital, such as at a pre-admission clinic or meeting. Completion of this assessment will allow the identification of transfer of care risks. Necessary referrals should be made before admission, where possible, and confirmed during the acute phase of care.

Emergency or direct admission

An emergency admission for a person with disability may result in a lack of optimal supports being readily available because of the absence of pre-admission planning.

Non-planned admissions through the Emergency Department or through direct admission should have a Transfer of Care Risk Assessment completed on the inpatient ward within the first 24 hours of admission.[15] This will ensure that all risks to the safety and wellbeing of the person while in hospital are identified, and appropriate arrangements made for the availability of supports needed by the person while they are in hospital. The risks identified and arrangements made should be documented in care plans, records and Transfer of Care Risk Assessment. This should be done as soon as practical either prior to transfer to the ward or once the person is settled in the ward.

People with disability admitted through the Emergency Department should be asked whether they are a NDIS participant. Refer to discussion under *Engage with the National Disability Insurance Agency* above for reasons and suggested action.

Where the patient has a known intellectual disability, the presence of a known person may reduce stress, reduce the risk of escalating challenging behaviours and improve overall health and safety outcomes for the health service and the person with disability alike.

Emergency admission to hospital from an Ageing, Disability and Home Care (ADHC) operated or funded supported accommodation

Reference should be made to *NSW Health and Ageing, Disability and Home Care (ADHC) Joint Guideline supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital*[16] NSW Health GL2013_001 (pages 9-10), which sets out what the disability support staff member who accompanies the person to hospital will do at presentation to the Emergency Department.

Emergency admission from non-government supported accommodation facilities and contracted accommodation providers under the NDIS.

LHDs / SHNs should consult with clients and their local non-government (NGO) supported accommodation providers, for example assisted boarding houses, to develop frameworks and protocols to establish arrangements for patients to be admitted through the Emergency Department from those facilities. Reference should be made to the Joint Guidelines for examples of issues for which there should be agreed frameworks and protocols between the LHD / SHN and the NGO. Refer to section 4.1 on NGO's.

[15] p.2, Policy Directive PD2011_015 *Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals*, http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_015.pdf
[16] http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_001.html

3.6 During the hospital stay

All staff providing care must ensure that they are familiar with the specific care and communication needs of the person with disability throughout the duration of their hospitalisation.

Staff will need to recognise the individual needs that some patients with complex impairments may have and make additional time is available for discussion and treatment.

Staff and other resources may need to be available to enable patients to access usual care in activities such as eating, drinking, toileting and personal hygiene. Some patients with disability may also require frequent checks on their safety.

In some cases, simple techniques can be used to enable patients to access usual care – for example, letting a patient who is blind know that their meal has arrived, where it is, and where different parts of the meal are on a plate, acknowledging the patient when entering or leaving the room; obtaining the visual attention of a person who is deaf or hard of hearing prior to addressing or approaching them.

Additional staffing resources may be required to meet these needs. Refer to section 2.5 Reasonable adjustment.

Multidisciplinary Team meeting

Refer to Policy Directive PD2011_015 - *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* for policy requirements on:

- Conducting multi-disciplinary team meetings
- Estimated Date of Discharge (EDD).

Referrals and Liaison

In consultation with the patient, their carer, family, guardian and/or disability support staff, it is important to agree what services are required after transfer from hospital following an acute episode of care. Where the supports are not chronic or disease focused, the patient may be able to acquire supports through NDIS funding.

Each hospital is required to develop a referral structure to enable staff to easily contact relevant chronic condition or disease service providers. When the patient is in the NDIS, they will need to provide details of their current relevant service providers as well as their plan management provider and be ready to contact the NDIA about their plan.

Involvement of NDIA planners, during discharge planning by multidisciplinary teams, should be considered to ensure that health related components are represented in NDIS applicant's plans and that a proper discharge timetable can be constructed.

Details for referrals should be recorded in one place in the patient's medical record and on any relevant individual referrals, for example to the patient's General Practitioner (GP) and other community based services. [17]

Where a patient has given permission for Health staff to contact their community service provider, Community based staff who will be involved in providing out of hospital care and support should be encouraged to visit the patient while they are in hospital to assess their ongoing needs at home and discuss the patient's needs with the Multidisciplinary Team.

Examples of out of hospital programs or services (non-NDIS) that may support transfer of patients from hospital, or patients in the community, are:

- Community Packages (ComPacks)
- Hospital outpatient department services
- Community nursing
- General Practitioners.

[17] p.5, Op.cit.

3.7 Transfer of care out of hospital

Clear communication between the patient, carer, family, guardian, hospital staff, community-based services and the person with disability's support network is vital to an effective transfer of care process.

Special information that should be noted and will assist in the completion of the Transfer of Care Risk Assessment and Transfer of Care Readiness Checklist, and identification of the Estimated Date of Transfer includes:

- Whether the person has capacity to consent to medical treatment, and, if not, what arrangements have been made for someone to make decisions on behalf of the person
- Clarification of the patients' NDIS status and of the role of people already involved in providing supports and their contact details
- Mobility and transport requirements.

Information provided to patients, and where appropriate, to carers, family, and disability support staff who will be involved in their ongoing care should be in plain English and explained to the patient and those who will be involved in their care.

The transfer of care process for the person with disability must include:

- Determination of the suitability of existing home support systems or the patient's NDIS plan components (if an NDIS client), when completing a Transfer of Care Risk Assessment. This should involve consultation with the patient, and, where appropriate, their carer, family, guardian, their advocate, and provider of supports to establish the level of care and support needs required. Environmental adjustments should be made as needed
- Referral to out of hospital, community-based health services, or specialist services as required by the patient:
    - Arrange appointments for post hospital services as required, examples:
        - Follow up appointments with medical specialists related to acute episode of care, and if needed, referrals for management of chronic conditions or disease
        - Allied Health services
        - Hospital outpatient department.
    - Refer the patient, if needed, to post hospital home visits by nursing services. For surgical admissions, post-surgery links with community health services (e.g. community nursing services). Referrals are to be made before transfer of care and service/s negotiated, including consideration if the patient's care needs can be met on a short or long-term basis
    - Provide information about the appointments and arrangements to the patient and where appropriate to their carer and or family. If the person's home is in supported accommodation this information should be provided to the disability support staff that provide support to the person
- Medication education / medical reconciliation: if the Multidisciplinary Team identifies the patient has a medication risk (as per Transfer of Care Risk Assessment) the patient should be prioritised for the pharmacist's review over non-urgent cases
- Provide information and relevant education and training to the patient, and, where appropriate, their carer, family, guardian, and disability support staff. The information should include: post-hospital care and support the person needs, including: changes to or new medication/s or treatments reflecting any changes in care required as a result of the hospitalisation or treatment provided
- Explain the transfer of care plan to the patient, and where appropriate, to their carer, family, guardian, and disability support staff

- In the case of a patient living in supported accommodation, the transfer of care plan needs to be developed in collaboration with the patient, and where appropriate their carer, family, guardian, and disability service provider/ staff in a case conference
- Notify, advise and confirm transfer date and time with carer, family, guardian and disability support staff.

It may not be feasible for the patient to return to their previous accommodation on leaving hospital, including people who were admitted from supported accommodation. For example, if a clinical event has changed their ongoing care needs the patient's support arrangements may need to be altered. Early identification of the person's care needs after the hospital stay and timely referrals to establish appropriate arrangements may minimise delay in transfer of care out of hospital. The person, their carer, family, and guardian should be involved in these discussions and supported while arrangements are made for alternative residential accommodation.

Progressively from June 2016 where a person with disability requires functional supports to be put in place in order to be safely transferred back to the community and they are not an NDIS participant, consideration should be given to an application being made to the NDIA. This should be done as soon as practical, ideally as a part of pre-admission planning or shortly after admission, in order for the NDIA to make a decision about eligibility and for an appropriate plan to be put in place.

Transfer of care referral (known as transfer of care summary or discharge summary)

The patient's General Practitioner (GP) or Aboriginal Community Controlled Health Service (ACCHS), and community nurse (where required) should receive a written transfer of care referral when the patient is transferred out of hospital or within 48 hours of the transfer.

The transfer of care referral should include:

- A summary of the person's clinical episode of care
- A list of medications with information about changes to medications
- Follow up advice for the GP or ACCHS
- Details of community services involved or residential care arrangements
- Information on the person's communication needs and preferences. Documentation should include: communication aids used by the patient, interpreting gestures, signs and behaviours which people may use to convey their needs and responses.

The transfer of care plan should be explained to the patient, and where appropriate, to their carer, family, guardian, and disability support staff.

In short stay services such as emergency departments, day only or planned day only services, a short stay referral summary may be utilised instead of a full transfer of care referral summary; as clinically appropriate.

4. IMPLEMENTATION AND MONITORING

4.1 Local working relationships

LHDs / SHNs should establish effective working relationships with local community based health and disability service providers to improve transfer of care for people with disability between public health facilities and community based service providers.

Examples of types of organisations include:

- National Disability Insurance Agency (NDIA)
- Plan Management Providers funded by the NDIA
- Community based medical practitioners, includes specialists and General Practitioners

- Community based allied health services (private; non-government)
- Disability service providers
- Community organisations
- Supported accommodation providers
- Aged care providers
- Aboriginal Medical Service (AMS)
- Aboriginal Community Controlled Health Service (ACCHS).

LHDs / SHNs should work collaboratively with community based service providers to establish effective referral pathways to ensure coordination of care around the needs of the person with disability.

Stakeholders

The phased implementation of the NDIS across NSW from July 2016 is likely to increase the number and diversity of non-government disability support services.

LHDs / SHNs should ensure that organisations representing people with disability, such as disability advocacy and carers organisations are consulted in implementing changes to health service systems to interface with the new disability service system that will result from the reforms.

4.2 Protocols between key agencies

LHDs / SHNs should develop and establish agreements and protocols with local disability support providers to apply in situations where disability support staff or disability support nurses provide disability supports in the hospital or acute care setting.

Section 2.5 Reasonable adjustment is relevant to this section.

Ageing, Disability and Home Care (ADHC) operated and funded accommodation support services

The NSW Health and Ageing, Disability and Home Care (ADHC) Joint Guideline: Supporting Residents of ADHC Operated and Funded Accommodation Support Services Who Present to a NSW Public Hospital, NSW Health GL2013_001 [18] (Joint Guideline) aims to ensure staff in hospitals and disability accommodation services operated and funded by ADHC are aware of their respective roles and responsibilities for people with disability before, during and after transfer of care from hospital.

Reference should be made to the Joint Guideline in situations when a person with disability is admitted to hospital from an ADHC operated or funded facility, for guidance on:

- Roles and responsibilities of staff in hospitals, and disability accommodation support services before, during and after transfer of care from hospital
- Identifying areas of risk that could compromise a person with disability's capacity to achieve the best health outcome and their safety and/ or dignity during their hospital stay
- Agreeing on what additional supports will be required to reduce identified risks
- Negotiating responsibility and resources for the provision of agreed additional support.

Non-government supported accommodation

People with disability living in non-government organisation (NGO) supported accommodation may receive support from disability support staff, which includes any of the following: residential care workers, assistants, physiotherapists, occupational therapists, speech pathologists, psychologists, social workers, nurses, case managers, and other support staff who are involved in the care or support of the person at the time of hospitalisation. Residential care workers are most likely support providers.

LHDs / SHNs should develop frameworks and protocols with NGO service providers in their district for the provision of supports and care to people with disability before, during and after transfer of care from

[18] http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_001.html The Joint Guideline was endorsed by ADHC and NSW Health, and was developed in consultation with key stakeholders across health and disability sectors. The Joint Guidelines notes some Local Health Districts and ADHC Regions have developed local protocols which provide the framework for effective support of ADHC clients during a hospital stay, and the Guideline aimed to facilitate a higher level of compliance with NSW Health and ADHC policies.

hospital for people who live in supported accommodation settings.

In some instances, disability support staff may assist with basic needs, but this should happen within the context of a protocol or agreement between the disability support provider and the hospital, with the respective roles clarified at pre-admission planning.

It is important at pre-admission that the expectations, roles and responsibilities of disability support staff are clarified within the context of a protocol or agreement between the disability agency and the LHDs / SHNs including who pays while disability support staff are providing support in hospitals.

The frameworks between the LHDs / SHNs and NGO service providers should address effective partnerships and provide a structure for protocols between local hospitals and the local community and/or disability services. Local protocols should:

- Address roles and responsibilities of disability support staff in the hospital or acute care setting including, work health and safety arrangements, workers compensation, professional indemnity, and public liability insurance
- Address what the disability support staff will do when accompanying a person to the Emergency Department. Refer to section 3.4.2 Admission
- Include a decision making escalation process for issues that cannot be negotiated at the level of Nurse Unit Manager with their counter-part representing the NGO service provider
- Include general principles and procedures to ensure that transfer of care between the hospital, community and disability services is articulated and coordinated clearly around the needs of people with disability. Section 3.4.3 on Transfer of care out of hospital is relevant here.

LHDs / SHNs may wish to use the Joint Guidelines as a reference for the range or types of issues that need to be jointly agreed across stages in the patient's journey.

4.3 Existing resources

In addition to patient safety and quality monitoring systems, a range of resources are available to support staff to meet the needs of people with disability during hospitalisation.

- Aboriginal Hospital Liaison Officers are an important resource for patients who identify as Aboriginal
- LHD / SHN Carer Support Services are available to provide staff with development and training, information, resources and advice on support for carers.[19]
- Courses and programs are offered by Health Education and Training Institute and Intellectual Disability Mental Health e-learning [20]
- The NSW Health and Ageing, Disability and Home Care Joint Guideline supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital, NSW Health GL2013_001[21]
- TOP 5 Model is a simple process that encourages health professionals to engage with carers to gain valuable non-clinical information to help personalise care[22]
- Health Care Interpreting and Translating Services – Patients, carers, and family who do not speak English as a first language or who are deaf have a right to free confidential and professional interpreters when they use public health services. Policy Directive 2006_053 - I*nterpreters – Standard Procedures for Working with Health Care Interpreters* is mandatory.[23] Information about the five Health Care Interpreter Services in NSW – three metropolitan and two rural, and three

[19] Information on:
  - NSW Health support for carers can be found here: http://www.health.nsw.gov.au/carers/Pages/default.aspx
  - Local Health District Carer Support Services can be found here: http://www.health.nsw.gov.au/carers/Pages/resources.aspx

[20] http://www.heti.nsw.gov.au/heti-online-modules/

[21] http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_001.html

[22] http://www.cec.health.nsw.gov.au/programs/partnering-with-patients/top5

[23] http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_053.html

Translation Services can be found on the Health Care Interpreting and Translating Services website. [24]

- Agency for Clinical Innovation (ACI) has developed resources that "relate to the care and health of people with intellectual disability across all ages, including acquired brain injuries by enhancing the capacity of primary and secondary health services." The link to these resources is: http://www.aci.health.nsw.gov.au/networks/intellectual-disability/resources [25]
- *NSW Health Carers (Recognition) Act and Carers Strategy Implementation Plan 2013-2016*[26]
- *NSW Carers 3 2014-2019*[27]; factsheet[28] on NSW Health website has actions that Health staff can undertake to reflect the strategy.

4.4 In-service, education and training

It is important that hospital staff are familiar with developments including contemporary practice in the support of people with disability in the community.

Training must include information about appropriate communication with people from culturally and linguistically diverse backgrounds (including people who are deaf) and people from an Aboriginal and / or Torres Strait Islander background.

LHDs / SHNs should support health staff to access to education and training on:

- Values and attitudes towards people with disability, their families and carer
- Skill development (e.g. communication and disability etiquette)
- Best practice in health provision for people with disability.

Organisations representing people with disability should also be consulted in the development of disability awareness training for staff.

4.5 Monitoring

An Implementation Checklist (Appendix 3) has been developed for use by LHDs / SHNs to assess their compliance with this policy directive. LHDs / SHNs can also use the checklist to monitor their implementation of the policy by undertaking assessments in different time periods or at stages of an implementation plan.

Safety and quality systems

In most LHDs / SHNs there are existing patient safety and quality monitoring processes that can be used to identify issues in the quality of health care provided to patients with disability and associated outcomes. These include:

- Incident Information Management System (IIMS)
- Complaints mechanisms
- Consumer, carer and patient satisfaction surveys and interviews
- Accreditation processes
- Periodic health record audits
- Length of stay reporting
- Monitoring of hospital readmissions.

Performance indicators, outcomes measures and patient experience

LHDs / SHNs should develop mechanisms to determine if there is a difference in outcomes for people with disability when compared to the general population. This information should be disaggregated by

[24] http://www.health.nsw.gov.au/multicultural/Pages/Health-Care-Interpreting-and-Translating-Services.aspx
[25] The ACI Intellectual Disability Network works to improve the care and health of people with intellectual disability across all ages by providing clinical leadership, research and education to enhance the capacity of primary and secondary health services. Information about the network including on becoming a member can be found here: http://www.aci.health.nsw.gov.au/networks/intellectual-disability/about
[26] http://www.health.nsw.gov.au/carers/pages/default.aspx
[27] https://www.adhc.nsw.gov.au/__data/assets/file/0017/300077/NSW_Carers_Strategy_2014-19.pdf
[28] http://www.health.nsw.gov.au/carers/Documents/carers-strat-fact-sheet-final.pdf

age, gender, type of disability, place of residence and cultural background. [29] See Appendix 1 for examples of performance indicators and outcome measures.

The type of assessment described above could be undertaken in targeted projects or reviews of specific areas or service types of interest.

Systematic monitoring of people with disability's access to health services, and comparing their outcomes against those of the general population requires data items to identify people with disability in data collection systems.

NSW Health is committed to enhancing services and building greater accountability by improving data collection and reporting on disability inclusion in Strategy 8 of the *Disability Inclusion Action Plan 2016-2019* (DIAP):

- Action 8.1 The DIAP Governance Group to work closely with relevant partners to consider appropriate systems to identify people with disability to improve equity in access and measure health outcomes compared to the general population.

The NSW Ministry of Health will monitor changes in the sensitivity and adaptability of LHDs / SHNs staff to the needs of people with disability during hospitalisation through an annual report which will be prepared by the Bureau of Health Information and made publically available:

- Action 8.2 Produce a disability focused report on an annual basis of patient perspectives on the care people with disability receive through NSW Health.

APPENDIX 1: POTENTIAL PERFORMANCE INDICATORS AND OUTCOMES MEASURES

The following are examples of performance indicators and outcomes measures that LHDs / SHNs may use to assess whether there is a difference in outcomes for people with disability when compared to the general population. Refer to *section 4.5 Monitoring*.

- Access by people with disability to health services (including hospitals) — how many seen; in what services; for what reasons
- Adherence to adjustments to meet the needs of people with disability — including audits of identified support needs/adjustments required and the adjustments made (and type of adjustment)
- Rates and trends over time for emergency department presentations, including:
  - Pathways to and from emergency department
  - Rates of ambulatory care sensitive presentations to emergency department for people with disability, disaggregated by disability type.
- Rates and trends over time for admitted patient data for people with disability, disaggregated by disability type and admission facility, including
  - Admission pathways
  - Diagnoses
  - Potentially avoidable admissions
  - Length of stay
  - Separation mode
  - 30-day readmission rates.
- Rates and trends over time for ambulatory care for people with disability, disaggregated by disability type and ambulatory care setting.
- Error rates for people with and without disability, disaggregated by disability type.
- Use of restraints (with examination of the identified support needs and the support provided)
- Inclusion in chronic disease management and other out-of-hospital programs.
- Inclusion in preventative health programs.

[29] United Nations *Convention on the Rights of Persons with Disabilities*, Article 31 – Statistics and data collection http://www.un.org/disabilities/convention/conventionfull.shtml

APPENDIX 2: OBTAINING CONSENT FROM A PERSON WHO LACKS CAPACITY

If a health care practitioner has doubts or concerns about whether their patient has capacity to make a particular decision, then a capacity assessment may be needed.

Capacity is specific to the particular decision that needs to be made. In some circumstances, the law sets out what tests must be met for capacity to make the decision, for example in relation to medical treatment. The NSW Capacity Toolkit produced by the NSW Department Justice aims to assist people in correctly identifying whether an individual has the capacity to make their own decisions. It provides information generally about capacity, capacity assessments and the various legal tests of capacity in NSW although it does not specifically address the assessment of capacity in regard to consent to medical treatment. For further information refer:
http://www.justice.nsw.gov.au/diversityservices/Documents/capacity_toolkit0609.pdf

Where a patient lacks capacity to consent – substitute decision makers

In circumstances where a patient lacks capacity to consent to medical or dental treatment, there are legislative and policy frameworks to assist health professionals identify a person who can make decisions on behalf of that patient.

The Responsible Person

The *Guardianship Act 1987* requires the health care practitioner to seek consent from the patient's 'Person Responsible' if the patient is not capable of consenting to their own treatment.

A Person Responsible may not necessarily be the patient's next of kin or carer. Section 33A(4) of the *Guardianship Act 1987* sets out a hierarchy of people who can be the Person Responsible.

NSW Civil and Administrative Tribunal (NCAT) Guardian Division Fact Sheet Person Responsible (April 2016) http://www.ncat.nsw.gov.au/Documents/gd_factsheet_person_responsible.pdf

Enduring Guardian

An adult can appoint an Enduring Guardian to make personal and lifestyle decisions on their behalf if they lose capacity to make such decisions. If a person appoints an Enduring Guardian with authority to make medical treatment decisions then they will be their Person Responsible.

In addition to the usual authority of a Person Responsible, an Enduring Guardian may also have the authority to make decisions about a range of personal/lifestyle areas on behalf of the appointee, not just medical treatment decisions. Find out more about how to appoint an Enduring Guardian at
http://planningaheadtools.com.au/appoint-an-enduring-guardian/

For more information see the Guardianship Division of the NSW Civil and Administrative Tribunal at
http://www.ncat.nsw.gov.au/Pages/guardianship/guardianship.aspx

Mental Health Act 2007

Under the Mental Health Act 2007, a patient who is either mentally ill or mentally disordered will be admitted or treated in a declared mental health facility as a voluntary or detained patient (including assessable patients, involuntary patients, correctional patients and forensic patients). This status determines how decisions should be made about their mental and physical health treatments and who has the legal authority to make them.

The *Mental Health Act* establishes obligations for health care practitioners to inform carers of patients being treated under the *Mental Health Act* depending on the category of patient and the medical treatment involved.

The two types of carers are designated carers and principal care providers.

A *designated carer* of a person (the patient) is defined in the Act to be:

(a) the guardian of the patient; or
(b) the parent of a patient who is a child (subject to any nomination by a patient referred to in paragraph (c)); or
(c) if the patient is over the age of 14 years and is not a person under guardianship, a person nominated by the patient as a designated carer under the Act under a nomination that is in force; or
(d) if the patient is not a patient referred to in paragraph (a) or (b) or there is no nomination in force as referred to in paragraph (c);
  a. the spouse of the patient, if any, if the relationship between the patient and the spouse is close and continuing; or
  b. any individual who is primarily responsible for providing support or care to the patient (other than wholly or substantially on a commercial basis); or
  c. a close friend or relative of the patient.

A person may nominate up to two persons to be their designated carers.

A *principal care provider* of a person is defined in the Act to be the individual who is primarily responsible for providing support or care to the person (other than wholly or substantially on a commercial basis).

A principal care provider may also be the designated carer of a person.

Voluntary patients without capacity under the Mental Health Act

If a voluntary patient lacks capacity to consent (due to mental illness or otherwise) and requires medical treatment, the substitute decision making provisions of the *Guardianship Act* will generally apply (see above).

Refer to NSW Health Policy Directive PD2005_406 - *Consent to Medical Treatment – Patient Information.*

Assessable patients, involuntary patients, correctional patients and forensic patients

The *Mental Health Act* provides for a substitute decision to be made for detained patients without capacity. The decision maker may vary according to the category of patient and the type of medical treatment required as well as the urgency of the need for such treatment. These decision makers include:

- The Secretary of NSW Health
- Senior Officers within NSW Health who have been designated as authorised medical officers by the Secretary of NSW Health
- The Mental Health Review Tribunal.

Refer to:

- The NSW Health Policy Directive *Consent to Medical Treatment – Patient Information,* PD2005_406

The Mental Health Review Tribunal: http://www.mhrt.nsw.gov.au/the-tribunal/

To download **APPENDIX 3: IMPLEMENTATION CHECKLIST** And

APPENDIX 4: GLOSSARY please refer to the following link:

Responding to Needs of People with Disability during Hospitalisation PD2017_001.pdf

NSW DRUG AND ALCOHOL CLINICAL SUPERVISION GUIDELINES (GL2006_009)

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1. Executive summary

This document provides comprehensive guidance in relation to the implementation of clinical supervision programs within NSW Drug and Alcohol (D&A) services. In summary, the key messages contained within the Guidelines are:

- *Participation in clinical supervision is expected* of all staff in D&A services who provide direct services to clients, including medical and nursing staff, psychologists, social workers, D&A workers and D&A counsellors.
- It is advisable for D&A services to clearly articulate their requirements, arrangements and expectations in relation to clinical supervision in policies and procedures and to make staff aware of these.
- Managers and clinical leaders can play an important role in *engendering a culture of support and acceptance* for clinical supervision within the organisation.
- The *purpose of clinical supervision* is to provide a tool for workforce development, a mechanism for quality assurance and clinical safety, and a means of providing professional support and debriefing to staff.
- Clinical supervision sessions involve the *review and discussion of a worker's clinical practice* with a clinical supervisor. The content of such discussions remains confidential, except in circumstances of serious concern related to the ethical or professional conduct of the worker, or the safety of a worker or client.
- *Clinical supervision is not line management* and the two processes ought to remain separate. It is generally inadvisable for line managers to act as clinical supervisors for their direct reports. However it should be noted that this might not apply in medical settings where traditionally the Clinical Medical Director provides both clinical supervision and line management to junior medical colleagues.
- Supervisors, supervisees and managers all have *specific roles and responsibilities* within the clinical supervision process, and all parties need to be clear about these. Ideally, roles and responsibilities will be articulated in contractual arrangements or service agreements.
- Organisations can elect to utilise clinical supervisors who are either internal *(employed by the organisation) or external*. Both models are in operation and have merit.
- Clinical supervision can be offered as either *individual (one supervisor with one worker)* or group (one supervisor to a small number of staff). Both models are in operation and have merit, although there are particular issues that need to be taken into account in group supervision models.

- Supervisors need to be *trained in clinical supervision*, ensure that they operate within relevant ethical and professional codes of conduct, and provide supervision in line with the requirements of the service. Ideally, they will also access supervision for their clinical supervision practice.
- Clinical supervisors should be appointed through *appropriate recruitment and selection* processes and there are generally agreed criteria applicable to the selection of appropriate supervisors.
- Effective clinical supervision relies on the development of a strong *alliance between supervisors and supervisees*, and ideally there should be a degree of choice for workers in selection of a supervisor.
- Clinical supervision *programs need to remain flexible* to ensure that they meet the needs of workers at all stages of their development and career path.
- It is important for policies and procedures to spell out the appropriate mechanisms whereby staff, managers and supervisors can *address any concerns they have about clinical supervision.*
- Organisations need to ensure they put in place *appropriate infrastructure* to support, coordinate and manage clinical supervision programs.
- *Monitoring and evaluation* of clinical supervision programs is considered important to ensure that they are meeting objectives, to identify the benefits, determine effectiveness and levels of staff satisfaction, and to report on uptake and compliance across the organisation. Any such mechanisms should ensure that the content of clinical supervision sessions remains appropriately confidential.

All of the above issues are discussed comprehensively within the Guidelines.

2. Introduction and background

These Guidelines have been developed for the NSW Health Drug and Alcohol sector. This section outlines the impetus for and process of their development, their intended application and the policy context within which they operate.

2.1 Impetus for the guidelines

A number of key factors created the impetus for the NSW Drug and Alcohol Council to commission the development of NSW D&A Clinical Supervision Guidelines. Considerations were:

- A growing recognition of the value and importance of clinical supervision, and a desire to provide support to its broader implementation.
- Some concerns that the extent to which workers in D&A services were able to access clinical supervision was somewhat ad-hoc across the state.
- The need for a greater level of understanding about the purpose and benefits of clinical supervision.
- A desire to develop greater consistency in the implementation of clinical supervision programs within D&A services.

2.2 Policy context

The broad policy context within which the Guidelines sit is twofold. Firstly the NSW D&A Policy context, which is outlined in the NSW Drug Treatment Services Plan 2000-2005 and which states that:

> *Clinical treatment should reflect good practice identified in the current research literature and documented in clinical outcome studies. Programs need to be flexible, individualised and based on the best available evidence of effectiveness'*[27]

[24] NSW Health Drug Treatment Services Plan 2000-2005.

Clinical supervision provides one mechanism whereby services can facilitate 'good practice' on the part of individual clinicians, because through supervision, clinical practice is subject to a process of professional enquiry that aims to ensure that services to clients remain within treatment modalities that are known to be the most effective.

The second important policy context is that of clinical governance, which places responsibility for the quality of care jointly on organisations and individuals. Clinical governance is defined as:

> *The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.*[28]

Ensuring the ongoing clinical competence of individual clinicians is a cornerstone of clinical governance, and this is formalised in NSW Health's Framework for Managing the Quality of Health Services in NSW and the supporting document The Clinician's Toolkit, which identifies the need for transparent and accountable processes to be in place, including clinical supervision for all clinicians. Clinical supervision is one of a number of activities that are designed to manage, enhance and monitor the delivery of clinical services, and active participation in clinical supervision is one way in which clinicians can exercise their individual responsibilities for clinical governance.[29]

In addition to the broad policy context described above, the majority of NSW Health D&A services already provide a level of clinical supervision for staff, and this is generally governed by local policies and procedures. As its name suggests, this document provides guidance, is not a policy, and is not intended to replace or take precedence over local policies and procedures, but rather to further inform local policies, and provide a framework for good practice that D&A services can refer to.

2.3 Intended application

The Guidelines are generic and intended to be applicable across disciplines to all workers in D&A services who have responsibility for the provision of direct services to clients, either individually or in groups. This includes medical staff, nursing staff, psychologists and social workers, as well as positions that are classified more generally as either D&A worker, or counsellor. At the outset, some comments related to scope and limitations of their application are warranted:

- The Guidelines are unlikely to be entirely appropriate for Aboriginal and Torres Strait Islander workers in D&A services. The scope of their development did not allow for extensive consultation and consideration of issues related to Indigenous staff; however, the indications are that Aboriginal and Torres Strait Islander workers may well have a particular need for clinical supervision given the complexities of their role, and because the potential for personal impact is greater, due to their dual responsibilities to organisation and community. Whilst these Guidelines provide a basis for good practice, they would require further review and adjustment to be appropriate. Any such review should occur in collaboration, for example with the NSW Health Aboriginal Workforce Development Branch.

- As indicated above, the Guidelines are intended to apply to medical staff working within D&A services. However, it is acknowledged that health services have historically experienced a level of difficulty in engaging all medical staff in the full range of quality assurance mechanisms expected of them. It is therefore worth noting at the outset that it is the intention that the Guidelines apply to medical staff and to stress the importance of services developing agreed pathways for clinical supervision for this key professional group.

[25] NHS 1998, The new NHS: Modern and Dependable, quoted in NSW Health's The Clinicians Toolkit for Improving Patient Care, 2001.

[29] Clinical Governance and Clinical Supervision; working together to ensure safe and accountable practice; A Briefing Paper. Butterworth and Woods, The School of Nursing, Midwifery and Health Visiting, University of Manchester 1999.

- There are specific requirements for clinical supervision associated with some professions, for example the requirements for psychologists seeking registration. These Guidelines are not intended to replace any such requirements, which clearly need to be adhered to as required, and negotiated on a case-by-case basis between workers and services.

- The Guidelines are applicable to staff employed within D&A services, and are not intended to apply to students on placement who are not employees. Whilst students may well have clinical and/or other supervision requirements associated with their placement, these are not referred to in this document.

- The intent of the Guidelines is to allow for flexibility. They are not prescriptive, but rather make suggestions about what constitutes good practice. Whilst the evidence related to clinical supervision is somewhat limited, there are themes in the literature about what is commonly considered to be sound or best practice, much of which is already reflected in some D&A clinical supervision programs. There is no single recommended model of clinical supervision, and there is a need for services to have flexibility to implement programs and processes appropriate to the local context, and within the available resources. The Guidelines are intended to provide a framework for, and support to local operations, and to encourage a degree of consistency across the state. In addition, the recent amalgamation of Area Health Services (AHSs) will potentially require the review of two existing approaches to clinical supervision and agreement about one Area-wide approach. It is anticipated that this document may assist with any such deliberations.

2.4 Development process

In June 2005 the CDA contracted an external consultant (Jacq Hackett Consulting) to develop the Guidelines and established an Advisory Group to provide oversight to the process. Membership of the Advisory Group is at Appendix 1. During the same timeframe, a related consultancy was commissioned for the development and delivery of Clinical Supervision Training for senior clinicians within NSW Health Drug and Alcohol Services. This project was undertaken by Access Macquarie Ltd, and work undertaken through this project also informed the development of the Guidelines.

Key steps in the development process were as follows:

- A review of current processes and policies for clinical supervision within D&A Services across the state.
- Broad consultation with stakeholders from AHSs[30] including D&A Directors, Service Managers, clinicians, D&A workers, MERIT staff and internal and external providers of clinical supervision. In addition interviews were undertaken with staff from Justice Health, Odyssey House, NADA (Network of Alcohol and Drug Agencies), the CDA, the Centre for Aboriginal Health, Aboriginal Workforce Development Branch, NCETA (National Centre for Education and Training on Addiction), Relationships Australia and with the co-chairs of the D&A Nursing Advisory Committee and the D&A Allied Health Workers Advisory Committee.
- Review of findings from work undertaken by Access Macquarie Ltd as part of their training needs analysis, including an email survey of NSW D&A workers and a series of consultations with Aboriginal and Torres Strait Islander D&A workers.
- A desktop review of relevant documentation and literature.

[30] Site visits were held in SSWAHS (Croydon), H&NEAHS (Tamworth and Newcastle sites) and SWAHS (Parramatta, Penrith and Blue Mountains), GWAHS (Dubbo), NCAHS (Lismore, and telephone consultations in Coffs Harbour).

- The development of a Discussion Paper that was distributed to all D&A Directors for comment and feedback.
- The development of Draft Guidelines, taking account of feedback from the Discussion Paper, also distributed to D&A Directors for comment and feedback.
- The development of Final Guidelines incorporating feedback on the Draft.
- Close collaboration and consultation with the Advisory Group at all key stages of the project.

3. Definition and purpose of Clinical Supervision

This section provides a working definition of clinical supervision as it applies throughout these Guidelines. It also outlines the common benefits of clinical supervision from the perspective of organisations and staff.

3.1 What is Clinical Supervision?

Agreeing a definition is never easy, and indeed the literature offers an extensive range of definitions for the term clinical supervision. In addition, the views of workers in the field about the meaning of clinical supervision are somewhat variable. However, there are some common themes, and three key purposes for clinical supervision emerge, it is a:

- **Tool for workforce development** - that is, through discussion of research findings and reflection on current practices, it provides an opportunity for the development of the worker's professional identity, skills and knowledge, and awareness of the impact of personal attitudes and issues on clients
- **Mechanism for quality assurance and clinical safety** - that is, it is part of a suite of activities designed to ensure that services to clients are appropriate, safe and effective, and to identify and address any concerns or breaches in a constructive manner, in an appropriately formal, but confidential setting.
- **Means of providing professional support and debriefing** - workers reportedly benefit from a formal forum where they can debrief aspects of their work and gain support to manage any personal impact. This can become even more necessary in the Drug and Alcohol field where the work can be particularly complex and demanding.

There is no single definition of clinical supervision that is more correct than any other, and D&A service policies already include definitions that are considered appropriate for the local context. Nonetheless it is important to include a definition in these Guidelines in order to engender a shared sense of meaning.

For the purposes of these Guidelines, clinical supervision is defined as:

> *A formal and ongoing arrangement between one worker and a (generally) more experienced practitioner whereby the clinical practice of the worker is reviewed and discussed in confidence for the purposes of:*
> - *Further developing the worker's professional identity and clinical practice skills and knowledge.*
> - *Ensuring workers are operating within relevant clinical, organisational, ethical and professional boundaries.*
> - *Monitoring and supporting the worker's wellbeing and coping capacity in relation to their work.*

3.2 Benefits of Clinical Supervision

As discussed earlier, the evidence based knowledge about the benefits of clinical supervision is somewhat limited, and comprehensive, reliable evaluation studies have yet to be undertaken in the field. Notwithstanding these limitations, the available evidence does suggest that clinical supervision:

- Is commonly valued by managers and practitioners.
- Can facilitate the acquisition of complex clinical skills.
- Is associated with higher levels of job satisfaction or morale, where it is perceived to be of high quality.
- Can support staff retention.

There is a wealth of anecdotal knowledge and theorising in the literature and resources pertaining to clinical supervision, and findings from these, and from the consultations held within NSW commonly suggest that the following benefits are likely:

For the organisation/service:

- It contributes to workforce development.
- It contributes to quality assurance and to maintaining clinical safety.
- It provides a mechanism for ensuring that professional boundaries and codes of ethics are being complied with in the delivery of services to clients.
- It ensures that individual workers are operating within agreed treatment modalities.
- It provides a level of assurance that new or inexperienced workers are receiving appropriate support, learning and guidance in developing their role.
- It provides a level of assurance that more experienced staff are being exposed to new ideas, reflecting on their current practices, and where appropriate, are being challenged and stretched in relation to their clinical practice.

For workers receiving clinical supervision:

- It provides a mechanism for support and debrief, and for managing workplace stress.
- It provides an opportunity for coaching and professional guidance, for enhancing skills, identifying new ways of working with clients, and identifying areas of further skill development.
- It provides a confidential mechanism through which they can reflect on and raise issues related to their practice.
- It can validate their work clinical skills and contribute to increasing confidence in their work with clients.
- It can prevent workers operating outside appropriate boundaries with clients.
- It can contribute to increased job satisfaction, reduced stress and prevention of burnout.

4. Key elements of Clinical Supervision

This section helps further clarify what we mean by clinical supervision by outlining its common characteristics, the key parties involved and the common structure and processes utilised in its implementation.

4.1 Common characteristics of Clinical Supervision

As outlined earlier, clinical supervision sits within an overall *framework of clinical governance* and as such, is one of a number of mechanisms that are put in place to facilitate clinical safety, and which workers are expected to participate in. Other examples include clinical case review meetings, clinical audits, mandatory training and critical incident debriefings. Whilst clinical supervision is not commonly mandated within NSW Health services[31], there is nonetheless an expectation that it will be organised and supported by management and that workers will participate.

Clinical supervision is a *formal organisational arrangement*, commonly governed by policies and/or procedures that set out its purpose, the administrative arrangements, and the expectations and responsibilities of the key parties. Whilst the content of clinical supervision sessions remains largely confidential, and can be tailored to the needs of individual workers, it is not a private arrangement. Rather, it is conducted as part and parcel of workplace activities, and in line with the needs and requirements of the organisation. As such, clinical supervision must reflect the goals of the organisation and support the agreed/endorsed organisational approaches and therapeutic modalities.

Clinical supervision sessions are formalised, have an agreed purpose, work towards outcomes and entail an element of rigour. It is expected that all three primary purposes of clinical supervision are addressed, namely issues relevant to clinical safety, skill and knowledge development, and support and debrief.

There are three parties involved in clinical supervision arrangements – the supervisee (worker), the supervisor and the organisation (manager). Whilst only the worker and supervisor actually participate in clinical supervision sessions, the organisation has a clear role in organising, managing and supporting the clinical supervision program. More information about the roles and responsibilities of the three parties can be found in section 5.

Clinical supervision is appropriate regardless of a staff member's level of experience or their professional background. All staff can benefit from clinical supervision and it is appropriate for services to expect participation from all workers that fall within the parameters of their local policy.

Clinical supervision needs to be flexible to ensure it meets the needs of workers at all stages of their development. The supervision requirements of a novice worker are likely to be very different from that of a highly experienced worker, and this requires flexibility within the clinical supervision program to ensure workers at all levels of experience benefit.

The primary focus is the clinical practice of the worker. Whilst discussion of clients and their case management is an integral part of the supervision process, this is principally for the purpose of providing a tool for reviewing and discussing the clinical practice of the supervisee. The focus remains on developing the worker's conceptualisations, skills and knowledge, rather than on providing indirect treatment of the client.

Effective clinical supervision relies on the development of a strong alliance between supervisors and supervisees. A successful alliance will involve the development of a bond between the two parties, the establishment of clear goals for the clinical supervision process, and an agreed set of tasks to achieve the goals.

[31] A small number of D&A service policies do state that participation in clinical supervision is mandatory for workers.

Ideally, there will be an element of choice on the part of the supervisee in selecting an appropriate supervisor. Clearly, achieving a 'match' between supervisee and supervisor is an important factor in ensuring a strong supervisory alliance, and having the flexibility for some negotiation on the part of the supervisee is likely to assist in achieving this. Notwithstanding this ideal, it is acknowledged that this may not always be possible, and there is a need for services to remain pragmatic in relation to this issue.

The content of clinical supervision is confidential, except in circumstances of serious concern related to the ethical or professional conduct of the worker, or the safety of a client. The intent is to allow for frank and open discussion about clinical practice, in a safe environment. Further discussion of confidentiality is discussed in section 6.

Clinical supervision is not line management and the two processes should remain separate. Whilst managers certainly have responsibilities in the clinical supervision program (see section 5.3), the purpose of clinical supervision is distinctly separate from that of line management supervision. Overall clinical accountability for services to clients is an organisational and line management responsibility, whereas clinical supervisors are responsible for addressing only those matters raised within clinical supervision sessions, and only within the agreed parameters outlined in the clinical supervision policy.

It is strongly recommended that line managers do not also provide clinical supervision to staff that report directly to them. Whilst it is acknowledged that there are exceptional circumstances where this cannot be avoided, it should be considered a last resort, and will require careful attention to clear boundaries to ensure an appropriate separation of the two roles, and a high degree of trust and mutual respect between the two parties.

4.2 Structure of Clinical Supervision sessions

What is outlined here are the common structures and processes involved in clinical supervision. These are not set in concrete, are offered as a guide, and there is scope for D&A services to have some flexibility around local arrangements.

Clinical supervision is organised as individual sessions or appointments, commonly of one hour's duration and held monthly. They involve a worker (or group of workers) and a supervisor working together in private and without interruption.

For novice workers or those with limited experience, a high degree of structure is common and the role of the supervisor tends to be somewhat directive, involving a high degree of guidance and modelling. For highly experienced workers, clinical supervision sessions are likely to have less need of such structure, and there is scope for more supervisee-led discussion and identification of relevant issues.

In newly establishing clinical supervision arrangements there is commonly a process at the outset whereby the goals of the supervisee are agreed, the boundaries of confidentiality are made clear, and there is discussion and agreement about how the two parties will work together. Commonly, such agreements are formalised in a written contract or agreement, and an example of a supervisor/ supervisee agreement can be found at Appendix 3.

Clinical supervision sessions utilise a range of processes to achieve their agreed purpose. As outlined earlier, the focus of sessions is always on the role and clinical practice of the supervisee, and it is the responsibility of the supervisor to ensure that sessions are appropriately structured to engage the supervisee in discussion, reflection and appropriate disclosure. The most common method of generating discussion and identifying the pertinent issues is through *case presentation or review*, in which a worker presents a case they are currently working on, commonly utilising an agreed presentation format, and requiring a degree of preparation on the part of the supervisee prior to the clinical supervision session. Less common, but important processes used in clinical supervision sessions are direct supervisor observation of a worker with a client, video or audio recording of a client intervention, and review of case notes and documentation.

Regardless of what method is used, it is the intention of clinical supervision sessions to generate discussion and reflection on a broad range of issues directly related to clinical practice, including but not limited to:

- The methods and modalities of clinical practice.
- Concerns the worker has in relation to any aspect of a case or client.
- Difficulties or lack of progress with a client.
- Awareness of the potential impact of the worker's personal values on their clinical practice.
- Identifying any negative impact on the worker from a case they are managing.
- Issues related to establishing and maintaining appropriate boundaries with clients.
- Ethical and professional practice, and compliance with codes of conduct.
- Professional identity and role development.
- Skill and knowledge development.
- Issues related to workload management, team functioning and career development.

5. Roles and responsibilities

This section provides guidance about the roles and responsibilities of the three key parties involved in clinical supervision - supervisors, supervisees and managers. It also outlines the responsibilities of all three in upholding the ethical and professional codes of conduct that are applicable in the clinical supervision process.

5.1 Supervisors

The common responsibilities of supervisors are to:

- Ensure they are clear about the organisational goals, the supported treatment modalities of the D&A Service, and any relevant codes of conduct or ethical standards applicable to those they are supervising. Ensure that their supervision practice is in line with all of the above.
- Ensure that supervisees are clear at the outset about the purpose of supervision, what is expected of them, the role of the supervisor, the parameters of confidentiality, and the appropriate mechanisms for addressing any difficulties or concerns about the clinical supervision process.
- Work with supervisees to agree on goals for supervision sessions, and put in place processes for regular review of progress.
- Enter into any required formal contractual arrangements in relation to the provision of clinical supervision services, including with the organisation and with individual supervisees. Examples of contracts between services and supervisors can be found at Appendices 4 and 5.
- Facilitate a safe and trusting environment for clinical supervision sessions.

- Ensure that clinical supervision sessions have structure, and work toward achievements in all three of the purpose areas identified earlier. This will require the initiation of processes whereby the supervisee can review and reflect on their clinical practice, identify areas of concern, explore new ways of working, identify development needs, and debrief issues of concern.
- Validate good practice and provide constructive feedback where appropriate.
- Challenge practice that is inappropriate, or which does not fit with the agreed treatment modalities of the Service, and facilitate the development of sound clinical skills and ethical practice.
- Work within the agreed boundaries of confidentiality and take responsibility for reporting any serious issues to line managers, and for informing supervisees when such a circumstance arises.
- Share their own knowledge, experience and skills with supervisees.
- Take responsibility for ensuring they provide clinical supervision only within the limits of their expertise.
- Participate in any agreed monitoring or reporting mechanisms related to the provision of clinical supervision.
- Contribute to evaluation of clinical supervision programs as required by the D&A service.
- For externally contracted supervisors, where general concerns arise in relation their clinical supervision (that is, not concerns related to individual supervisees) take steps to address these issues with the appropriate manager, not with supervisees. Examples of such concerns include issues related to the agreed clinical modalities or work practices of the service, or the contractual arrangements. In the event that an external supervisor considers their own professional views are inconsistent with those of the organisation, or in the event of any conflict of interest, take appropriate steps to terminate the contract.

5.2 Supervisees

In reality, workers have a range of different values and attitudes towards the idea of clinical supervision, along the spectrum from positive to negative, often related to their professional background, or their previous experience of clinical supervision. This inevitably results in some workers being willing, responsive participants, and others being reluctant or even resistant. Notwithstanding this, participation in clinical supervision is expected of all workers in D&A services and they also have responsibilities related to this.

The common responsibilities of supervisees include:

- Negotiate arrangements for clinical supervision, in line with organisational polices or procedures, and with line management approval.
- Ensure regular attendance as agreed with the organisation, and in line with local policies.
- Work with the supervisor to agree the goals of clinical supervision, and agree ways of working together.
- Undertake an appropriate level of preparation for clinical supervision sessions, for example preparation of case review material and completion of any agreed homework.
- Actively participate in all sessions.
- Take action in relation to any development needs identified through clinical supervision.
- Maintain any records related to clinical supervision sessions as set out in local policies or procedures.
- Resolve any difficulties or concerns with supervision through appropriate processes, for example in the first instance by discussing the matter with the supervisor, and if the matter remains unresolved, taking it up with the line manager and/or appropriate others within the service. In circumstances in which concerns have not been resolved through these processes, workers should refer to the applicable grievance or complaints procedure.

Contribute to evaluation of clinical supervision programs as required by the D&A service. For group supervision, comply with the parameters of confidentiality that are agreed by the group.

5.3 Managers

Because clinical supervision is a formal organisational arrangement, managers play a key role in its implementation. The common responsibilities of managers include:

- Ensure staff are aware of the D&A service's policy and procedures related to clinical supervision, and the expectations of their participation.
- Ensure that all relevant staff can access clinical supervision. This includes making any changes in the workplace required to enable staff to attend, for example rostering arrangements, making transport available, establishing group supervision arrangements, making meeting rooms available etc.
- Where an external supervision model is in operation, recruit and arrange contracts with appropriate clinical supervisors and ensure attention to key issues such as insurance requirements and criminal record checks. Where internal supervision models operate, ensure compliance with any formal agreements.
- Ensure clinical supervisors are appropriately briefed. This will be particularly important for external supervisors to ensure they are oriented to the requirements of the D&A service, including the supported treatment modalities and any relevant codes of ethics or conduct. It may also be helpful for supervisors to be informed about any related policies and procedures, for example in relation to managing suicide risk, violent or intoxicated clients, guidelines for home visiting etc. Managers need to also keep supervisors informed of any changes in policies or treatment practices in a timely manner.
- Where an internal supervision model is in operation, ensure that staff are made aware of the processes for engaging a supervisor and undertake any necessary approval processes as prescribed in local policies/procedures.
- Take reasonable steps to ensure that workers have an element of choice in selection of a clinical supervisor.
- Comply with any organisational reporting requirements in relation to clinical supervision, for example reporting attendance numbers and frequency, and associated costs and resources.
- Participate in and/or take responsibility for regular review and evaluation of clinical supervision programs.
- Take reasonable steps to resolve any concerns raised by supervisees in relation to their clinical supervision.

5.4 Ethical guidelines and codes of conduct

Managers, supervisees and supervisors all need to be aware of their common responsibilities in ensuring compliance with relevant codes of conduct, ethics and professional practice. Clinical supervision is one mechanism through which breaches of such codes can be identified, and concerns about inappropriate practice can be identified and addressed early, potentially preventing future breaches. (For example addressing the early signs of inappropriate boundaries with clients). What constitutes appropriate and sound clinical practice is outlined within a number of key documents, some of which apply to all workers, and some of which apply to workers within specific professions.

All workers must comply with the following:

- Mandatory reporting requirements under the *Children and Young Persons Care and Protection Act*, which requires them to report suspicion that a child is at risk of harm, as defined in the Act and which is clearly outlined in the NSW Health Frontline Procedures for the Protection of Children and Young People.
- The legal obligations outlined within the NSW Policy for Identifying and Responding to Domestic Violence; and which outline the obligations of AHSs to ensure appropriate response to individuals at risk of, or having experienced domestic violence across health settings.
- Their local Area Health Service Code of Conduct. Whilst there may be some variations in such Codes of Conduct, commonly they provide guidance about appropriate conduct in relation to conflicts of interest, the acceptance of gifts or benefits, bribery and corrupt conduct, the development of inappropriate personal relationships with clients (including social, sexual or financial relationships), acting with honesty and integrity, harassment and bullying and professional standards of behaviour.

Supervisors need to be familiar with all of the above documents and have a sound understanding of compliance as it relates directly to the provision of services within the D&A setting. Managers need to ensure that supervisors are provided with copies of all relevant documents.

In addition to the above requirements, there are also specific professional and ethical codes that apply to some individual professions, and supervisors also need to be aware of which of these additional codes apply to their supervisees. In summary, these codes are:

- The NSW Medical Board Code of Professional Conduct.
- Code of Ethics for Nurses in Australia (Developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia, and the Australian Nursing Federation).
- Code of Professional Conduct for Nurses in Australia (Australian Nursing and Midwifery Council).
- Australian Association of Social Workers Code of Ethics.
- NSW Psychologists Registration Board Code of Professional Conduct.
- The Australian Psychological Society Code of Ethics.
- Australian Counselling Association Code of Conduct.

Further information related to ethical and professional codes of conduct, including web references to access the complete documents as listed above can be found at Appendix 2.

Supervisors also need to ensure that their own clinical supervision practices remain within ethical and professional parameters, and to ensure they take appropriate steps to protect themselves, the supervisee and the organisation, for example by ensuring that:

- Their clinical supervision practice remains within their level of competence and capabilities.
- They are appropriately trained to provide supervision.
- They operate with clear contractual arrangements in relation to their role and responsibilities with the organisation, and in relation to their work with supervisees.
- They operate within the agreed parameters of confidentiality.
- They do not develop inappropriate boundaries or relationships with supervisees.

6. Confidentiality

Issues related to the confidentiality of clinical supervision can be somewhat contentious. On the one hand there is a need to ensure the confidentiality of individual sessions in order to provide a safe and constructive learning environment, and to encourage a sufficient level of disclosure. On the other, given the role of clinical supervision as a mechanism for clinical quality and safety, there is a need to ensure that any sufficiently serious issues related to clinical practice are dealt with appropriately and transparently. To balance these two legitimate concerns, the parameters of confidentiality need to be clear, documented, and communicated to all participating parties.

These Guidelines propose that to ensure an appropriate measure of accountability for clinical supervision, confidentiality is ensured except in circumstances where there is:

- A breach of the code of conduct of the organisation.
- A breach of professional code of ethics.
- A breach of duty of care.
- Serious concern about the safety of the worker or a client.
- Issues identified that are subject to mandatory reporting requirements.

Adherence to these parameters requires that supervisors are sufficiently clear about the particular role of the worker, and are cognisant of the relevant codes of ethics, professional conduct, duty of care and mandatory reporting requirements.

In any of the circumstances outlined above, it is the responsibility of the clinical supervisor to inform the worker of their concerns and of the need to inform the line manager. Clinical supervisors need to take such concerns to managers as soon as is practical once they are identified.

7. Operational approaches to Clinical Supervision

This section of the Guidelines provides information about internal and external supervision approaches to clinical supervision, and about individual and group supervision approaches. All these approaches are appropriate and have merit, and D&A services commonly have to make decisions about which models to implement. The following information is intended to be of assistance to services in their decision-making, and to facilitate sound practice, whichever approach is in place.

7.1 Internal Clinical Supervision

In this approach to clinical supervision, supervisors are employees of the organisation, and take on clinical supervision as an adjunct to their primary role. This model is commonly selected by services because:

- The majority of resources required to provide clinical supervision can be found internally within the organisation, and therefore do not incur additional costs.
- It utilises and values existing expertise and experience.
- It can provide an opportunity for some staff to extend their role, skills and experience through taking on a clinical supervision role.
- There can be benefits where internal clinical supervisors have a greater understanding about the needs of the organisation, for example, the agreed treatment modalities, the working environment, and the specific complexities of the client group.
- It is often perceived to be more straightforward to organise and administer.

There are many different operational models of internal clinical supervision in place in D&A services, reportedly with varying degrees of success. Ideally, internal models of clinical supervision will take account of the following factors, which are considered to represent good or sound practice, and which will likely assist in ensuring the effectiveness of the clinical supervision program.[32]

Appropriate and transparent processes for recruitment and selection of clinical supervisors. Whilst more comprehensive guidance can be found in relation to this in section 8.2, it is important to stress that the need for such processes is a critical, yet sometimes overlooked factor in the implementation of programs that utilise internal supervisors. Whereas formal processes for recruitment and selection of external supervisions is common, they tend to be less rigorous for internal supervisors, and yet are equally important.

The provision of training for selected supervisors in the clinical supervision role. Ideally, the training will be conducted by an external individual or organisation with relevant expertise, with sufficient briefing about the particular organisational issues/requirements.

The use of contracts or service agreements to govern the clinical supervision work of staff that clearly outlines the expectations and parameters of the role. Again, this can tend to be overlooked when utilising internal clinical supervisors, when in fact, there is potentially a heightened need for transparency about the role, function and expectations.

The establishment of a pool of clinical supervisors from which workers can choose. Offering an element of choice on the part of the worker in selecting a clinical supervisor is always ideal; however, where internal clinical supervisors are utilised this becomes somewhat of an imperative. Internal supervisors inevitably have less objectivity than external supervisors, and the reality of organisations is that there is generally history and baggage between some staff. The literature confirms the importance of 'match' between supervisor and supervisee if the process is to be effective, and when using internal arrangements, choice is particularly important.

The establishment of protocols for reaching agreement between a worker and a clinical supervisor to work together. Workers require more than a list of names if they are to make an informed choice in relation to selecting a clinical supervisor. Clinical supervisors need to feel confident that they can work effectively with their supervisee, and also have an element of choice and decision-making. Suggested protocols include:

- Ready availability of relevant written information about the clinical supervisors in the organisational pool. For example information about their background, qualifications and experience, their particular strengths and areas of interest, and information about their preferred counselling or treatment modalities.
- A meeting to undertake a process of 'mutual interview' between worker and clinical supervisor to assess expectations and 'fit', prior to committing to any ongoing arrangements.
- Early review of the appropriateness of the arrangement and an understanding of 'no blame' or recourse if there is agreement to terminate.

The need to ensure that the supervisors fully understand the boundaries of confidentiality of clinical supervision sessions, and are provided with documentation that outlines the ethical and professional codes of conduct applicable to staff they will be supervising.

[32] Some of the factors outlined are also applicable for external supervision models, and whilst efforts are made to minimise repetition in these Guidelines, some repetition is unavoidable.

The establishment of mechanisms for accountability for internal clinical supervisors to ensure that their supervision practice remains sound over the longer term, and in line with the requirements of the organisation. Whilst section 8 provides further guidance about organisational issues, what is being stressed here is the need for mandatory participation on the part of internal clinical supervisors in a range of activities designed to bring a level of accountability to the clinical supervision program. For example participation in supervision of their clinical supervision work, preferably from an external practitioner, attendance at clinical supervision network meetings, participation in ongoing training and development opportunities.

The use of formal written agreements between internal supervisors and supervisees, for example to agree the goals of supervision, the frequency and duration, the agreed processes and ways of working together. This is considered particularly important for novice or inexperienced workers and supervisors.

Flexibility to ensure that highly experienced senior staff have access to appropriate clinical supervision, which may mean offering exemption from the internal model. It is well acknowledged in the literature that accessing appropriate clinical supervision is generally more difficult for those staff with extensive experience, or who are considered to be the most senior staff within a service. Ideally, clinical supervision is provided by a more senior practitioner, and this may only be possible by going externally. Alternatively, peer supervision may be an appropriate option, and this may also require flexibility for this to be sought externally.

7.2 External Clinical Supervision

In this approach supervisors are external to the organisation and are contracted to provide an agreed level of clinical supervision services. Commonly in D&A services external clinical supervisors are registered clinical psychologists, and are paid on an hourly basis in line with the standard professional rate. This model is commonly selected by services because:

- It provides an opportunity to recruit from a broader field and potentially a greater capacity to be selective.
- External people can bring external ideas, views and perspectives, which are potentially helpful to the organisation.
- Contractual arrangements are required, and so there is generally a greater acceptance that the role, responsibilities, reporting requirements and circumstances under which the services will be terminated can be clearly stipulated (than with internal arrangements).
- External supervisors are more likely to bring a lack of bias or subjectivity, which is beneficial to the supervision process.
- There is potential for a more open and honest supervisory process than with some internal arrangements because staff are more confident about the confidential nature of the relationship and do not have to interact with the supervisor in other settings.
- Internal staff time, training and support is not required (for supervisors).

Ideally, external models of clinical supervision will take account of the following factors:

Appropriate and transparent processes for recruitment and selection of clinical supervisors. (See section 8.2.) In addition, recruitment processes will need to ensure that a criminal record check is undertaken.

The need to ensure that external clinical supervisors are fully cognisant of relevant organisational issues, for example:

- The goals, priorities and agreed treatment modalities.
- Organisational structure.
- The role and responsibilities of staff they will be supervising.
- Intake and assessment procedures.
- Weekly operational structure.

The need to ensure that external supervisors fully understand the boundaries of confidentiality of clinical supervision sessions, and are provided with documentation that outlines the ethical and professional codes of conduct applicable to staff they will be supervising.

Appropriate briefing and orientation of external supervisors by managers, and regular monitoring and review of services provided.

The selection of supervisors whose professional values are sufficiently congruent with those required by the organisation. In particular it will be important to select supervisors who are able to support harm minimisation approaches common to the provision of treatment services within the NSW Health D&A environment.

Contractual arrangements are put in place that clearly specify all aspects of the clinical supervision arrangement, for example the responsibilities of the clinical supervisor, requirements for any documentation related to clinical supervision sessions, payment, term of the contract, reporting requirements.

7.3 Individual and Group Supervision

Another key consideration for D&A services is whether to provide group or individual supervision. Both are common and have merit. As it implies, individual clinical supervision is a one-to-one process between a clinical supervisor and an individual worker. In group supervision a number of workers get together with one clinical supervisor. Many D&A services opt for a group supervision approach primarily because of its cost effectiveness, however there are other benefits, including:

- It can be a less threatening approach for some people compared to individual clinical supervision.
- It can contribute to team building and cohesiveness.
- It can draw on the expertise and knowledge of other group members, which can be extremely valuable.

Not surprisingly, individual clinical supervision tends to be the more straightforward approach, and does have some advantages over group supervision, for example:

- It involves building one trusting relationship.
- Confidentiality can be more easily guaranteed.
- Workers tend to have a greater level of self-disclosure that can lead to increased insight.
- There is more time available to focus on each individual worker.

The supervisory role is more easily managed with one supervisee.

There is a greater capacity to find a good match between supervisor and supervisee.

Notwithstanding the above, group supervision is a common approach within D&A services currently, and because it can be less straightforward, and there are additional factors that need to be considered, this section provides some guidance in relation to this.

Group clinical supervision (as defined within these Guidelines) involves a clinical supervisor. This may seem an obvious point to make, however, peer supervision in groups does occur in health settings, and these Guidelines seek to draw a distinction between that and the approach intended here, where there is a designated role of supervisor, with responsibilities as outlined earlier in section 5.1.

If group supervision is to be effective, clinical supervisors must have skills and experience in facilitating groups. Generally, clinical supervision training does not include training in group work, and such expertise is usually developed over time through hands on experience working with groups. In selecting supervisors for group supervision, group work skills and experience need to be added to the essential selection criteria.

As a general rule, small is better in terms of numbers. Given the purpose of clinical supervision (to develop skills and knowledge, provide professional support and facilitate sound clinical practice) it is clear that there are limitations to how effective a group setting can be in achieving this if the numbers are high. As a general rule, three or four is considered ideal.

It will be helpful to have more than one clinical supervisor operating group supervision within the organisation, thereby allowing workers some element of choice. The importance of match has been referred to previously, and the issue of choice is obviously more difficult to achieve with group supervision; however, limited choice is preferable to none.

It is important to pay attention to the membership mix when establishing group supervision arrangements. The sessions need to offer all members an opportunity for learning and growth, and provide a safe and trusting environment in which disclosure and honesty are the norm. To achieve this, it is important that some planning takes place at the outset, rather than having groups either selected at random or completely self selected. Useful considerations are having workers who are at a similar level of experience and skill, similar professional backgrounds, and avoiding situations in which there are power differentials between members, for example by including a worker and their team leader in the same group. Inevitably in organisations there are also situations where negative history between workers make it inappropriate to have them join the same group, and this may require some sensitive management.

Discipline specific and multidisciplinary groups can both be effective. There are mixed views in the field about this issue, and a tendency for some workers to believe that they should only be in groups with others from the same profession. However, there is no evidence to support this approach exclusively and both models are in use and can work well.

There are some inevitable limitations to group approaches to clinical supervision compared with individual supervision. They are outlined below not to promote one approach in favour of another, but rather to provide useful additional information for consideration in implementation. Common limitations are:

- Some people are not sufficiently comfortable in a group setting to openly discuss and explore issues related to their work practices, or to debrief difficult issues. Where this is the case, those workers can tend to be low contributors, or can be so uncomfortable as to have a generally negative experience of clinical supervision (which essentially renders it ineffective).
- It can be more difficult to address issues or problems related to team functioning, which is a legitimate issue that clinical supervision can be helpful in addressing. Without skilled facilitation there can be a tendency for sessions to become simply a forum for complaints.

- There are limitations in the extent to which workers are likely to disclose in relation to certain issues because they are with colleagues. In reality, group sessions cannot offer the same level of confidentiality as individual sessions, and this will impact on the extent to which workers are prepared to disclose. In turn, this can limit the depth of insight and learning that can occur as a result.
- Where primarily group supervision is offered, it may be helpful for services to have the flexibility or discretion to offer individual supervision sessions to staff on an as needs basis, for example for a limited number of sessions if things have been particularly difficult or stressful for a worker, if a worker is just so uncomfortable with group settings that it is simply not helpful to require them to attend, or for very senior workers, for whom it would be difficult to have their needs met in a group with less experienced workers.

8. Organisational considerations

8.1 Developing a supportive environment

It is important for services to consider what strategies might be needed to engender a culture of support for clinical supervision. Commonly in D&A services the values of workers in relation to the concept of clinical supervision are variable, as is their degree of support for it. In addition, workers have varied experiences of clinical supervision, often related to their professional background. For example:

- Psychologists and social workers have generally participated in clinical supervision from the outset of their training and tend to value it highly.
- There is less consistency in the understanding and experiences of nurses in relation to clinical supervision, and their training has often included a quite different type of supervision focused on competency development. Where nurses have not accessed clinical supervision (as defined in these Guidelines) they can be wary or suspicious of it.
- Workers who do not have tertiary or formal qualifications can have limited understanding of, or experience in, clinical supervision and can also be wary or suspicious.
- There are wide variations in the extent to which medical staff have participated in clinical supervision, and historically there can be a measure of resistance from some individual clinicians to participation in such activities.
- Across all professional groups there are workers who believe that they do not need clinical supervision, usually because they consider themselves to be sufficiently experienced. There are also workers who do not want to participate due to a fear of having to change, or of being exposed as inadequate.

The comments above are clearly generalised, and are not intended to reflect negatively on any professional group or individual. Rather they are highlighted because in being aware of such differences, D&A services can consider how they might best work with these factors in building a climate of support for their clinical supervision program, increase staffs' understanding about its purpose and benefits, and increase compliance in line with the service's expectations of staff participation.

How clinical supervision is marketed or introduced to staff can be critical to the success of its uptake. Line managers and clinical leaders can play an important role in building support, and it is likely that where people in such positions present a positive and encouraging attitude, this will have a constructive effect. Conversely in organisations where managers and clinical leaders are not supportive, and make their views known either overtly or covertly, this can have a negative impact on the climate of support for and participation in clinical supervision.

In particular it is considered important for managers and clinical leaders to:

- Provide staff with clear information about what supervision is and take the necessary time to introduce the concept, and allow for discussion of their queries, concerns or issues.
- Be clear about what clinical supervision isn't; make sure that staff understand that it is not a line management function, that it is not an opportunity simply to find fault with their work, and that it is not simply a mechanism for debriefing.
- Make sure that staff are provided with clear information about the boundaries of confidentiality that apply to supervision sessions.
- Highlight the benefits of supervision for staff, rather than simply focusing on its role in clinical quality. Staff should be made aware that it is a process put in place for their benefit and gain, for example to ensure they have an appropriate level of professional support for their work and to assist them in developing their clinical skills and expanding their experiences.
- Actively demonstrate their support for clinical supervision, for example by participating in their own clinical supervision, and through enabling staff to participate by arranging rostering to accommodate it, and assisting in their selection of clinical supervisors.

8.2 Recruitment and selection of supervisors

The success of clinical supervision is heavily dependent on having competent, appropriate and effective supervisors, and ensuring there are appropriate recruitment and selection processes in place for both internal and external supervisors is a key organisational consideration. There is a high level of constancy in the literature about appropriate criteria for the selection of supervisors. These are outlined below and are recommended as a basis for selection processes within D&A services. Clinical supervisors will ideally have:

- Relevant formal qualifications.
- Extensive clinical experience, specifically a breadth of counselling and/or therapy experience, particularly with complex clients and behavioural therapies. In general it is considered ideal for the supervisor to have more experience than the supervisee, although this is obviously not possible for some very senior staff, for whom peer supervision is appropriate.
- A clear understanding of the role and function of clinical supervision.
- A demonstrated history of continued professional development and supervision of their own clinical supervision practices.
- A demonstrated interest in and ability to enhance the skills and abilities of others, particularly to provide constructive feedback and to ensure a safe environment for disclosure and challenge.
- Held in high respect within their field or specialty.
- An understanding of and respect for the particular role of the supervisee.
- If providing group supervision, supervisors need demonstrated facilitation, group work and mediation skills.
- The ability to remain impartial and balanced in their views.
- An empathetic and non-judgemental approach.
- An intellectual interest in their professional arena.
- If providing supervision to Aboriginal and Torres Strait Islander workers, they must have demonstrated cultural awareness, and previous experience working with Aboriginal and Torres Strait Islander workers.

Selection processes for supervisors should be similar to those in place for recruitment to other positions, and in line with the organisation's recruitment policy, for example the development of a duty statement outlining the role and responsibilities, submission of formal, written applications, the convening of a selection panel to make decisions, and the requirement for referee checks. Where external clinical supervisors are contracted, they should also undergo a criminal record check.

8.3 The importance of policy, procedures and record keeping

Ideally, clinical supervision within D&A services should be governed by a written policy, and currently this is common practice. Staff and supervisors should be made aware of the policy and any accompanying procedures. In addition, a degree of record-keeping and documentation is recommended, some of which can be kept confidential.

Records which are not considered confidential, and which are commonly provided to managers include summary information from supervisors about numbers of attendees, session times and general, de-identified reports summarising the conduct of clinical supervision over a period of time.

A level of confidential record keeping is also expected in most D&A services, and recommended in the literature, for example records kept by both supervisors and supervisees relating to the goals and expectations, plans for achieving agreed goals, summaries of what has been undertaken in individual clinical supervision sessions, and reports arising from regular review about goals and achievements. (Examples at Appendices 6 and 7). All such records would remain confidential except in the circumstances outlined in section 6, in which case they may be required for the purposes of any investigation arising from breaches of code of conduct or clinical safety, or in the event of any other formal investigation related to a worker.

Whilst there is room for flexibility in terms of record keeping, local policies need to make clear their expectations and requirements.

8.4 Infrastructure and support for Clinical Supervision

Clinical supervision programs, like any other initiative, require a degree of organisational support and infrastructure if they are to be effective and efficient. Most D&A services have a policy that provides some governance and this is considered essential. However, there are additional factors to consider, outlined below:

- The need to locate responsibility for clinical supervision within an appropriate organisational portfolio. Given its stated purpose, the two obvious fits are workforce development and clinical quality, and ensuring that some overarching responsibility and leadership is provided through one of these portfolios is recommended.
- Consideration of a staff member with designated responsibility for coordinating the clinical supervision program. The roles of the key parties (managers, supervisors and supervisees) have been outlined earlier; however, there is also merit in the organisation designating responsibility for overall coordination and management of the clinical supervision program. This is not to suggest that a full-time position is required, but rather that a staff member with an appropriate related role (for example Coordinator of Quality, Workforce Development Manager) could also take on responsibility for clinical supervision.
- Establishing a clinical supervision advisory committee (or similar) with appropriate membership and specific terms of reference to oversight the policy and its implementation.
- Where an internal supervision model is used, establishing a network of supervisors, with a designated coordinator. The aims of the network could include ongoing training and development, support and debriefing.
- Embedding the organisational requirements about clinical supervision in relevant job descriptions. This is applicable to staff who are expected to access supervision, and to staff who provide internal clinical supervision.

8.5 Resourcing Clinical Supervision

Like any other activity or program, clinical supervision requires human and financial resourcing. Contributing resourcing factors include the time and effort required to provide appropriate infrastructure and coordination functions, to provide training, support and external clinical supervision for internal supervisors, staff time to participate, costs associated with travel to attend, and payment for the use of external supervisors. If the implementation of clinical supervision programs is to be an expectation across the board in D&A services then Directors and managers will need to take account of this in budget and business planning. It is beyond the scope of these Guidelines to suggest or recommend any strategies related to budget, suffice to highlight that it is an important organisational consideration.

8.6 Monitoring and evaluation

There has historically been a level of tension between the principle of confidentiality that applies to clinical supervision and the desire for organisations to have in place an appropriate level of monitoring and accountability for clinical supervision processes. The important distinction to highlight here is between performance management issues related to *individuals*, which need to be identified and addressed through other mechanisms, and mechanisms for quality assurance in relation to the overall clinical supervision *program*, which are appropriate and necessary.

Unless there are breaches of relevant codes of conduct, concerns for client or worker safety or breaches of duty of care (as outlined in section 6) the content of individual supervision sessions remains confidential, and issues related to the supervisee's clinical practice do not enter into the public domain of the organisation. However, the organisation does have a responsibility to have a level of reporting in place in relation to clinical supervision, and to have mechanisms in place to monitor and evaluate its effectiveness. For example it is appropriate for organisations to have information related to:

- The extent of uptake of supervision, specifically, which staff are attending supervision and how often.
- Where internal supervisors are utilised, which staff are active and their clinical supervision caseload.
- The extent of human and financial resources being utilised for the provision of clinical supervision.
- The satisfaction levels of staff in relation to the clinical supervision that is provided.
- Any areas of concern about the current clinical supervision program.
- The effectiveness of individual clinical supervisors.
- The impact and benefits of clinical supervision from the perspectives of staff and managers.
- Where internal supervisors are used, information about their participation in any required or recommended quality assurance processes, for example supervision of supervisors, attendance at supervision network meetings, and participation in ongoing training and development opportunities related to their supervisory role.

Some of the above information can be collected by ensuring a basic level of record keeping and reporting on the part of supervisors and managers, for example in relation to attendance and numbers, and it is suggested that such information be collected and reported as a matter of course. To assess satisfaction, impact and effectiveness, formal evaluation tools will need to be utilised. Some of the key issues to consider in evaluating clinical supervision are:

- The importance of having a degree of independence when seeking staff feedback about clinical supervision processes, for example having someone in a neutral role coordinate the process, analyse and report on results.
- The importance of getting feedback from supervisees and supervisors. Both viewpoints will provide useful information in relation to perceptions of the quality of clinical supervision sessions, satisfaction levels, if and how it has been helpful, the degree of fit between supervisor and supervisee, and ideas about strengthening the current processes.
- The need to ensure that supervisees can provide anonymous feedback, which will be particularly important where supervisors are internal.
- Being able to identify individual supervisors in any evaluation process so that constructive feedback can be provided, areas of development identified, and any serious concerns can be addressed directly with the individual supervisor.
- Ensuring that supervisors and supervisees are informed from the outset of any monitoring or evaluation processes that may be implemented, including the expectations of their participation in formal evaluation.

Some D&A services have agreed proformas for monitoring and evaluation purposes and there are samples at Appendices 8, 9, and 10.

8.7 Managing difficulties

Difficulties can and do arise within clinical supervision programs, and it is wise for local policies to clearly identify the intended processes for dealing with problems or conflict. Examples of issues that can arise are:

- A staff member is not happy with their clinical supervisor.
- There are problems with the mix of membership of a clinical supervision group.
- Managers have concerns about a particular supervisor.
- There are breaches of confidentiality of clinical supervision sessions.
- A staff member consistently doesn't attend their agreed clinical supervision.
- A staff member has been unable to resolve an issue with clinical supervision through their line manager.

Common principles for addressing these or similar issues are for the matter to be raised between the relevant parties in the first instance and attempts made to manage or resolve the issues. Where issues remain, it is generally recommended that they are taken to the line manager, or where appropriate, to a more senior staff member. Whilst this may seem an overly obvious approach, it is considered useful for local clinical supervision policies to highlight some of the common problems that may arise, and outline the expectations of how these will be managed so that all parties have a clear way forward. All AHSs have grievance procedures that should be followed when all other attempts at resolution have been unsuccessful.

A common concern for line managers can be the lack of information flow between clinical supervisors and managers about the performance of individual workers.

As a general rule, and for reasons outlined earlier related to the role, purpose and key characteristics of clinical supervision, it is recommended that services do not blur the boundaries between line management and clinical supervision, for example by managers approaching supervisors with concerns they have, or seeking comments or information about individual workers.

8.8 Issues for rural D&A services

There are particular issues in relation to implementing clinical supervision in rural D&A services. These include:

- Barriers associated with the provision of supervision to remote staff who were often isolated and therefore potentially in greater need of clinical supervision.
- The extent of time and travel required for staff to access face-to-face supervision.
- Difficulties in accessing appropriate supervisors. Internally, there may be insufficient professional distance between supervisees and supervisors. Externally there are often limitations or shortages in the number of private practitioners working in rural communities and there may not be appropriately skilled or senior staff available within the local community.

Rural D&A services need to consider alternative mechanisms to face-to-face clinical supervision such as telephone, email or videoconferencing, all of which have been utilised successfully for clinical supervision purposes. Studies in e-supervision have been undertaken and report both advantages and disadvantages, with the noted advantages being more relaxed communication styles, greater immediacy of responses, and greater mentoring capacity. Some of the noted challenges of electronic supervision are the need for increased time for planning supervisory sessions and the need for frequent and ongoing training for operating the required technology.[33]

Useful resources and additional reading

This document provides guidance for D&A services in relation to the operation and management of clinical supervision programs, drawn from what is commonly considered sound practice in the literature, and within the NSW D&A field. It is not intended to be prescriptive, nor wholly comprehensive, and has been informed by a range of existing resources and previous work by other authors. This section provides a summary of additional sources of clinical supervision information and advice that D&A services will likely find valuable.

9.1 D&A specific resources

Three resources are worthy of particular note.

The first is the recently produced, and very comprehensive *Clinical Supervision Resource Kit for the Alcohol and Other Drugs Field*. Developed by the National Centre for Education and Training on Addiction (NCETA) at Flinders University, this kit is intended to build capacity of the D&A workforce, and includes the following components:

- An *Overview* booklet that provides an overview of all the materials contained in the Resource Kit, as well as a sample one-day training program for clinical supervisors
- A comprehensive *Practical Guide* for the AOD field, which includes a review of the relevant literature and practical recommendations for establishing clinical supervision programs and conducting supervision sessions.
- A *Clinical Supervision Training Demonstration* on DVD which contains a 40 minute scripted demonstration of clinical supervision in four sessions, revealing the key process and content issues.
- A *Training Demonstration Booklet*, which is a supplement to the DVD and provides guidance about the DVD's use for training purposes.

[33] Noreen Graf, Using email for clinical supervision in practicum: a qualitative analysis of email supervision, in Journal of Rehabilitation July-Sept 2002.

- A *CD* containing PDF versions of all the materials contained within the kit, as well as a set of 75 PowerPoint training slides.

Further information about the kit can be found at the NCETA website http://www.nceta.flinders.edu.au/

The second is the *Workforce Development Resource Kit: A Guide to Workforce Development for Alcohol and Other Drugs Agencies*. Produced by the Network of Alcohol and Other Drugs Agencies (NADA) this resource includes useful information about implementing clinical supervision programs in section 4.6, and includes relevant case studies. The Kit can be found on the NADA website http://www.nada.org.au/projects/workforce-development/

Finally, there is the considerable work that was conducted by *Access Macquarie Ltd* as part of their related project to develop and deliver a training package in clinical supervision for NSW Health D&A services. This work includes:

- The training package *Clinical Supervision Training for D&A Professionals - Participant Handbook*, developed by Daphne Hewson, Access Macquarie Ltd, November 2005, for the CDA, NSW Health.
- *Clinical Supervision training package, Final Report to the CDA*, Daphne Hewson, Access Macquarie Ltd, November 2005. (Including appendices on Aboriginal Consultations, Interviews and the Email Survey.)

9.2 Useful Clinical Supervision references

In addition to the above resources, many other articles and references were reviewed, and the following is a summary of those that were considered particularly helpful or relevant in the development of the Guidelines.

- Butterworth and Woods, Clinical Governance and Clinical Supervision; working together to ensure safe and accountable practice; A Briefing Paper. The School of Nursing, Midwifery and Health Visiting, University of Manchester 1999.
- Kavanagh et al, Achieving effective supervision. Drug and Alcohol Review 2002.
- The Development of models of nursing supervision in the UK, and other documents and information contained on the website of Steve Cottrell and Georgina Smith at http://www.northwestsolutions.co.uk/resources.php
- Chris Shanley, Clinical Supervision – an untapped resource for the alcohol and other drug field, Centre for Education and Information on Drugs and Alcohol, NSW (CEIDA).
- Butterworth et al, First Steps Towards Evaluating Clinical Supervision in Nursing and Health Visiting. Journal of Clinical Nursing Vol 5(2) March 1996.
- Ian Clift and Janet Perks, Clinical Supervision Policy and Framework, The Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, 2004.
- JE Mills, KL Franciss & A Bonner, Mentoring, clinical supervision and preceptoring: Clarifying the conceptual definitions for Australian Rural Nurses. A review of the literature, Rural and Remote Health, the International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 2005.
- Noreen Graf, Using email for clinical supervision in practicum: a qualitative analysis of email supervision, Journal of Rehabilitation July-Sept 2002.
- Winstanley J and White E (2002) Clinical Supervision: Models, Measures and Best Practice. Australia and New Zealand College of Mental Health Nurses Inc, Sydney.

Appendix 1 - Membership of the advisory group

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Appendix 2 - Codes of conduct and professional practice

Attention to issues related to codes of conduct and ethical behaviour operate on two separate levels. Firstly there is a need for supervisors to ensure that their own clinical supervision practices are carried out within the parameters of relevant codes of conduct; and secondly there is a need for supervisors to be cognisant of the codes of conduct and ethical practice that apply to the staff they are supervising.

In relation to the first of these, namely the clinical supervision practices of supervisors, the following highlights the key issues that supervisors should be aware of:

- The potential for vicarious liability, whereby a supervisor can be held liable for the conduct of the supervisee, especially if the supervisee is not a fully licensed professional.
- The need to ensure that the limits of the confidentiality of supervision are clearly stated at the outset. Should it become necessary to disclose, only information that is necessary and sufficient to address the pertinent issue should be disclosed.
- Supervisors should not practice outside their area of competence or overextend themselves and they should ensure that supervisees do not practice outside their area of competence or overextend themselves.
- Supervisors have a duty to warn and to protect, and are responsible for ensuring that clients at risk (eg suicide risk) are protected and, when legally warranted, that others are warned if they are at risk from a client.
- Supervisors are responsible for ensuring that they and those they supervise conduct themselves within the ethical guidelines and codes of conduct of their profession, and their employing organisation. Particular attention should be paid to gaining relevant informed consent (eg from clinicians for degree of self-disclosure in supervision; from clients to receiving treatment from and intern/trainee).
- Supervisors are responsible for ensuring that neither they nor those they supervise have dual relationships(eg can't be supervisor and therapist; no sexual relationships between supervisor and counsellors or counsellors and clients, etc). The dual relationship of Line-Manager and Supervisor is not ideal; and if it becomes necessary, extra care should be taken to create safe boundaries between the two roles.
- Supervisors are responsible for ensuring that the supervisee's rights are addressed by providing a clear statement of the requirements of clinical supervision, and specific information about what will be evaluated, through the supervisory process and how.

In addition, the Australian Psychological Society has produced an ethical guidelines paper on clinical supervision. Whilst the paper is only available online to members, most D&A services will have staff who are members and will have access. The paper is entitled Australian Psychological Society Ethical Guidelines: Guidelines on Supervision, July 2003 and can be found at http://www.psychology.org.au/

Supervisors also need to ensure that they are familiar with the relevant ethical guidelines and codes of conduct that apply to staff they are supervising. A number of codes are likely to apply within D&A services as follows:

- Area Health Service Codes of Conduct.
- NSW Medical Board Code of Professional Conduct.
- Code of Ethics for Nurses in Australia (Developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia and the Australian Nursing Federation).

- Code of Professional Conduct for Nurses in Australia (Australian Nursing and Midwifery Council).
- Australian Association of Social Workers Code of Ethics.
- NSW Psychologists Registration Board Code of Professional Conduct.
- The Australian Psychological Society Code of Ethics.
- Australian Counselling Association Code of Conduct.

Whilst a brief summary of information contained within the above codes is outlined below, it is strongly recommended that supervisors access the relevant codes in full to ensure they are clear about the full extent of ethical and professional parameters that apply.

In circumstances where a supervisor is unclear about the application or interpretation of a particular code, they are encouraged to seek advice from a senior staff member from within the same profession as the supervisee.

D&A Services Codes of Conduct

All Area Health Services have codes of conduct in place for staff and D&A services need to ensure that staff and supervisors are provided with copies of the relevant organisational policy documents. Notwithstanding the need for all parties to have a sound understanding of the particular ethical and professional guidelines, commonly AHS Codes of Conduct refer to the need for staff to comply as follows:

- To be aware of and avoid potential situations of conflict of interest, for example whereby they could be influenced or perceived to be influenced by a personal interest when carrying out their public duty.
- Staff must not accept gifts or benefits from clients which could in any way influence, or appear to influence, their official capacity.
- Staff must not submit or accept bribes or inducements from individuals or organisations.
- The requirement for staff to behave honestly and with integrity in the execution of their duties.
- Staff must not develop inappropriate personal relationships with clients, including social, sexual or financial relationships.
- Staff must not harass, bully or discriminate against others, including colleagues and clients.
- Staff must not use official resources for non-official purposes.
- Staff must not engage in corrupt conduct, as defined in sections 8 and 9 of the *Independent Commission Against Corruption Act (1988)*, including in relation to official misconduct, bribery and blackmail, unauthorised use of confidential information, fraud and theft.

NSW Medical Board Code of Professional Conduct

There are four standards outlined in this code as follows:

Standard 1

You must possess and apply adequate knowledge and skill in the practice of medicine.

Standard 2

You must observe professional and ethical obligations. These include:

- Education, teaching and training responsibilities.
- Providing honest assessment of the performance of colleagues.
- Putting patients first while putting aside your own personal views.
- Maintaining trust with patients through your interaction with patients.
- Arranging appropriate alternative treatment when the doctor/patient relationship deteriorates.
- Disclosure of adverse events to appropriate authorities.
- Responding appropriately to situations in which a complaint is made about your treatment or where treatment is unsuccessful.
- Co-operating fully with the investigating authorities such as the HCCC and the NSW Medical Board in respect of adverse events.
- Dealing appropriately with the next of kin of deceased patients.
- Ensuring your professional position is not abused or compromised through improper financial or personal dealings with patients.
- Ensuring that your own health or that of another practitioner does not put patients at risk.
- Ensuring other practitioners do not place patients at risk through their health, conduct or performance.
- Providing factual information about your services.

Standard 3

You must ensure that you enjoy a good relationship with all colleagues in health care teams:

- Through treating colleagues with respect regardless of your personal views.
- By working constructively with health care teams.
- By ensuring patient treatment is covered during your own absence or unavailability.
- Ensuring that a patient's care is co-ordinated.
- Ensuring appropriate delegation and referral of care of a patient.

Standard 4

You must display probity in your professional practice in respect of:

- Financial and commercial dealings.
- Financial interests in hospitals, nursing homes and other medical organisations.
- Not accepting gifts or other inducements.
- Not entering into financial agreements with patients which may compromise the therapeutic relationship.
- Ensuring that any documents signed by you are not false or misleading.
- Ensuring that research in which you are engaged is conducted ethically and according to protocol and that you report fraud or misconduct in research to the appropriate authority.

The full document can be found at: http://healthcpd.com.au/

Code of Ethics for Nurses in Australia

The Code of Ethics includes the following six key value statements. Nurses respect individuals' needs, values, culture and vulnerability in the provision of nursing care.

- Nurses accept the rights of individuals to make informed choices in relation to their care.
- Nurses promote and uphold the provision of quality nursing care for all people.
- Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
- Nurses fulfil the accountability and responsibility inherent in their roles.
- Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well-being.

The full document can be found at:
http://anf.org.au/documents/policies/PS_Compulsory_reporting.pdf

Code of Professional Conduct for Nurses in Australia

The purpose of the Code of Professional Conduct for Nurses in Australia is to:

- Set an expected national standard of conduct for the nursing profession.
- Inform the community of the standards for professional conduct of nurses in Australia.
- Provide consumer, regulatory, employing and professional bodies with a basis for decisions regarding standards of professional conduct.

Under the code of professional conduct a nurse must:

- Practise in a safe and competent manner.
- Practise in accordance with the agreed standards of the profession.
- Not bring discredit upon the reputation of the nursing profession.
- Practise in accordance with laws relevant to the nurse's area of practice.
- Respect the dignity, culture, values and beliefs of an individual and any significant other person.
- Support the health, well being and informed decision-making of an individual.
- Promote and preserve the trust that is inherent in the privileged relationship between a nurse and an individual, and respect both the person and property of that individual.
- Treat personal information obtained in a professional capacity as confidential.
- Refrain from engaging in exploitation, misinformation and misrepresentation in regard to health care products and nursing services.

The full document can be found at: http://nursesstaging.elcom.com.au/professional-conduct-book/default.aspx

Australian Association of Social Workers Code of Ethics 1999

The purpose of the Code is to:

- Identify the values and principles which underpin ethical social work practice.
- Provide a guide and standard for ethical social work conduct and accountable service.
- Provide a foundation for ethical reflection and decision-making.
- Guide social workers when determining what demands they may legitimately make on their employers, colleagues and the AASW.
- Provide clarification of social workers' actions in the context of industrial or legal disputes.
- Act as a basis for investigation and adjudication of formal complaints about unethical conduct.

The full document can be found at: http://www.aasw.asn.au/document/item/740

NSW Psychologists Registration Board Code of Professional Conduct

The Code of Professional Conduct provides principles and guidelines for observation by registered psychologists in their professional practice, and that guide the interpretations relevant to Part 4 of the *Psychologists Act 2001* related to complaints and disciplinary proceedings). Under the code psychologists will:

- Demonstrate continuing competence in their practice of psychology that includes adequate knowledge, skill, judgment and care.
- Aim to maximise benefit and do no harm in their practice of psychology.
- Respect the dignity and welfare of individuals and groups with whom they have professional contact.
- Act ethically and properly and will promote accuracy, fairness and honesty in their practice of psychology.

The full document can be found at:
http://www.hpca.nsw.gov.au/ArticleDocuments/250/Psychology%20Council%20GIPA%20%20Publication%20Guide%202011.pdf.aspx

The Australian Psychological Society Code of Ethics

The code outlines principles of ethics and professional practice for members of the Society which aim to safeguard the welfare of consumers of psychological services and the integrity of the profession. Its general principles state that:

- Members remain personally responsible for the professional decisions they make.
- Members shall bring and maintain appropriate skills and learning in their areas of professional practice.
- The welfare of clients and the public, and the integrity of the profession shall take precedence over a member's self interest and over the interests of the member's employer and colleagues.

The full document can be found at:
http://www.psychology.org.au/about/ethics/#s1

Australian Counselling Association Code of Conduct

This code is intended to provide standards of professional conduct that can be applied by the ACA and by other bodies that chose to adopt them in Australia. Under the code, members will:

- Offer a non judgmental professional service, free from discrimination, honouring the individuality of the client.
- Establish the helping relationship in order to maintain the integrity and empowerment of the client without offering advice.
- Be committed to ongoing personal and professional development.
- Ensure client understanding of the purpose, process and boundaries of the counseling relationship.
- Offer a promise of confidentiality and explain the limits of duty of care.
- For the purpose of advocacy, receive written permission from the client before divulging any information or contacting other parties.
- Endeavour to make suitable referral where competent service cannot be provided.

- Undertake regular supervision and debriefing to develop skills, monitor performance and sustain professional accountability.
- Be responsive to the needs of peers and provide a supportive environment for their professional development.
- Not act as or practice legal council on behalf of or to a client when practicing as a counsellor or act as an agent for a client.
- Not initiate, develop or pursue a relationship be it sexual or nonsexual with past or current clients, within 2 years of the last counselling session.
- Be responsible for your own updating and continued knowledge of theories, ethics and practices through journals, the association and other relevant bodies.
- Be committed to the above code of ethics and recognise that procedures for withdrawal of membership will be implemented for breaches.

Full document can be found at:
http://www.theaca.net.au/documents/ACA%20Code%20of%20Ethics%20and%20Practice%20Ver%2010.pdf

Appendix 3.
Clinical Supervision contract (example)

This proforma is an example of the kind of contract or agreement used between supervisor and supervisee in relation to the arrangements and processes for clinical supervision sessions. It is a sample only and D&A services need to ensure contracts meet their specific needs.

This agreement covers the clinical supervision arrangements between:

_____

(Supervisee), and

_____

(Supervisor)

Structure of sessions

We agree the structure of clinical supervision sessions will be as follows:

Frequency _____

Duration _____

Time _____

Location _____

Goals of clinical supervision for the agreed contract period:

_____

_____

_____

_____

_____

Agreed strategies and methods of achieving these goals:

_____

_____

_____

_____

_____

Agreed records to be kept in relation to clinical supervision:

_____

_____

_____

_____

_____

We have read the D&A Service Clinical Supervision Policy and agree to operate in compliance with it.

Supervisors signature _____

Date _____/_____/_____

Supervisees signature _____

Date _____/_____/_____

Appendix 4. External Clinical Supervisor contract 1 (example)

This proforma is one of two examples of the kind of contract or agreement used between the D&A service and an external clinical supervisor. It is a sample only and D&A services need to ensure contracts meet their specific needs.

Parties to the contract

This contract is between:

_____

(D&A Service), and

_____

(external Clinical Supervisor)

The agreed terms of the contract are:

Commencing date _____/_____/_____

Completion date _____/_____/_____

Renewal of Contract is subject to performance review and availability of funds.

Services and remuneration

The number of hours per month will be approximately

_____ Variations to be approved by Area Manager, Drug & Alcohol, as required.

Remuneration will be at Australian Psychological Society (APS) current standard rate currently _____ per hour plus GST.

Clinical supervision services will be provided in accordance with the D&A Service Clinical Supervision Policy and as per the attached schedule.

Insurance

The Provider shall insure themselves and keep himself/herself insured during the period of the Contract with an insurance office approved by the Health Service to the full extent against his liability to his/her employees employed in the performance of the Contract, under the laws relating to Workers' Compensation. The Contractor shall also on demand produce to the Health Service evidence of renewal of such insurance.

The Provider shall also insure themselves and keep himself/herself insured during the period of the Contract for public liability and Professional Indemnity insurance in the amounts as follows:

$_____ Public liability insurance

$_____ Professional indemnity insurance

The Provider will supply the following information in relation to insurance:

- Name of insurance companies with whom cover is affected.
- Policy number of the Policies.
- The expiry date or currency of the policies.

Termination of Contract

The Contract shall be terminated:

a. Upon the expiry of the period for which it was made or on such earlier date and may be agreed between the Clinical Supervisor and the Health Service.

b. By one months' notice in writing given by either the Clinical Supervisor or the Health Service.

c. If the Clinical Supervisor ceases to be registered as a Psychologist in NSW.

d. If the Clinical Supervisor becomes permanently mentally or physically incapable of rendering services under the contract.

e. If the Clinical Supervisor commits serious and/or willful misconduct; or

f. If the Clinical Supervisor appointment is terminated by operation of any Act or Regulation.

On the termination of a Contract, any amount due and payable to the Clinical Supervisor pursuant to the Contract shall be paid at the time of such termination or as soon thereafter as reasonably practicable.

Dispute Resolution Procedure

In the event that the Clinical Supervisor or Health Service is dissatisfied with any aspect of the operation of the Contract, the Clinical Supervisor or Health Service may give the other party notice in writing, identifying the matter or matters the subject of dispute. As soon as practicable after the giving of notice, Health Service staff and the Clinical Supervisor, who may be accompanied by an observer of his/her choice, shall meet to discuss the dispute and attempt to resolve it by a mutually agreed method.

Appendix 5: External Clinical Supervisor contract 2 (example)

This proforma is one of two examples of the kind of contract or agreement used between the D&A service and an external clinical supervisor. It is a sample only and D&A services need to ensure contracts meet their specific needs.

This contract is for a period of _____ months,

starting _____/_____/_____

Payment for clinical supervision services provided will be

$_____ per hour.

Supervision sessions contracted will be _____ hours per month.

As part of my role as an external supervisor, I agree to:

- Provide supervision, which is consistent with the services' aims and objectives.
- Consult with supervisee(s) in order to prepare a supervision contract. The supervision contract includes negotiated goals for a specified supervision period, strategies and methods to be used for achieving those goals, an outline of the structure and process of supervision, and a review date.
- Consent to annual internal staff satisfaction surveys.
- Maintain an accurate log of supervision sessions in accordance with plans agreed to with supervisees, which include the date and duration of each session. This is submitted annually to the line manager.
- Provide documentation on past professional experience and professional qualifications to the service manager.
- Continue my own professional development and supervision.
- Provide the Director of Drug and Alcohol Services (or delegate) with access to the supervision log when requested.
- Address any difficulties arising from the supervision relationship in accordance with the supervision guidelines within Drug and Alcohol Services.
- Ensure appropriate client and supervisee confidentiality
- Inform management and appropriate professional bodies where there is serious concerns about the client/patient health and safety due to the health status of the supervisee or non-adherence to professional codes of ethics and the Service's code of conduct
- Undergo a criminal record check.

I have read and understand the terms of this contract and the supervision guidelines for the Drug and Alcohol Service.

Signed _____

Date _____/_____/_____

Date for Review _____/_____/_____

Appendix 6. Record of Clinical Supervision session (example)

This is a sample of the kind of record that can be kept by individual **supervisees** following each clinical supervision session.

Date _____/_____/_____

Name of Supervisor _____

Name of Supervisee _____

What was the contract for the session?

Key issues identified during the session?

Action taken:

What was learnt?

What will I do differently in the future?

Further agreements:

Comments:

Appendix 7. Record of Clinical Supervision session (example)

This is a sample of the kind of record that can be kept by **supervisors** following each clinical supervision session.

Date _____/_____/_____

Supervisor _____

Supervisee _____

What was the contract for the session?

Key issues identified during the session:

Action taken:

What will be done differently and by whom?

Checklist:

- ☐ Issues identified
- ☐ Ethical practice/compliance with codes of conduct
- ☐ Increased learning
- ☐ Objectives met

Notes and evaluation:

Plans for next supervision session:

Appendix 8.
Annual evaluation form (example)

The following is an example of an annual evaluation form used by an external clinical supervisor to gather information from supervisees. **End of year clinical supervision evaluation.**

The following questionnaire has been designed to evaluate the clinical supervision sessions you have been receiving over the past year.

All responses are ANONYMOUS. Feel free to add any additional comments. Your responses will be provided to the Manager of your service for consideration for future clinical supervision in 2005.

How helpful has been clinical supervision been?

0 1 2 3 4 5 6 7 8 9 10

Not helpful at all Very helpful

What have been the most helpful aspects of clinical supervision?

_____

_____

_____

_____

_____

_____

What have been the least helpful aspects of clinical supervision?

_____

_____

_____

_____

_____

_____

How has clinical supervision influenced your work with drug and alcohol clients?

_____

_____

_____

_____

_____

_____

Has clinical supervision improved your understanding in working with drug and alcohol clients?

Great deal A little Not at all

Has clinical supervision improved the way you work therapeutically with drug and alcohol clients?

Great deal A little Not at all

Tick the areas you think your knowledge and skills have improved in:

- ☐ Assessment
- ☐ Understanding the clients concerns
- ☐ Interviewing skills
- ☐ Dual diagnosis
- ☐ Intervention skills
- ☐ Problem solving
- ☐ Team issues
- ☐ Other areas *(please state)* _____

_____

Appendix 8: Annual evaluation form (example)

What recommendations do you have to improve clinical supervision in the future?

_____

_____

_____

_____

_____

_____

Other comments:

_____

_____

_____

_____

_____

_____

Many thanks for completing this form.

Acknowledgement for this evaluation format to Christine Senediak

Appendix 9. Annual report from Clinical Supervisors (example)

The following is an example of an annual report provided by clinical supervisors to service managers. Note whilst there is no detailed information about the content of clinical supervision sessions, there is summary information related to compliance with the policy, and ethical practice.

CONFIDENTIAL

Annual Report

_____

(Supervisee's name)

has attended clinical supervision sessions with me

_____

(Supervisor's name)

on _____ occasions from

_____/_____/_____to_____/_____/_____.

Both supervisor and supervisee have signed records of these sessions.

The general goals of supervision as detailed in the Clinical Supervision Policy and the specific goals of the contracts agreed to during the period under review are designed to promote best practice. In my opinion, the supervisee is working towards these supervision goals.

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

From discussion during supervision it would appear that the supervisee is performing according to the service Code of Conduct and in line with appropriate Professional Codes of Ethics for the discipline.

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

Supervisors signature _____

Date _____/_____/_____

Supervisees signature _____

Date _____/_____/_____

cc Manager

Appendix 10. Clinical Supervision evaluation format (example)

The following supervision questionnaire was developed by Ladany, Hill and Nutt (1966) as measure of supervisee perceptions of the quality and outcomes of supervision. The score is the sum of the items.

1. How would you rate the quality of the supervision you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of supervision you wanted?

1	2	3	4
No definitely not	No not really	Yes generally	Yes definitely

3. To what extent has this supervision fit your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of supervision, would you recommend this supervisor to him or her?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

5. How satisfied are you with the amount of supervision you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the supervision you received helped you to deal more effectively in your role as a counselor or therapist?

4	3	2	1
Yes definitely	Yes generally	No not really	No definitely

7. In an overall, general sense, how satisfied are you with the supervision you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek supervision again, would you come back to this supervisor?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

MANAGING WITHDRAWAL FROM ALCOHOL AND OTHER DRUGS (IB2022_041)

IB2022_041 replaces GL2008_011

Purpose

This information bulletin advises clinicians about new clinical guidance for managing withdrawal from alcohol and other drugs (AOD). Implementation of the clinical guidance is mandatory in NSW Health facilities. The document also seeks to guide clinicians in other settings including private facilities, aged care facilities, the primary health sector and community settings.

Key information

Clinical guidance for managing withdrawal from alcohol and other drugs

NSW Health has published updated clinical guidance on managing withdrawal from alcohol and other drugs. It is available here.

The document summarises the appropriate management of patients who are experiencing, or who are at risk of, withdrawal from alcohol or other drugs. It provides guidance on screening, assessment, care planning, medications and transfer to post-withdrawal care. It will form the basis for development and implementation of evidenced-based local procedures for screening, assessing and managing patients experiencing or at risk of withdrawal from alcohol and other drugs.

This clinical guidance applies to NSW Health staff in specialist withdrawal units of hospitals, general inpatient units, emergency departments and community health settings. Clinicians in other settings such as non-government facilities and primary care settings such as general practice, Aboriginal Community Controlled Health Organisations and community and welfare services are also encouraged to use this clinical guidance.

The Chief Executives of NSW Local Health Districts and Specialty Health Networks are responsible for the implementation of this guidance within their services/facilities to ensure that local protocols, models of care or operating procedures are in place that are aligned and consistent with the guidance.

All clinicians working in NSW Health facilities who are involved in the care of patients who are, or who are at risk of, withdrawing from alcohol or other drugs are to be aware of the clinical guidance and actively participate in its implementation.

Local Health Districts and Specialty Health Networks are to use this clinical guidance to develop, implement and monitor strategies and tools aligned to the key actions specified in the document, including in electronic clinical information systems.

PREVENTION OF VENOUS THROMBOEMBOLISM (PD2019_057)

PD2019_057 rescinds PD2014_032.

PURPOSE

This Policy Directive outlines the mandatory requirements for an effective Venous Thromboembolism (VTE) Prevention Program and aims to ensure that systems are in place that support clinicians to undertake these requirements.

MANDATORY REQUIREMENTS

- All NSW Public Health Organisations (PHOs) have a strategy to embed systems to comply with the actions summarised in the Prevention of Venous Thromboembolism Framework (Appendix 4.1 of this policy).
- The systems would enable risk assessments for VTE to be undertaken for:
  - All adult patients admitted to NSW public hospitals within 24 hours, and reassessed regularly as clinically appropriate (as a minimum every 7 days), if clinical condition changes and at transfers of care
  - All adult patients discharged home from the Emergency Department who, as a result of acute illness or injury, have significantly reduced mobility relative to normal state
  - All pregnant and postpartum women during the first comprehensive antenatal assessment; within 24 hours of any antenatal admission; when clinical situation alters; and during postpartum care, within 2 hours of birth (vaginal or caesarean section)
- The systems would also enable patients identified at risk of VTE to receive prophylaxis most appropriate to that risk and their clinical condition.
- All PHOs should make available decision support tools to guide prescription of prophylaxis appropriate for the patient's risk level.
- All PHOs are to have a strategy in place that includes regular monitoring of VTE prevention indicators to facilitate continuous improvement, and a system of communicating findings from review of VTE indicators.
- Clinicians are made aware of their role in undertaking routine VTE risk assessment, providing appropriate prophylaxis where patients are identified at risk of VTE, and to participate in their local public health organisation's VTE prevention program.

IMPLEMENTATION

Clinical Excellence Commission

- Provide the tools to support PHOs in the implementation of this Policy.

Chief Executives of Local Health Districts and Specialty Health Networks

- Assign leadership responsibility and resources to support implementation and compliance with this Policy.

Director of Clinical Governance

- Ensure that a local monitoring and evaluation program is in place that includes regular review of VTE prevention indicators, assess the effectiveness of VTE prevention strategies and assist with identifying areas that require focused attention.
- Regularly report on VTE prevention indicators to local quality committees, the Clinical Excellence Commission and other relevant State committees.

Director of Clinical Operations, Hospital, Facility and Clinical Network Managers

- Ensure all relevant staff receive education regarding VTE prophylaxis.
- Distribute VTE risk assessment and prophylaxis decision support tools to all clinical units.
- Ensure formulary management includes availability of medications recommended for VTE prophylaxis.
- Ensure clinical speciality protocols include VTE prophylaxis where appropriate.
- Participate and contribute to the PHO's monitoring and evaluation program for VTE prevention and include compliance review in routine clinical audit programs.
- Ensure data on indicators for VTE prevention processes are collected at clinical audit and provided, as required to, the Clinical Excellence Commission to enable and support quality improvement initiatives at a state level, the NSW Ministry of Health for state wide performance and compliance monitoring, and Clinical Department Heads to communicate findings from review of VTE indicators to clinical staff and support local improvement strategies.
- Ensure case review of patients developing a VTE that occurs during, or as a result of, a hospital admission.
- Ensure each clinical unit regularly reviews their VTE data and develops strategies towards improving prophylaxis where required.

Attending Medical Officer (or Delegate)

- Actively participate in their local public health organisation's VTE prevention program.
- Are aware of undertaking VTE risk assessment on all eligible patients (as noted above).
- Review the patient's related bleeding risk and based on that assessment, ensure prescription and administration of appropriate prophylaxis as required.
- Partner with patients and their carers to have an active role in preventing VTE by discussing the reason for treatment, risks and consequences of VTE prophylaxis on admission and on transfer to community or home care where required.
- Document outcome of VTE risk assessment, prophylaxis treatment; and other significant information, including any relevant dosage adjustment in the patient's health care record, approved risk assessment tools, or other locally approved forms.
- Confirm appropriate peri-operative prescription of both pharmacological and mechanical prophylaxis where indicated.
- Regularly review VTE risk during the patient care episode, particularly as clinical condition changes, and that prophylaxis is monitored and adjusted accordingly.

Prevention of Venous Thromboembolism Procedures

1 BACKGROUND

1.1 About this document

Venous thromboembolism (VTE) is a significant preventable adverse event for hospitalised patients. The incidence of developing a VTE has been shown to be 100 times greater among hospitalised patients than those in community[1]. Serious adverse outcomes resulting from VTE may occur, including an increased risk of recurrent thrombosis, morbidity from post-thrombotic syndrome or death.

Effective prevention of VTE is achieved through assessment of risk factors and the provision of appropriate prophylaxis.

This Procedure describes the system processes required to be embedded into standard workflow and clinical practice, to reduce a patient's risk of developing VTE.
These include:

- Identifying patients who should be assessed for VTE risk
- Assessing VTE risk
- Prescribing appropriate prophylaxis
- Reassessing VTE risk during care
- Engaging the patient
- Monitoring performance and practice, to assess compliance and to facilitate continuous improvement.

This Policy requires:

- All public health organisations (PHOs) to have a strategy to embed systems to support clinicians assess and manage VTE risk in patients.

  The Prevention of Venous Thromboembolism Framework (Appendix 4.1) provides a summary of the required actions for NSW public hospitals and health services.

- Attending Medical Officers and their medical teams to review all adult patients that require assessment for risk of VTE and, based on that assessment in correlation with evidence-based guidelines, prescribe prophylaxis accordingly.

  Assessment outcome must be noted in the patient health care record or other approved form, and the rationale behind decision to prescribe or withhold prophylaxis should also be noted.

- Nursing staff/ midwives, pharmacists and other relevant allied health staff to be aware of VTE risk and assist in ensuring the processes for prevention are implemented.

To support the implementation of this Policy, the Clinical Excellence Commission (CEC) has developed tools to support clinicians to undertake VTE risk assessments. NSW VTE risk assessment tools and other resources can be found on the CEC website http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention).

The use of these VTE risk assessment tools is NOT mandatory. Where not used, a similar tool meeting the requirements set out in this Procedure document must be implemented.

The CEC will continue to work with PHOs to facilitate VTE prevention strategies across NSW public hospitals.

1.2 Related Documents

This Policy is to be read in conjunction with the following NSW Health Policies:

- High-Risk Medicines Management
- Clinical Handover
- Incident Management

1.3 Key definitions

Anticoagulant	Any agent used to prevent the formation of blood clots. These include oral agents, such as warfarin, dabigatran, rivaroxaban and apixaban, and others which are injected into the vein or under the skin, such as unfractionated heparin and low molecular weight heparin e.g. enoxaparin sodium.
Attending Medical Officer (AMO)	The Attending Medical Officer (AMO) is the senior medical practitioner who has primary responsibility for the patient during admission. This AMO is a consultant who may be a visiting medical officer or a staff specialist. The AMO may lead a team that includes related medical officers and this team plays a critical role in the assessment and prevention of VTE.
Australian Commission on Safety and Quality in Health Care (ACSQHC)	The Australian Commission on Safety and Quality in Health Care is a government agency that leads and coordinates national improvements in safety and quality in health care across Australia.
Deep Vein Thrombosis (DVT)	A blood clot that occurs in the "deep veins" in the legs, thighs or pelvis. - ***Asymptomatic deep vein thrombosis*** is defined as painless DVT detected only by ultrasound, or ascending venography and is often confined to the distal veins. - ***Symptomatic deep vein thrombosis*** results from occlusion of a major leg vein and results in leg pain or swelling. It requires specific investigation and treatment which in hospitalised patients may delay discharge, or require readmission to hospital.
Family of Measures	There are three types of measures. **Outcome measures:** - Refer to the 'voice of the customer or user' - Define how the system is performing - Broadly speaking describe what the result is. **Process measures:** - Refer to the 'voice of the workings of the system' - Serve to answer process questions i.e. are the parts and/or steps in the system performing as planned? **Balancing measures:** - Reflect on what happened to the system as we improved the outcome and process measures (e.g. unanticipated consequences, other factors influencing outcome).
Health Information Exchange (HIE)	HIE data is coded data based on the medical record. The quality of this information depends on the quality of the medical records, currency and accuracy of coding.

Mechanical Prophylaxis	VTE prophylaxis in the form of a Graduated Compression Stocking, anti-embolic stocking, Intermittent Pneumatic Compression or Foot Impulse Device.
Must	Indicates a mandatory action requiring compliance.
Postpartum Period	Period beginning immediately after the birth of a child and extending for about six weeks.
PowerPlan	An electronic order set listing pharmacological and mechanical options based on protocols, grouped for faster electronic order entry.
Prescriber	A health professional legally entitled to prescribe medicines according to prevailing *NSW Poisons and Therapeutic Goods Act 1966* and Regulations.
Pulmonary embolism (PE)	A blood clot that breaks off from the deep veins and travels around the circulation to block the pulmonary arteries (arteries in the lung). Most deaths arising from deep vein thrombosis are caused by pulmonary emboli. *(Plural = pulmonary emboli)*
Public Health Organisation (PHO)	Under the *Health Services Act 1997 (NSW)*, a local health district, statutory health corporation or affiliated health organisation in respect of its recognised establishments and recognised services.
Quality Audit Reporting System (QARS)	The QARS has been developed by the CEC to provide local health districts (LHDs) and speciality networks (SNs), and their facilities with a tool to conduct quality audits to provide evidence for the accreditation process, evaluate performance and initiate relevant action plans. The QARS allows evaluation at LHD, facility or ward levels. Benchmarking against the NSW average and peer groups is also available.
Quality Improvement Data System (QIDS)	The QIDS is a system that takes data and presents in charts for quality improvement. It was designed for unit level managers and clinicians to have easy access to information to improve their services.
Should	Indicates a recommended action that is best followed unless there are sound reasons for taking a different course of action.
Significantly Reduced Mobility Relative to Normal State	Refers to patients who are bedbound, or likely to spend a substantial proportion of the day in bed or in a chair due to the clinical condition for which they are being treated, or unable to walk unaided due to injury such as severe lower leg injury (e.g. fracture, dislocation, complete tendon rupture), requiring rigid immobilisation, or non-weight bearing status. The change in mobility should be assessed in relation to the patient's normal state of functioning.
Transfer of Care	Transfer of care involves transferring professional responsibility and accountability for the care of a patient to another person or professional or a combination of professionals. It includes discharge from an acute inpatient setting to the community setting, subacute care or non-acute care. It can also include transfer between hospitals, or transfer between attending teams and/or units within a hospital..
Thromboprophylaxis	Measures taken to assist in reduction of the risk of thrombosis.
Venous thromboembolism (VTE)	The blocking of a blood vessel by a blood clot. Includes both deep vein thrombosis and pulmonary embolism.

VTE Risk Outcome	The decision reached after a risk assessment is carried out to evaluate the likelihood of a patient developing a VTE due to existing risk factors. The patients risk outcome can fall under one of three categories. **Lower Risk:** Patient has a lower risk of developing a VTE and requires no active treatment. **Moderate Risk:** Patient is at risk of developing a VTE and requires treatment with pharmacological prophylaxis (where no contraindications exist) and mechanical prophylaxis should be used where pharmacological therapy is contraindicated. **Higher Risk:** Patient is at a relatively higher risk of developing a VTE and requires combination treatment (where no contraindications exist) with both pharmacological AND mechanical prophylaxis.

2 VENOUS THROMBOEMBOLISM PREVENTION

2.1 Identifying Patients for Assessment

All PHOs must have systems in place to support clinicians to assess and manage VTE risk in patients. The following patient groups must be identified and undergo a VTE risk assessment.

2.1.1 Patients in the Emergency Department

Adult patients (>16 years) to be discharged home from an Emergency Department who, as a result of their acute illness or injury (including interventions such as leg casts/braces), have significantly reduced mobility relative to normal state. They should undergo VTE risk assessment and be prescribed appropriate prophylaxis by an Emergency Department clinician prior to leaving the Emergency Department.

All other patients to be discharged home from an Emergency Department do not need to be assessed for VTE risk.

PHOs need to have systems in place that ensure adult patients being admitted to an inpatient ward or unit from an Emergency Department undergo a VTE risk assessment and be prescribed appropriate prophylaxis within 24 hours of presentation.

2.1.2 Admitted Patients

All adult patients (>16 years) admitted to a NSW public hospital or health service should undergo a VTE risk assessment within 24 hours of admission and, if appropriate, be prescribed prophylaxis.

This includes patients admitted to an inpatient ward (medical or surgical), or a unit such as a mental health unit or sub-acute facility (such as rehabilitation or palliative care).

Although, VTE prevention processes within the mental health setting are currently not as robust as in the general population, there is growing evidence to suggest that atypical antipsychotics (particularly clozapine) increase VTE risk. Additionally, reduced mobility is a strong risk factor for VTE and should be considered in the context of mental health patients, particularly in catatonia, neuroleptic malignant syndrome, over-sedation, use of physical restraints, severe depression, bed rest in anorexia nervosa and other acute states of reduced activity.

It should also be noted that while palliative care patients are required to undergo VTE risk assessment, patients in the terminal stage of life may not require VTE prophylaxis and therefore may not need to undergo assessment. This decision should be aligned with the goals of care, which are to be considered in consultation with the patient and their family and/or carers.

2.1.3 Pregnant and Postpartum Women

All pregnant and postpartum women should undergo VTE risk assessment:

- During the first comprehensive antenatal assessment
- Within 24 hours of admission into a non-obstetric setting for a non-pregnancy related complaint
- Within 24 hours of admission into an obstetric setting for a pregnancy or non-pregnancy related complaint
- During postpartum care, within 2 hours of birth (vaginal or caesarean section)

2.1.4 Planned Admission and Day Surgery

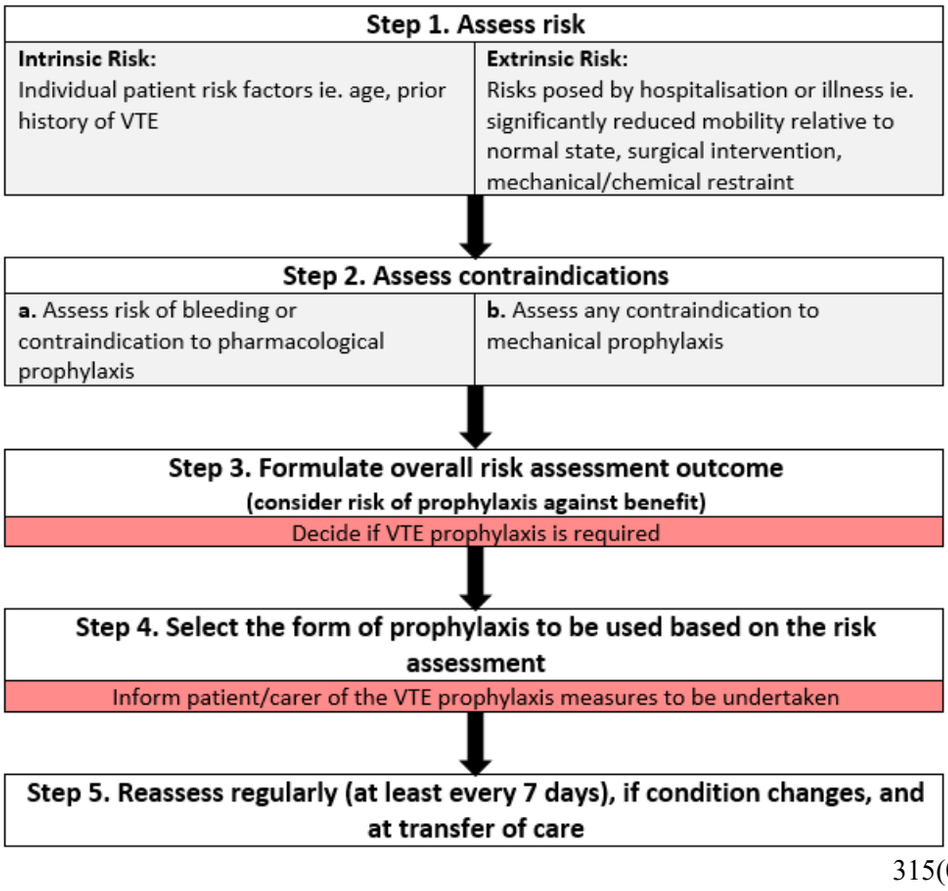
Patients undergoing planned surgical and invasive interventions and/or imaging guided invasive interventions are required to be assessed by a medical officer to determine the risks and benefits of stopping pre-existing, established anticoagulation or anti-platelet therapy before discontinuing these therapies.

- Prophylaxis should be considered for day surgery patients based on evidence in situations of significantly reduced mobility relative to normal state, prolonged and/or general anaesthesia and for patients demonstrating one or more other risk factors.

Day surgery or procedure patients who receive only local anaesthesia without any reduction in mobility relative to normal state, do not require routine VTE assessment, unless otherwise clinically appropriate.

2.2 Risk Assessment

Systems introduced by PHOs should support clinicians to complete a VTE risk assessment for the identified target patient groups. Standardised, approved risk assessment tools are to be made available to all clinical staff.The risk assessment tool must ensure the following steps are undertaken during the assessment.



2.2.1 Assessing VTE Risk in Admitted Patients

Systems introduced by PHOs should are to support Attending Medical Officers (and delegates) to complete a VTE risk assessment for all adult patients admitted to NSW public hospitals within 24 hours.

A **NSW Adult Venous Thromboembolism Risk Assessment Tool** has been developed for use in admitted patients and to support implementation. See the CEC website for a copy of the tool (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/risk-assessment).

2.2.2 Assessing VTE Risk in Pregnant and Postpartum Women

Systems introduced by PHOs should support midwives and medical officers to complete a VTE risk assessment. Where a midwife completes the assessment, systems need to ensure that the outcome of the assessment is referred to the attending medical officer (or delegate).
Any standard risk assessment tool used within the PHO must identify all pregnant and postpartum women to be at risk of VTE. These women should then be referred to an obstetrics consultant/team for risk assessment and decision to commence pharmacological and/or mechanical prophylaxis.
A pregnant woman admitted into a non-obstetric setting for a non-pregnancy related complaint can initially be assessed using a standard risk assessment tool given it complies with the requirements highlighted above.
A dedicated obstetric VTE risk assessment tool should be used to assess pregnant and postpartum women in an obstetrics setting. It should identify risk factors, contraindications and evidence-based treatment options that are unique to this target group.
A **NSW Maternity Venous Thromboembolism Risk Assessment Tool** has been developed to support implementation. See the CEC website for a copy of the tool (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/maternity).

2.2.3 Documenting VTE Risk

Systems introduced by PHOs should support clinicians to document:

- That a risk assessment has been completed
- The outcome of the risk assessment.

When in use, clinicians are to document once a risk assessment has been completed on the dedicated VTE section of the acute National Inpatient Medication Chart (NIMC) (not included on the long-stay version).
Additional areas for documentation may include:

- Electronic medical record
- The patients' health care record
- Approved risk assessment tools
- Maternal antenatal hand-held record
- Other locally approved forms, such as patient care plans.

2.2.4 Additional Prevention Strategies

Irrespective of a patient's VTE risk outcome, the following prevention strategies should be considered and promoted.

- Patients remain adequately hydrated (unless contraindicated due to their clinical condition e.g. fluid restriction due to chronic heart failure) and must be encouraged to mobilise as soon as possible and to continue being mobile post discharge.[2]
- A plan for early mobilisation should be developed by a multidisciplinary team with the patient and their family/ carer.

2.3 Prescribing and Administration of Appropriate Prophylaxis

If pharmacological and/or mechanical prophylaxis is required and appropriate, prophylaxis should be prescribed and administered as early as possible during the patient's admission or as scheduled after the commencement of care and risk assessment is carried out.
The choice of pharmacological and mechanical prophylaxis must be informed by evidence. PHOs should ensure that systems are in place to provide clinicians with access to evidenced-based guidelines, a clinical specialty protocol, as well as reference to drugs available on the hospital formulary. Pharmacological prophylaxis in this setting is in the form of an anticoagulant, and should be managed in accordance with the *NSW Health High-Risk Medicines Management* Policy Directive.
The standardised risk assessment tool made available should provide clinical decision support for Attending Medical Officers or other authorised prescribers such as Nurse Practitioners, when prescribing prophylaxis.
This procedure should be read in conjunction with clinical guidelines on VTE Prophylaxis. These include (but not limited to):

- Venous Thromboembolism Prevention Clinical Care Standard, Australian Commission on Safety and Quality in Health Care, Oct 2018 https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/
- Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism VTE: Reducing the Risk for Patients in Hospital, NICE guideline [NG89], Mar 2018
- VTE Prophylaxis, BMJ Best Practice, July 2018
- Antithrombotic Therapy and Prevention of Thrombosis, 9th ed (2012): American College of Chest Physicians (ACCP) Evidence-Based Clinical Practice Guidelines
- Prevention and Treatment of VTE, International Consensus Statement, International Angiology, April 2013

2.3.1 Documentation of Prophylaxis

- Where electronic prescribing systems are in use, Attending Medical Officers or other authorised prescribers such as Nurse Practitioners should prescribe pharmacological and/ or mechanical prophylaxis as per local protocol. Where available, prescribing via a VTE PowerPlan (or similar) is encouraged and to be promoted.
    - The regular NIMC (acute), contains a dedicated VTE section. Where this chart is used, the Attending Medical Officer (or delegate) or other authorised prescribers such as Nurse Practitioners, must prescribe pharmacological and/ or mechanical prophylaxis within the dedicated section. Prescribing outside of this section may lead to duplication of orders and risk of patient harm.

  Where other versions of the NIMC without this section are in use, such as the long-stay chart, prescribing should be completed within the normal sections.

  Checks associated with mechanical prophylaxis must also be documented at least twice daily by nursing staff/midwives. Checks should be documented on the NIMC (acute) or in an electronic medical record, where mechanical prophylaxis has been prescribed.

- For pregnant women, prescribed prophylaxis is also to be noted on the Antenatal hand held record, and electronic antenatal record where in use.

2.3.2 Contraindications and other considerations with Prophylaxis

- The risk of bleeding is a significant complication of pharmacological prophylaxis, particularly in surgical patients. The decision to commence pharmacological prophylaxis should be made after considering the benefits of treatment i.e. reducing VTE risk, against the risk associated with treatment (bleeding and other contraindications).

To support clinicians select the most appropriate prophylaxis for their patients, the standardised risk assessment tool should promote consideration of absolute or relative contraindications to pharmacological prophylaxis before a patient is prescribed therapy.
Where an absolute contraindication exists (e.g. bleeding disorders, active bleeding), the use of pharmacological prophylaxis should be avoided due to life-threatening risk, while relative contraindications require caution to be exercised and the benefits of therapy to be weighed against the risk.
Where pharmacological prophylaxis is contraindicated, mechanical prophylaxis remains an option and should be considered, as indicated, until the patient is mobile.

- Prescribers should refer to the current product information to select a safe dose for individual patients. Some agents are contraindicated or may require a reduction of dose i.e. in elderly patients or those with renal impairment.

  Prescribers should take care to select the dose recommended for prophylaxis and not the dose recommended for therapeutic anticoagulation.
- In certain clinical scenarios where there is limited evidence and guidance available, careful consideration of individual patient risks and specialist advice may be required. This includes the following scenarios:
  - Peri-operative and peri-procedural management with anticoagulants
  - Cessation of oestrogen-containing oral contraceptives or hormone replacement therapy, if clinically appropriate.
  - Selecting an appropriate dose for extremes of total body weight <50kg or >120kg or body mass index ≥35kg/m^2).
- **Anaesthesia and VTE**

  It is recommended that clinicians follow the advice provided in Section 5.9 of the Acute pain management: scientific evidence guidelines produced by the Australian and New Zealand College of Anaesthetists and Faculty of Pain Management (2015)[3]

  For a practical guide on how to appropriately manage pregnant women receiving pharmacological prophylaxis requiring anaesthesia, clinicians may refer to the published consensus statement by the Society for Obstetric Anaesthesia and Perinatology (SOAP)[4]

2.4 Partnering with Patients

Systems introduced by PHOs should support clinicians to partner with patients and their carers in managing their risks and to have an active role in preventing VTE. Systems are in place for clinicians to provide patients information about VTE to enable shared-decision making regarding their VTE prevention plan.

Patients, carers and their families should be informed about:

- What a VTE is
- Signs and symptoms of VTE
- Risk factors specific to the patient's condition
- Effective interventions to reduce the risk of VTE developing
- Any pharmacological and/or mechanical prophylaxis they are receiving
- VTE prevention discharge plans (where required).

Written information should accompany any counselling points. Patient information highlighting the risk of developing a VTE in hospital should be available, and patient leaflets summarising key points should be provided. Resources are available at:

- CEC VTE Prevention website contains information for adult admitted patients http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention and for women who are pregnant or postpartum http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/maternity
- ACQSHC website https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/Information about the pharmacological agent used must also be provided. For example, Consumer Medicines Information (CMI) is available at https://www.ebs.tga.gov.au/.

2.4.1 Documenting Patient Information

When a treatment decision has been made, clinicians should document that the patient has received an explanation of risks and benefits of prophylaxis, including the provision of additional information regarding VTE prevention. This should be recorded within the patients' health care record and/ or other approved form or tool.

2.5 Reassessing VTE Risk

Systems are in place for clinicians to undertake a reassessment of patient's VTE and bleeding risks:

- Regularly as clinically appropriate, as a minimum every 7 days
- When clinical condition changes (e.g. unplanned surgery, changes in mobility)
- At transfer of care.[2]
- Pregnant and Postpartum Women with a protracted antenatal admission should be reassessed every 7 days, as a minimum

Reassessment is required to:

- ensure that appropriate methods of VTE prophylaxis are used
- ensure that VTE prophylaxis is being used correctly
- identify adverse events resulting from VTE prophylaxis or its absence.

2.5.1 Reassessing Risk at Discharge and Continuity of Care

Systems should enable clinicians to reassess patients identified at risk at the point of discharge. Consideration should be made regarding the need for extended prophylaxis.

Attending Medical Officers are to ensure the development of a prospective action plan for patients requiring continuation of pharmacological and/ or mechanical prophylaxis on transfer home or to another care level. The plan is to be communicated in a timely manner to the patient's primary healthcare provider and explained to the patient/carer/family. This is particularly important when patients are transferred into community or residential aged care.

Clinicians must comply with key principles for transition of care and clinical handover with special regard to VTE prophylaxis treatment. This should occur at all transition points including transfer home or to another care service. Key principles are outlined in the *Venous Thromboembolism Prevention Clinical Care Standard* and the *NSW Health Clinical Handover* Policy Directive.

On transfer to home or another care service, a patient's supply of prophylactic medication should be arranged to enable uninterrupted treatment. Referral to another care model should be arranged including assurance of follow-up and continuity of supply as needed. Patients should be informed of the reason for ongoing treatment and the anticipated timeframe for discontinuation of the treatment. Patients must receive education on the administration of treatment as needed and be encouraged to mobilise (unless instructions for mobility restriction are in place).

2.6 Monitoring Performance and Practice

PHOs must ensure they have in place a monitoring and evaluation program that includes regular review of VTE prevention indicators to monitor performance, assess the effectiveness of VTE prevention strategies and assist with identifying areas that may require focused attention.

PHOs are required to regularly report on VTE prevention indicators to local governing quality committees and other relevant State committees.

As a minimum, the following indicators are required to be included in the monitoring and evaluation framework:

Indicator	Type of Measure	Suggested Data Sources
1. Rate of Hospital Acquired VTE events where prophylaxis was not prescribed appropriate to the level of risk in accordance with guidelines or local protocols. Numerator = Hospital-acquired VTE events where appropriate prophylaxis was not prescribed Denominator = All hospital-acquired VTE events	Outcome	• Clinical Audit • Non-Fatal VTE Incident Tool • Incident Investigations i.e. RCAs
2. Hospital Acquired VTE (rate per 1000 separations).	Outcome	• HIE • QIDS
3.1. Rate of documented VTE risk assessment completion within 24 hours for all adult inpatient admissions.	Process	• Clinical Audit (QARS question ID 7110)
3.2. Rate of documented VTE risk assessment completion on the first comprehensive antenatal assessment (for Maternity patients)	Process	• Clinical Audit (QARS) • eMaternity
3.3. Rate of documented VTE risk assessment completion during postpartum care, within 2 hours of birth (vaginal or caesarean section) (for Maternity patients).	Process	• Clinical Audit (QARS) • eMaternity
3.4. Rate of documented VTE risk assessment completion for adult patients discharged from ED with isolated lower limb injury requiring temporary lower limb mobilisation (for ED patients).	Process	• Clinical Audit (QARS)
4. Rate of VTE prophylaxis appropriate to the level of risk in accordance with Guidelines or local protocols.	Process	• Clinical Audit (QARS question ID 7115)

2.6.1 Clinical Audit

Regular clinical auditing is required to capture the necessary data to inform PHOs on VTE prevention indicators i.e. process measures relating to compliance with risk assessment completion and the prescription of appropriate prophylaxis.

For the purpose of monitoring performance for assurance, PHOs must review VTE indicator data from regular clinical auditing. As a guide, clinical audit should occur at least annually if the system is considered to be in a reliable state and more frequently i.e. quarterly to biannually where compliance is considered unreliable.

As well as providing assurance for local VTE prevention performance, data collection by clinical auditing and feedback play an important role in driving improvement.

Measurement for improvement generally require smaller sample sizes and short timeframes for data collection, to allow it to be repeated frequently for trending changes over time.

A simple VTE Prevention questionnaire is available within Quality Audit Reporting System (QARS) to assist PHOs to conduct clinical audit to capture data on VTE process measures and assessing compliance with the Prevention of Venous Thromboembolism Policy Directive. The questionnaire can be modified by adding or removing questions to suit local needs. However, the following questions must be included in any locally adapted QARS questionnaires:

- Rate of documented VTE risk assessment completion within 24 hours for all adult inpatient admissions. (question ID 7110)
- Rate of VTE prophylaxis appropriate to the level of risk in accordance with Guidelines or local protocols. (question ID 7115).

See the CEC website for further information: (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/monitoring-practice)

The following audit tools and metrics are also available to assist with review of clinical processes and outcome. These include:

- The National Quality Use of Medicines indicators (accessible from NSW TAG website: http://www.nswtag.org.au/qum-indicators/)
- The NIMC (acute) VTE Prophylaxis Section Audit and Reporting Tool (accessible from ACSQHC website: https://www.safetyandquality.gov.au/our-work/medication-safety/vteprophylaxis/)
- VTE event rates using ACSQHC's hospital acquired complication (HAC) specifications or CEC defined ICD10 VTE codes (accessible from the VTE dashboard on QIDS)
- National Surgical Quality Improvement Program (NSQIP). Hospitals participating in the Agency for Clinical Innovation's NSQIP Collaborative may have access to data presenting performance against VTE metrics relating to preventable surgical complications.

2.6.2 Incident Reporting

All patients who present on admission with a VTE resulting from a previous hospitalisation (within 90 days of discharge) or who develop a VTE during hospitalisation must have the incident documented in the patient's health care record and recorded into the incident monitoring system.

Any significant unexpected change in a patient's condition relating to VTE prophylaxis including embolism and bleeding, must be considered an adverse event and be recorded in the incident monitoring system with the appropriate level of investigation initiated as per the requirements outlined in the *NSW Health Incident Management* Policy Directive.

2.6.3 Feedback to Clinical Staff

The PHO's VTE prevention monitoring and evaluation program must include a system of communicating VTE indicator data to clinicians in a timely manner to enable practice and quality improvement.

VTE incidents are to be reviewed with other clinical indicators and to be included as part of the existing hospital morbidity and mortality review process. Apart from PHO's Safety and Quality Committees, Morbidity and Mortality meetings should be considered as a forum to present data on VTE indicators.

2.6.4 Staff Education

Clinical staff should be provided with education on VTE prevention strategies.

Training resources can be found at:

- The CEC website http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention
- 'Electronic Venous Thromboembolism (VTE) Risk Assessment Tool for Adult Inpatients' My Health Learning (Course Code: 212082420)

- ACSQHCHC website: NIMC (acute) VTE Prophylaxis section: https://www.safetyandquality.gov.au/our-work/medication-safety/vteprophylaxis/
- ACSQHC website: Hospital Acquired Complication (HAC) clinician fact sheet - Venous thromboembolism: https://www.safetyandquality.gov.au/publications/hacs-information-kit-fact-sheet-venous-thromboembolism/
- ACQSHC website for the Venous Thromboembolism Prevention Clinical Care Standard and implementation resources (including clinician fact sheet): https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/

3 REFERENCES

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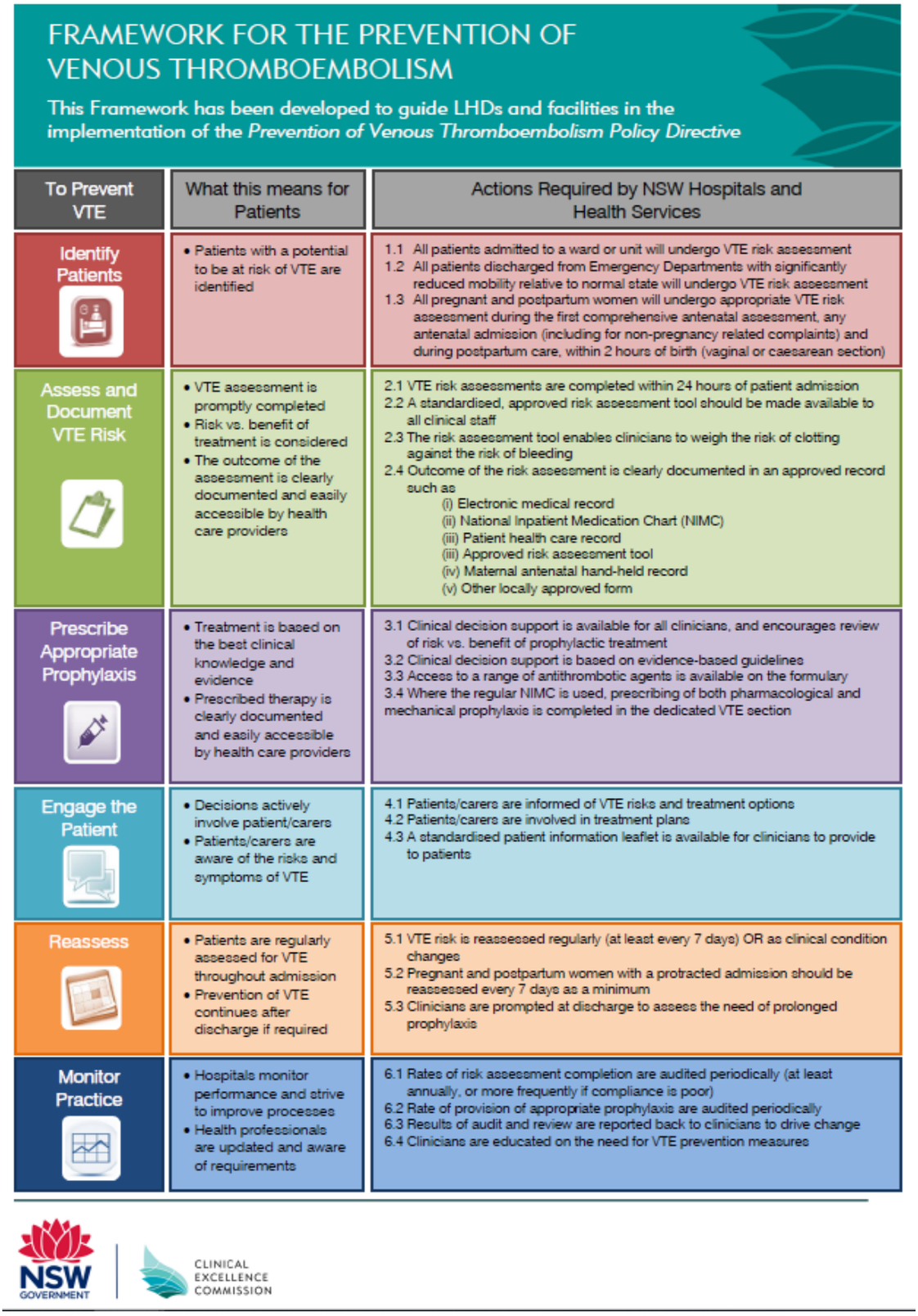
4. Leffert L, Butwick A, Carvalho B, Arendt K, Bates SM, Friedman A, et al. The Society for Obstetric Anesthesia and Perinatology Consensus Statement on the Anesthetic Management of Pregnant and Postpartum Women Receiving Thromboprophylaxis or Higher Dose Anticoagulants. *Anesthesia and analgesia* 2018;126(3):928-44.

4 APPENDIX

4.1 Prevention of Venous Thromboembolism Framework



FRAMEWORK FOR THE PREVENTION OF VENOUS THROMBOEMBOLISM

This Framework has been developed to guide LHDs and facilities in the implementation of the *Prevention of Venous Thromboembolism Policy Directive*

To Prevent VTE	What this means for Patients	Actions Required by NSW Hospitals and Health Services
Identify Patients	• Patients with a potential to be at risk of VTE are identified	1.1 All patients admitted to a ward or unit will undergo VTE risk assessment 1.2 All patients discharged from Emergency Departments with significantly reduced mobility relative to normal state will undergo VTE risk assessment 1.3 All pregnant and postpartum women will undergo appropriate VTE risk assessment during the first comprehensive antenatal assessment, any antenatal admission (including for non-pregnancy related complaints) and during postpartum care, within 2 hours of birth (vaginal or caesarean section)
Assess and Document VTE Risk	• VTE assessment is promptly completed • Risk vs. benefit of treatment is considered • The outcome of the assessment is clearly documented and easily accessible by health care providers	2.1 VTE risk assessments are completed within 24 hours of patient admission 2.2 A standardised, approved risk assessment tool should be made available to all clinical staff 2.3 The risk assessment tool enables clinicians to weigh the risk of clotting against the risk of bleeding 2.4 Outcome of the risk assessment is clearly documented in an approved record such as (i) Electronic medical record (ii) National Inpatient Medication Chart (NIMC) (iii) Patient health care record (iii) Approved risk assessment tool (iv) Maternal antenatal hand-held record (v) Other locally approved form
Prescribe Appropriate Prophylaxis	• Treatment is based on the best clinical knowledge and evidence • Prescribed therapy is clearly documented and easily accessible by health care providers	3.1 Clinical decision support is available for all clinicians, and encourages review of risk vs. benefit of prophylactic treatment 3.2 Clinical decision support is based on evidence-based guidelines 3.3 Access to a range of antithrombotic agents is available on the formulary 3.4 Where the regular NIMC is used, prescribing of both pharmacological and mechanical prophylaxis is completed in the dedicated VTE section
Engage the Patient	• Decisions actively involve patient/carers • Patients/carers are aware of the risks and symptoms of VTE	4.1 Patients/carers are informed of VTE risks and treatment options 4.2 Patients/carers are involved in treatment plans 4.3 A standardised patient information leaflet is available for clinicians to provide to patients
Reassess	• Patients are regularly assessed for VTE throughout admission • Prevention of VTE continues after discharge if required	5.1 VTE risk is reassessed regularly (at least every 7 days) OR as clinical condition changes 5.2 Pregnant and postpartum women with a protracted admission should be reassessed every 7 days as a minimum 5.3 Clinicians are prompted at discharge to assess the need of prolonged prophylaxis
Monitor Practice	• Hospitals monitor performance and strive to improve processes • Health professionals are updated and aware of requirements	6.1 Rates of risk assessment completion are audited periodically (at least annually, or more frequently if compliance is poor) 6.2 Rate of provision of appropriate prophylaxis are audited periodically 6.3 Results of audit and review are reported back to clinicians to drive change 6.4 Clinicians are educated on the need for VTE prevention measures

NSW GOVERNMENT | CLINICAL EXCELLENCE COMMISSION

TERM CHANGEOVER – ENSURING AN EFFECTIVE HANDOVER OF PATIENT CARE (GL2008_015)

Guidelines to ensure that patient care and patient flow are maintained by clinical teams during end of term changeover for junior medical staff and registrars.

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2008/GL2008_015.html

USING RESUSCITATION PLANS IN END OF LIFE DECISIONS (PD2014_030)

PD2014_030 rescinds GL2008_018.

PURPOSE

This policy directive supersedes GL2008_018 *Decisions relating to No Cardio-Pulmonary Resuscitation (CPR) Orders.*

Planning care for patients who are approaching end of life will generally involve a shift in the focus of care away from aggressive medical intervention and towards a palliative approach, opting out of Rapid Response Systems and/or initiating palliative care.

Making a Resuscitation Plan is one important step in this process of planning quality end of life care. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

MANDATORY REQUIREMENTS

Development of standardised Resuscitation Plans and implementation policy is required by the NSW Health *Advance Planning for Quality Care at End of Life: Action Plan 2013-2014* (Action 2.1, 2.2). Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

This policy directive will commence two weeks after release when the state Resuscitation Plans (adult and paediatric) are available.

All Public Health Organisations must:

- Adopt the state Resuscitation Plans (adult and paediatric). T hese should replace similar existing LHD forms (e.g. No CPR Orders, Not for Resuscitation Orders).
- Incorporate evaluation of whether Resuscitation Plans were completed into death audit protocols.

NSW Health Resuscitation Plans are not valid for community patients under the medical care of a doctor who is not a NSW Health staff member. General Practitioners with admitting rights are considered NSW Health staff.

IMPLEMENTATION

Roles and Responsibilities

NSW Ministry of Health

- Significant developments regarding end of life planning and care are underway in NSW Health that impact use of Resuscitation Plans. These include death audit standards, development of clinical triggers for end of life planning and targeted education for health professionals. However, as these broader implementation measures are still under development, this Policy Directive has been confined in scope to principles and standards related to usage of the Resuscitation Plan.
- Provide current policy to support use of Resuscitation Plans. A guideline will be developed in 18 months addressing how Resuscitation Plans integrate with other state level projects and programs. The Ministry will also evaluate the Resuscitation Plan forms in two years to assess whether they are meeting clinical need given rapid changes in End of Life care in NSW.
- Establish an end of life education strategy in partnership with the pillar agencies, that includes best practice approaches to training health professionals in having end of life conversations (relevant to Resuscitation Plans).
- Develop an appropriate service measure for Resuscitation Plans in readiness for the 2015/16 Service Level Agreements.

LHD and Specialty Network Chief Executives

- Identify an appropriate Executive Sponsor for this policy.
- Provide an appropriate governance mechanism to oversee implementation planning related to Resuscitation Plans consistent with *Advance Planning for Quality Care at End of Life: Action Plan 2013-2018.*
- Establish means of identifying the Person Responsible as a routine part of procedures for all admissions.
- Integrate Resuscitation Plans into the electronic Medical Record.
- Include assessment of whether Resuscitation Plans have been completed prior to in-hospital deaths as part of death audit standards.

Ambulance Service NSW

- Incorporate Resuscitation Plans into relevant protocols.

1. BACKGROUND

1.1 Purpose

This policy directive supersedes GL2008_018 Decisions relating to No Cardio-Pulmonary Resuscitation (CPR) Orders.

This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

Development of standardised adult and paediatric Resuscitation Plans and implementation policy is required by the *NSW Health Advance Planning for Quality Care at End of Life: Action Plan 2013-2018* (Action 2.1 and 2.2).

Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

Key terms used in this document are defined in the Glossary.

1.2 Mandatory Requirements

All Public Health Organisations must adopt the NSW Health Resuscitation Plans (adult and paediatric). Resuscitation Plans are intended for use in all NSW Public Health Organisations, including acute facilities, sub-acute facilities, ambulatory and community settings, and NSW Ambulance for patients 29 days and older.

NSW Health Resuscitation Plans are not valid for community patients under the medical care of a doctor that is not a NSW Health staff member. General Practitioners with admitting rights are considered NSW Health staff.

1.3 Legal and legislative framework

The Resuscitation Plan – state forms included in this Policy Directive are legally enforceable medical orders and must be followed by staff.

Interdisciplinary disputes should be managed in accordance with GL2005_057 End-of- Life Care and Decision-Making - Guidelines.

The existing legal framework in NSW supports end of life decisions, including Resuscitation Plans and permits:

- Refusal of any and all life-sustaining treatments by a person with decision making capacity at the end of life.
- Advance refusal for a time of future incapacity.
- Decisions made by a doctor, in consultation with and preferably agreement of the Person Responsible, where a person has no decision-making capacity to withhold or withdraw life-sustaining measures so as to focus primarily on palliative care. (*Advance Planning for Quality Care at End of Life: Action Plan 2013-2018*).

A Resuscitation Plan must be made:

- With reference to pre-planning by patients (such as Advance Care Plans or Directives).
- In consultation with the patient/Person Responsible.
- Taking into account the current clinical status, prognosis, wishes of the patient, and goals of care.

In NSW, common law governs many aspects of end of life decision-making, including use of Advance Care Directives and these must be adhered to when valid. In NSW an Advance Care Directive must be adhered to provided that it is made voluntarily by a capable adult; was made without undue influence; and it is clear and unambiguous in applying to the circumstances at hand.

The NSW *Guardianship Act 1987* governs the legal standards for substitute decision-making i.e. regarding roles and responsibilities of the Person Responsible.

See also web-resource *End of life decisions, the law and clinical practice: legal considerations for health care practitioners in NSW* (2014).

2. WHEN RESUSCITATION PLANS SHOULD BE CONSIDERED

Planning care for patients who are approaching end of life will generally include a shift in the focus of care away from aggressive medical intervention and towards a palliative approach; opting out of Rapid Response Systems; initiating palliative care; and/or making arrangements to facilitate dying in place of choice. Making a Resuscitation Plan is one important step in this process of planning. (See Figure 1)

Improved end of life care will be achieved, in part, if conversations between doctors, patients and families about changing goals of care and appropriate use of life-sustaining measures as end of life approaches are undertaken earlier than currently occurs.

Patients and their families should be genuinely reassured that quality, individualised care consistent with the ongoing goals of treatment will continue to be provided to the patient, regardless of whether or not resuscitation is appropriate.

Decisions to withhold CPR and other resuscitation measures seek to avoid unwanted, excessively burdensome or insufficiently beneficial interventions for patients at the end of life. At some point in the course of life-limiting illness, a shift in the focus of care away from aggressive intervention and towards a palliative approach is often the agreed outcome.

2.1 Triggers for discussing a Resuscitation Plan

Resuscitation Planning is one component of Advance Care Planning and End of Life care (see Figure 1).

Discussing a Resuscitation Plan should be undertaken:

- If the patient's recovery is uncertain.
- If the treating clinician asks him or herself, 'Would I be surprised if this patient were to die in 6-12 months?' (so-called 'surprise question') and the answer is 'No'.
- If a patient clinically deteriorates requiring activation of a Rapid Response System, or is anticipated to do so.
- If the patient's condition is considered high risk, for example recurrent admission to hospital with severe chronic illness; a diagnosis of metastatic cancer; steady deterioration of a chronic respiratory, cardiac, liver or neurological illness; and other progressive advanced life limiting illnesses e.g. severe end stage dementia or frailty.

2.2 Rationale for withholding resuscitation

In general, the rationales for not instituting CPR are:

2.2.1 Where there is a clearly stated, adequately informed and properly documented or verbally expressed refusal by a person with decision-making capacity.

- Such a person has a lawful right to refuse any medical interventions, including resuscitation and other emergency interventions, even where that refusal will predictably result in death. This decision legally takes precedence over the contrary wishes of family or treating doctors; or

2.2.2 Where the person has no capacity to make this decision, there is an adequately informed and properly documented decision to withhold resuscitation by the Attending Medical Officer in consultation with the Person Responsible.

- This should be based on any known previous refusal of resuscitation or, in the absence of such refusal, a decision that resuscitation would not be in the patient's best interests. The Attending Medical Officer must also document a reason for overriding a documented decision such as an Advance Care Directive, for example that it does not adequately apply to the clinical situation at hand; or

2.2.3 Where the Attending Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient.

- Given that judgments about the benefits or otherwise of a therapy ultimately reflect the values, beliefs and hopes/goals of the patient, any decision to withhold resuscitation on clinical grounds alone must be carefully considered, properly justified and documented .
- Focussing on patient comfort also entails withholding life-sustaining measures sometimes considered to be of negligible benefit (for example, where the ability to restore spontaneous rhythm or circulation with CPR is highly unlikely).
- A medical practitioner does not need to obtain agreement from the patient or family to withhold interventions considered to be of negligible benefit, but it is still good clinical practice to discuss why these are not being offered in the context of broader end of life goals of care conversation. This includes scenarios that may present at an Emergency Department. If consent is not sought, the reasons why should be documented in the patient record. It is also the case that engaging patients in such discussion does not obligate the treating team to provide treatments that they believe are considered to be of negligible benefit.

2.3 Disagreement about end of life decisions

- Planning end-of-life care is an iterative or cyclic process based on assessment, disclosure, discussion and consensus building with the patient and/or their family and the treatment team. Disagreement within families of patients without decision-making capacity, or between families and the health care team about whether resuscitation is appropriate can generate significant impediments to good patient care planning.
- Use a Resuscitation Plan to record agreement. Efforts to reach consensus and/or resolve disagreement within a family or between the family and the treating team about appropriate use of life-sustaining measures should precede this.
- Where a patient, family or Person Responsible requests a second medical opinion as to the predicted outcome with, or without resuscitation, such requests should always be respected and facilitated.
- These scenarios should be managed sensitively and according to options outlined in GL2005_057 Guidelines for end of life care and decision-making. See also NSW Health Conflict Resolution in End of Life Settings Project Report. http://www.health.nsw.gov.au/patients/acp/Pages/conflict-resolution.aspx

3. USE OF THE RESUSCITATION PLAN FORMS

The following section addresses the technical requirements, rationales and related clinical process when completing Resuscitation Plans. These are presented so as to complement the structure of the Resuscitation Plans and the clinical process they are used in.

3.1 Is there evidence of any prior planning?

- Check if the patient has previously prepared an Advance Care Plan (ACP) or Advance Care Directive (ACD). The ACD/ACP reflects the patient's preferences/wishes, often including those relevant to resuscitation. An ACP often becomes a synopsis of previous discussions which will be useful in completing the 'goals of care' section. Where one exists, this must inform decisions recorded in the Resuscitation Plan. This 'translation' or bridging step is critical if patients' prior wishes are to effectively determine how health professionals practically respond to clinical deterioration, most importantly as death approaches.
- If the ACD/ACP is ambiguous or it is unclear if it applies to the situation at hand, conversation should be revisited with the patient and/or Person Responsible, as appropriate.
- Identify the patient's Person Responsible irrespective of whether the patient now has decision capacity. An informed Person Responsible is important to support decision-making where the patient does not have capacity at many times throughout illness, including but not limited to end of life.

3.2 Capacity and participation

- Doctors prescribing medical orders, including 'Resuscitation Plans', hold responsibility for reaching those decisions, in consultation with patients.
- Where the patient does not have decision-making capacity, a consensus building approach to end-of-life decision-making that considers the patient's best interests as paramount is recommended. The patient, Person Responsible and/or family should be informed about the nature of CPR; the likely effects of resuscitation, including CPR, in this particular circumstance; and its possible adverse outcomes e.g. broken ribs; and the consequences of not instituting CPR. These should be discussed in the context of broader goals of care applicable at that time. As part of such discussions it may be helpful to seek advice from other health professionals who may have been involved in the care of the patient and had conversations about end of life care, such as the patient's General Practitioner. The Attending Medical Officer should recommend a course of action when discussing resuscitation in the context of goals of care with the patient, Person Responsible or family.

3.2.1 Where the patient wishes to discuss resuscitation

- Where the patient has decision capacity and is willing to discuss resuscitation and treatment goals, they should be asked who (if anyone) they would like to be involved in discussions.
- Patients and families from culturally and linguistically diverse groups may have preferences for different decision-making styles, other than involving solely the patient and their doctor. These should be explored and cultural differences respected. For Aboriginal patients, the involvement of an Aboriginal Liaison Officer, where available, is advised.

3.2.2 Where the patient does not wish to discuss resuscitation

- Discussion about diagnosis, prognosis and preferences for care should be encouraged, but not forced. A patient's desire not to discuss resuscitation, or the possibility of his or her own death, should always be respected and emotional support provided, for example through social work or chaplaincy as appropriate.
- In situations where the patient does not want to discuss or decide on resuscitation, the health care professional should establish whether the patient would prefer to have others make resuscitation planning decisions on their behalf.

3.2.3 Where the patient does not have decision-making capacity

- Where decision-making capacity is impaired, reasonable efforts should be considered to maximise his or her capacity to participate in decisions regarding resuscitation.
- If there is any doubt that the patient has sufficient decision-making capacity, their decision-making capacity should be assessed and documented in the patient's records. See *Capacity Toolkit*: http://www.diversityservices.lawlink.nsw.gov.au/agdbasev7wr/divserv/documents/pdf/capacity_toolkit0609.pdf

- Where the patient lacks decision-making capacity, the Attending Medical Officer or their delegate should identify the Enduring Guardian (or other category of Person Responsible). Enduring Guardians can refuse life sustaining measures if they have been expressly given such a power in their appointment.

3.2.4 Where the person's wishes regarding resuscitation are unknown

- Cardiorespiratory arrest may occur before there has been sufficient time to hold discussions regarding resuscitation. Health professionals still need to decide about use of resuscitation without knowing the person's wishes in some circumstances. This is addressed in PD2005_406 *Consent to Medical Treatment - Patient Information* in providing medical treatment in emergency situations.
- Not having a Resuscitation Plan does not necessarily mean that resuscitation is a default action that *must* be applied in all situations. Clinical judgement should be used where resuscitation is manifestly inappropriate and/or the patient is deceased.

3.2.5 Withholding resuscitation without explicit discussion

Where there is time to plan end of life care and to make decisions regarding resuscitation, then the discussion should be had. There are some exceptions to the general requirement to discuss a Resuscitation Plan with the patient, or Person Responsible, or family:

- The patient (Person Responsible/enduring guardian/or family) does not wish to discuss resuscitation. Decisions may then be undertaken by the Attending Medical Officer.
- The patient is aware they are dying and has already expressed a desire for palliative care.
- The health care facility does not provide resuscitation as a matter of course, consistent with the values and practices relevant to their patient population, such as hospices, and this has been made clear to the patient and their family when the facility assumes care; or
- The patient has had a prior therapeutic relationship with a doctor other than the Attending Medical Officer and prior discussion has made the patient's views regarding resuscitation apparent.

3.3 Clinical interventions and monitoring

- Vital sign monitoring should be (re)considered if the patient is in their last days and this should be consistent with monitoring frequency prescribed on the Standard Adult General Observation chart, or equivalent standard observation chart.
- Implantable devices such as defibrillators or pacemakers may need to be deactivated in patients at end of life.
- Nurses may call for medical review of unrelieved symptoms associated with dying, even where activating an urgent Clinical Review call has been considered unnecessary. A plan for monitoring and managing symptoms associated with dying should be put in place if this is the case.

3.4 Referral/Transfer

- 'Referral to palliative care' means referral for specialist palliative care review.
- 'Referral home' may be applicable in some scenarios where discharge to supported care may be feasible and appropriate.
- Careful consideration should be given to the need for, and appropriateness of transfer of an individual with a 'Resuscitation Plan' in place where there is possible need for resuscitation en route, for example if the individual is pre-terminal.
- NSW Health Resuscitation Plans are valid for use by NSW Ambulance staff in all situations involving patient contact.

- A hard copy of the Resuscitation Plan should accompany the patient on inter-facility transfer.
- Where a patient is transferred to a non-NSW Health facility, the receiving medical practitioner should be encouraged to review the Resuscitation Plan's contents and consider whether they authorise a consistent Plan (according to that facility's documentation protocol). Immediate repeat conversation with the patient or family about the decision to use a local Resuscitation Plan is not necessarily required.

3.5 Authorising and Signing the Resuscitation Plan

- Every patient who is admitted to a public hospital is admitted under the bed care of a doctor (Attending Medical Officer) who has medico-legal responsibility for that patient. As part of the AMO's responsibility, it is incumbent that they or their delegate clarify with others including the health practitioners who may have known that patient for many years (such as the patient's General Practitioner), about the patient's background, ongoing management and resuscitation or advance care plans.
- Discussion with the patient/Person Responsible about resuscitation should generally be undertaken by the most experienced clinician.
- Neither the patient, nor their Person Responsible, is required to sign the Resuscitation Plan.
- The 'delegated signatory Medical Officer' e.g. registrar who is not the Attending Medical Officer may undertake the conversation with the patient/Person Responsible and complete and sign the Resuscitation Plan. However, this must be authorised by the responsible Attending Medical Officer at the earliest opportunity.
- Delegation to a junior medical officer should only occur with adequate training, supervision and support. If a junior medical officer is required to discuss and document a Resuscitation Plan (e.g. out of hours) this must be discussed with the Attending Medical Officer at the earliest opportunity.
- Both sides of the form must be completed and signed.
- Consistent with PD2005_406, other health care professionals (including nurses) cannot be delegated the task of informing patients or obtaining consent for resuscitation planning. When requested by a patient, they are permitted to provide information and should document this in the medical record.
- A copy of the form may be provided to the patient or Person Responsible.

3.6 Reviewing the Resuscitation Plan

- A fixed frequency for review is not appropriate for all scenarios. Generally, a Resuscitation Plan needs to be clarified from one acute admission to the next where a change in prognosis is likely.
- A Resuscitation Plan may be valid for up to 3 months for frequent and routine 'admissions' e.g. renal dialysis.
- A Resuscitation Plan should be reviewed prior to elective minor procedures.
- A Resuscitation Plan may be compatible with palliative surgical procedures, and potentially time and goal limited ICU support in some cases.
- Where surgery is planned for someone with a Resuscitation Plan, this should be reviewed in consultation with the patient, Person Responsible, anaesthetist and surgeon as to whether it is appropriate to suspend it during the intra- or post-operative period. This decision should be clearly documented in the medical record.

3.7 Revoking or amending the Resuscitation Plan

- The procedure for revoking the Resuscitation Plan is to rule a diagonal line through both sides, then print and sign your name and date on the line.
- For significant amendments (for example, a change to the CPR order), the Resuscitation Plan must be revoked and a new Plan completed.

- For less significant amendments (for example, a change to the intervention section), the Resuscitation Plan can be amended and initialled. This should be documented in the medical record. It should be noted that this option may not exist if the form is included in an Electronic Medical Record. If this is the case, the Resuscitation Plan must be revoked and reissued – documentation in the medical notes alone is not sufficient.

3.8 Storage of Resuscitation Plans

- The current Resuscitation Plan must be made readily accessible to attending health professionals. It is preferable that multiple copies are not made because of the potential for confusion.
- It is recommended that the current hard copy should be kept at the front of the patient's health record. Details of the Resuscitation Plan should be included in handover between shifts.
- Resuscitation Plans must be integrated into electronic health record systems in appropriate forms e.g. alerts/orders;
- Resuscitation Plans should be incorporated into hospital discharge summaries, where possible

4. USE OF RESUSCITATION PLANS IN CHILDREN

- The general principles and process guiding the completion of a Resuscitation Plan are the same for children as for adults, with a focus on communication and exploration of goals of care with the person/s responsible, and where appropriate, the child.
- The Paediatric Resuscitation Plan is not intended for use in Neonates (patients under 29 days), although it may be used to guide discussions.
- The Paediatric Resuscitation Plan should be used for patients older than 29 days and up to and including the age of 17 years. The Adult Plan should be used for patients aged 18 years and over.
- Decisions to withhold resuscitation may also be required where a child is in care of the state. The Minister for Family and Community Services is required by the *Children and Young Person's Care and Protection Act* to be responsible for this kind of medical decision. It is the Minister's delegate (the Director-General, NSW Family and Community Services) who authorises a Resuscitation Plan where the Attending Medical Officer considers resuscitation limitation appropriate.
- Refer to PD2005_406 Consent to Medical Treatment - Patient Information for information regarding the potentially complex consent issues for children (persons aged under 16 years) and young people (persons aged 16 or 17).

5. GLOSSARY

Attending Medical Officer
The Attending Medical Officer (AMO) is the senior medical practitioner who has primary responsibility for the patient during admission. This medical officer is a consultant who may be a visiting medical officer or a staff specialist. The AMO may lead a team that includes related medical staff. This team plays a critical role in the clinical review of the patient.

Advance Care Directive
An Advance Care Directive is a type of advance planning tool that can only be completed by a person with decision capacity. These were formerly known, in particular in the US, as "living wills". They should inform a Resuscitation Plan.

Advance Care Plan
An Advance Care Plan is the outcome of an Advance Care Planning process. Like an Advance Care Directive, an Advance Care Plan also records preferences about health and personal care and treatment goals. However, it may be completed by discussion or in writing and it may be made by, with, or for the individual. It should inform a Resuscitation Plan.

Capacity
In broad terms, when a person has capacity to make a particular decision they can:
- Understand the facts and the choices involved
- Weigh up the consequences
- Communicate the decision.

Clinical review
This is a patient review undertaken within 30 minutes by the attending medical team. Depending on local protocol, the review may be undertaken by a medical officer on call or an appropriately experienced Registered Nurse/Midwife, preferably First Line Emergency Care accredited or with post graduate qualifications in emergency/critical care nursing or other relevant qualifications.

Enduring Guardian
An Enduring Guardian is someone appointed by a person to make personal (including medical) or lifestyle decisions on their behalf when they are not capable of doing so for themselves. Enduring Guardians and those appointed by the Guardianship Tribunal may make end of life decisions on the person's behalf. The appointment of an Enduring Guardian comes into effect when the appointing individual loses capacity to make personal or lifestyle decisions. People can choose which decisions (called functions) they want their Enduring Guardian to make. These functions are governed by the *NSW Guardianship Act 1987*

Goals of care
The general goal of medical treatment is the health and wellbeing of the patient. The specific goal of medical treatment may, in the circumstances, be cure of an illness, relief of the symptoms of an illness, stabilisation of the patient in a satisfactory condition, improvement in the way the patient dies, etc.

Person Responsible
The *NSW Guardianship Act 1987* establishes who can give valid consent for medical treatment to an incompetent patient aged 16 years and over. The Act establishes a hierarchy for determination of who is the Person Responsible as follows:
- The patient's lawfully appointed guardian (including an Enduring Guardian) but only if the order or instrument appointing the guardian extends to medical treatment.
- If there is no guardian, a spouse including a de facto spouse and same sex partner with whom the person has a close continuing relationship.
- If there is no such person, a person who has the care of the patient (otherwise than for fee and reward).
- If there is no such person, a close friend or relative.

Currently in NSW a Person Responsible who has not been appointed as Enduring Guardian or by the Tribunal does not have the same decision authority in end of life decisions. Guardians (including Enduring Guardians) can consent to treatment being withheld or withdrawn if they have been expressly given such a power in their appointment.

Rapid response
This refers to an immediate review undertaken by an individual or multidisciplinary team of healthcare professionals who have been trained and assessed to hold an advanced level of competence in resuscitation and stabilisation of patients. A Rapid Response call must be made if a patient's observations fall into the 'Red Zone' of NSW Health Standard Observation Charts.

Resuscitation
Resuscitation encompasses a spectrum of emergency interventions such as supplemental oxygen, intravenous fluids and non-invasive ventilation. It is not limited to cardiopulmonary resuscitation.

Resuscitation Plan
A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and document other time critical clinical decisions related to end of life. These were formerly called No CPR Orders. A Resuscitation Plan is made:

- With reference to pre-planning by patients (such as Advance Care Plans or directives)
- In consultation with patients/families
- Taking account of the current clinical status, as well as the wishes and goals of the patient.

Standard observation charts
Observation Charts approved for use by NSW Health System e.g. the Standard Adult General Observation (SAGO) Chart, Standard Paediatric Observation Chart (SPOC), Standard Maternity Observation Chart (SMOC), Adult and Paediatric Emergency Department Observation Charts.

Attachment 1: Resuscitation Plan – Adult (SMR020.056)

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

RESUSCITATION PLAN - ADULT

For patients aged 18 years and over
Refer to PD2014_030

SMR020056

Patient Name: ..... (PRINT)

This Plan was discussed with and authorised by the Attending Medical Officer

.....(PRINT NAME) on ...../...../..... (DATE).

Diagnoses .....

.....

Planning for end of life does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support after a compassionate discussion to allow appropriate care in the location of the patient or Person Responsible's* choice.

Has the patient's Advance Care Plan/Directive been considered in completing this form? Yes ☐ No ☐ N/A ☐

The **Goals of Care** negotiated through conversations with the doctor/patient/family/Person Responsible* are:

.....

.....

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

- **Respiratory Support:**

Pharyngeal suction	Yes ☐	No ☐			
Supplemental oxygen	Yes ☐	No ☐	Bag & mask ventilation	Yes ☐	No ☐
Non-invasive ventilation	Yes ☐	No ☐	Intubation	Yes ☐	No ☐

- Referral to ICU Yes ☐ No ☐
- Are other non-urgent interventions appropriate? Yes ☐ No ☐

(e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record.

Additional details, if required: _____

Clinical Review Call are to be activated Yes ☐ No ☐

YELLOW ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Rapid Response Call are to be activated Yes ☐ No ☐

RED ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Nurses/midwives may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life prolonging treatment is not indicated.

- Is a plan in place for monitoring and managing symptoms in anticipated last days of life? Yes ☐ No ☐

In the event of cardiopulmonary arrest:

CPR ☐ **No CPR** ☐

(see rationale overleaf)

Delegated signatory Medical Officer (the AMO must authorise this decision)

PRINT NAME ..... DESIGNATION ..... TIME .....

PAGER/PHONE ..... DATE ..... SIGNATURE .....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print & sign your name & date on the line.

NO WRITING

Page 1 of 2

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BINDING MARGIN - NO WRITING

RESUSCITATION PLAN - ADULT

SMR020.056

NSW GOVERNMENT Health

Facility:

RESUSCITATION PLAN - ADULT
For patients aged 18 years and over
Refer to PD2014_030

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Capacity and Participation:

Good practice involves consulting with the family. The patient and/or Person Responsible* have been advised they can revisit these decisions at any time.

This Plan was discussed with the patient and/or Person Responsible* (circle which one applies)

on...../...../..... (date).

- **An interpreter (if required) was present.** Yes ☐ No ☐ N/A ☐

If no to any of the above, or the patient and/or Person Responsible* has not been involved in discussions, record details in the patient's health care record.

Name of the Person Responsible* .....(PRINT)

Relationship to patient..... Phone number/s .....

*The *NSW Guardianship Act* establishes the Person Responsible who can give valid consent for medical treatment to an incompetent patient aged 16 years and over according to this hierarchy as:

1. The patient's lawfully appointed guardian (including an enduring guardian) but only if the order or instrument appointing the guardian extends to medical treatment.
2. If there is no guardian, a spouse including a de facto spouse and same sex partner with whom the person has a close continuing relationship.
3. If there is no such person, a person who has the care of the patient (other than for fee and reward).
4. If there is no such person, a close friend or relative.

Rationale for withholding CPR:

- Withholding CPR complies with the competent patient's verbally expressed wishes. ☐
- Withholding CPR complies with the patient's applicable Advance Care Directive. ☐
- The patient's Enduring Guardian agrees that withholding CPR is consistent with the patient's wishes. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

Referral/Transfer/eMR Alert: (tick as appropriate)

- Referral to Palliative Care Specialist/Team/Facility ☐
- Transfer to other facility (specify) ..... ☐
- Transfer home (if patient/family choice) ☐
- Has the eMR clinical alert 'Check Resuscitation Plan' been activated? ☐

This Resuscitation Plan remains valid:

- Until a change in prognosis warrants medical review ☐
- Until the patient and/or Person Responsible* request a change. ☐
- For this admission only (including inter-facility Ambulance transfers). ☐
- For up to 3 months for frequent and routine admissions (e.g. dialysis) ☐
- Until review date at ...../...../..... and/or time at..... ☐

Delegated signatory Medical Officer (must have discussed this decision with the AMO)

PRINT NAME ..... DESIGNATION ..... TIME .....

PAGER/PHONE ..... DATE ..... SIGNATURE .....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.

Page 2 of 2

NO WRITING

Attachment 2: Resuscitation Plan – Paediatric (SMR020.055)

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

RESUSCITATION PLAN - PAEDIATRIC

For patients aged between 29 days and 18 years

Refer to PD2014_030

SMR020055

Patient Name: ..... (PRINT)

This Plan was discussed with and authorised by the Attending Medical Officer

.....(PRINT NAME) on ...../...../..... (DATE).

Diagnoses .....

.....

Planning for end of life does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support after a compassionate discussion to allow appropriate care in the location of the patient / parents / guardian's choice.

Has the patient's Advance Care Plan/Directive been considered in completing this form? Yes ☐ No ☐

The Goals of Care negotiated through conversations with the doctor/patient/family/guardians

.....

.....

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

- **Respiratory Support:**

Pharyngeal suction	Yes ☐	No ☐			
Supplemental oxygen	Yes ☐	No ☐	Bag & mask ventilation	Yes ☐	No ☐
Non-invasive ventilation	Yes ☐	No ☐	Intubation	Yes ☐	No ☐

- Referral to ICU Yes ☐ No ☐
- Are other non-urgent interventions appropriate? Yes ☐ No ☐

(e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record.

Additional details, if required: _____

_____

_____

Clinical Review Calls are to be activated Yes ☐ No ☐

YELLOW ZONE on Standard Paediatric Observation Chart

Rapid Response Call are to be activated Yes ☐ No ☐

RED ZONE on Standard Paediatric Observation Chart

Nurses/midwives may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life prolonging treatment is not indicated.

- Is a plan in place for monitoring and managing symptoms in anticipated last days of life? Yes ☐ No ☐

In the event of cardiopulmonary arrest:

CPR ☐ **No CPR** ☐

(see rationale overleaf)

Delegated signatory Medical Officer (the AMO must authorise this decision)

PRINT NAME ..... DESIGNATION ..... TIME .....

PAGER/PHONE ..... DATE ..... SIGNATURE .....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.

NO WRITING

Page 1 of 2

SAMPLE - DO NOT PRINT

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RESUSCITATION PLAN - PAEDIATRIC SMR020.055

NSW HEALTH RESUSCITATION PLAN PAEDIATRIC 100914.indd 1 10/09/2014 10:37:53 AM

NSW Health

Facility:

RESUSCITATION PLAN - PAEDIATRIC

For patients aged between 29 days and 18 years

Refer to PD2014_030

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Capacity and Participation:

Use this Resuscitation Plan for minors aged from 29 days up to and including 17 years. For 18 years and above use the Adult Resuscitation Plan.

Good practice involves consulting with the family. The patient / parents / guardian have been advised they can revisit these decisions at any time.

This Plan was discussed with the patient / parents / guardians (circle which one/s apply)

on...../...../..... (date). Include the family in discussions where possible.

- **An interpreter (if required) was present.** Yes ☐ No ☐ N/A ☐

If no to any of the above, or the patient / parents / guardian have not been involved in discussions, record details in the patient's health care record.

Name of the parents / guardians / family members.....(PRINT)

Relationship to patient..... Phone number/s .....

When a child is under the parental responsibility of the Minister, only the Director General of FaCS has the delegated authority to authorise a Resuscitation Plan. Phone the Child Protection Line: 133 627 available 24/7.

Rationale for withholding CPR:

- Following consensus with the patient / parents / guardians, resuscitation is inappropriate. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

Referral/Transfer/eMR Alert: (tick as appropriate)

- Referral to Palliative Care Specialist/Team/Facility ☐
- Transfer to other facility (specify) ..... ☐
- Transfer home (if patient/family choice) ☐
- Has the eMR clinical alert 'Check Resuscitation Plan' been activated ☐

This Resuscitation Plan remains valid:

- Until a change in prognosis warrants medical review. ☐
- Until the patient / parents / guardians request a change. ☐
- For this admission only (including inter-facility Ambulance transfers). ☐
- For up to 3 months for frequent and routine admissions (e.g. regular immunoglobulin infusions) ☐
- Until review date at ...../...../..... and/or time at..... ☐

Delegated signatory Medical Officer (the AMO must authorise this decision)

PRINT NAME..... DESIGNATION..... TIME .....

PAGER/PHONE..... DATE..... SIGNATURE.....

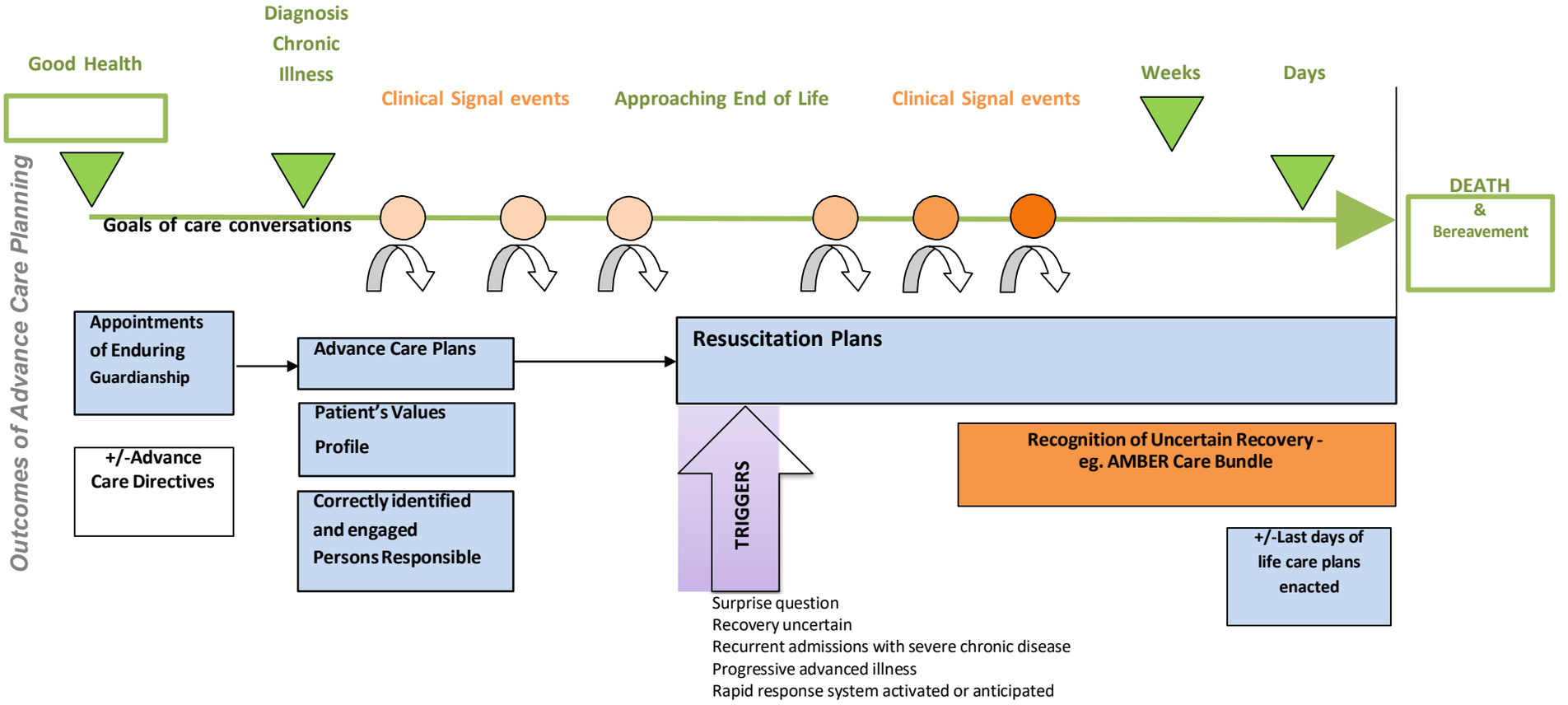
Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.

Page 2 of 2

NO WRITING

Attachment 3: Figure 1: ***Resuscitation Plans in the context of Advance Care Planning and End of Life***



INSERTION AND MANAGEMENT OF NASOGASTRIC AND OROGASTRIC TUBES IN ADULTS (GL2023_001)

GL2023_001 replaced PD2009_019

GUIDELINE SUMMARY

This Guideline provides direction to clinicians who are responsible for the insertion and/or management of intragastric tubes, such as nasogastric or orogastric tubes, in conscious adult patients. Clinicians performing the insertion / management are expected to be appropriately trained, or under appropriate supervision, to perform the procedures.

The Guideline covers strategies for each stage of tube insertion and management including pre-insertion of the tube, insertion of the tube, confirmation of placement of the tube (both radiologically and non-radiologically) tube care and maintenance, and removal of the tube.

It also guides on the health record documentation requirements, and incident reporting.

The insertion and management of post pyloric tubes, and the insertion and management of nasogastric and orogastric tubes in children are out of scope of this document.

GUIDELINE SUMMARY

NSW Health organisations are responsible for the implementation of this Guideline within their services / facilities to ensure local protocols or operating procedures are in place and aligned and consistent with this Guideline. This includes where education and training may be required to improve skill and competency, and a process for monitoring practice.

Decisions to insert an intragastric tube are the responsibility of a medical officer. This decision making must consider the indications for use of an intragastric tube, and the complexity of the presenting clinical condition. Some complex clinical presentations require senior medical officer / medical consultant assessment.

Nasogastric tube insertion is commonly performed at the ward level by a nurse or medical officer. The clinician responsible for tube insertion must have relevant training, and recency of practice in tube insertion. Where experience is limited, the insertion should be supported by a more experienced clinician.

Orogastric tube insertion however is a specialised procedure not routinely performed in a ward, but more likely a critical care unit. The insertion must be completed by, or under the supervision of, a clinician experienced in orogastric tube insertion. As this procedure may require use of a laryngoscope, insertion may be completed at the time of intubation, and usually in a critical care setting.

There are risks associated with incorrect intragastric tube insertion. This risk could include death. Use of an incorrectly positioned naso- or oro-gastric tube resulting in serious harm or death is classified as an Australian Sentinel Event. The patient should be monitored for early warning signs of deterioration and if recognised the local clinical emergency response system must be initiated.

Before an inserted tube can be used for any enteric intake (feeding formula, medication or fluids), confirmation of correct tube placement must be actioned and documented.

Confirmation of tube placement can be done radiologically (via chest x-ray), or via pH testing of aspirates. Radiological confirmation also requires that the chest x-ray is reported by a radiologist, or reviewed by an experienced medical officer, who can exclude insertion complications and can confirm the anatomical position of the tip of the tube below the diaphragm and in the stomach.

Radiological confirmation must be ordered by a medical officer to confirm safe placement of a tube if:

- there was difficulty experienced when inserting the tube
- the patient had a clinical presentation which may have increased the risk of tube misplacement during the insertion
- there is any concern about potential tube misplacement
- an aspirate cannot be obtained
- the pH testing of the aspirate is greater than five.

pH testing can be performed in other instances. It requires attainment of an aspirate via the tube, and testing of the pH level on pH indicator strips with clear gradation markings, with a result of five or less (Litmus paper must not to be used).

Tube care and maintenance is important to maintain effectiveness of the tube and prevent the need for removal and replacement. It involves monitoring for tube migration, monitoring tube condition and patient skin integrity, maintenance of tube patency and safe and appropriate management of tube blockages.

Although an orogastric tube may not be inserted on a ward, management of an orogastric tube may be occasionally required on a ward, e.g., if a patient is transferred from critical care. The ongoing care and maintenance of orogastric tubes is similar to a nasogastric tube with differences in management in tube measurement guidance and securement, and dislodgement and reinsertion protocols.

The entire Insertion and Management of Nasogastric and Orogastric Tubes in Adults guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2023_001

HEALTHCARE RIGHTS (IB2023_032)

IB2023_032 replaced PD2011_022

PURPOSE

This Information Bulletin advises NSW Health has adopted the *Australian Charter of Healthcare Rights* (second edition) and the *Charter on the Rights of Children and Young People in Healthcare Services in Australia* (collectively referred to as the Charters)

The Charters reflect NSW Health focus on elevating the human experience and the responsibility of health service staff to ensure that consumers or someone they care for are aware of their healthcare rights.

KEY INFORMATION

The Partnering with Consumers Standard of the National Safety and Quality Health Service (NSQHS) Standards requires that all health organisations have a charter of rights that is consistent with the *Australian Charter of Healthcare Rights* and easily accessible for patients, carers, families and consumers at different points throughout the healthcare journey.

The Charters are essential to ensure that safe and high-quality care is provided to all people, in all health settings. NSW Health facilities/ services should select the Charter that is relevant to their facility/ service. For some facilities/ services the use of both Charters may be appropriate.

The Australian Commission of Safety and Quality in Health Care (ACSQHC) has developed a range of resources to support people to understand and use the *Australian Charter of Healthcare Rights*. These include both text based and multimedia resources. The Charter is available in languages other than English as well as accessible formats including Auslan, Braille and Easy English.

NSW Health has also developed a range of resources to support people to understand and use the *Charter on the Rights of Children and Young People in Healthcare Services in Australia*.

The Charters in various formats and languages, along with supportive resources for staff and consumers are available for order through stream solutions.

The Charters are to be accessible via local health district/ speciality health network websites and other appropriate digital applications.

All health professionals delivering healthcare services within NSW Health must be aware of the detailed rights outlined in the Charters and their responsibility to ensure all consumers understand their rights and have their rights protected and respected.

Staff are to provide consumers with the relevant Charter in their preferred language and format.

A process of education must exist for all staff to ensure there is up-to-date knowledge of the Charters and how they relate to NSW Health services.

The use and impact of the Charters is to be measured by local health districts and specialty health networks. This can be achieved through strategies such as audits of printing and distribution, interviews or surveys of patients, families and carers, and interviews or surveys of the workforce.

Consumers and the broader community can have confidence in our ability to uphold healthcare rights through our feedback and complaints management systems and public reporting mechanisms.

A frequently asked questions document is available.

Additional information about rights of consumers detained under the *Mental Health Act 2007* (NSW) is available here.

CLINICAL HANDOVER (PD2019_020)

PD2019_020 rescinds PD2009_060

PURPOSE

The purpose of this policy is to enhance patient safety by ensuring systems and processes are in place to provide a consistent approach to clinical handover. The policy outlines key principles designed to guide and direct NSW Health staff to implement a minimum standard for conducting patient care handovers. Health services must demonstrate the engagement of patients and family/carer as key participants. This policy applies to all staff involved in the delivery of health care to patients in the NSW Public Health System.

MANDATORY REQUIREMENTS

NSW Health Local Health Districts/ Specialty Health Networks must have a governance structure in place to support all elements of clinical handover and demonstrate systems are in place to:

- Ensure a documented, consistent approach to clinical handover
- Apply the seven (7) key principles outlined in this policy for all types of clinical handover
- Partner with patients and family/carer during clinical handover
- Monitor the effectiveness of clinical handover and documentation processes
- Develop an action plan for continuous quality improvement, based on the outcomes of monitoring.

IMPLEMENTATION

Clinical Excellence Commission

- Work with clinical staff and Executive Sponsors to support implementation of this policy across NSW Health.
- Provide tools to support implementation, monitoring and evaluation.

eHealth and local Information and Communication Technology

- Collaborate with local teams to ensure tools based on the key principles are available in a responsive manner.
- Collaborate with clinical staff to identify digital solution needs in relation to this policy.

Chief Executive of Local Health Districts/ Specialty Health Networks

- Assign leadership responsibility, personnel and resources to implement and monitor this policy.

Directors of Clinical Governance

- Ensure that the policy is communicated to all managers and health workers.
- Ensure local monitoring and reporting processes are in place.
- Address system issues relating to compliance with this policy.
- Take responsibility for the oversight of continuous quality improvement and the development of action plans.

Hospital, facility, clinical stream and unit managers

- Set the expectation that clinical handover is valued and an essential part of patient care and safety.
- Develop a documented process for clinical handover based on this policy maximising consistency across all settings.
- Ensure sufficient resources and staff training opportunities are available to support clinical handover.
- Demonstrate continuous quality improvement activity, through action plan development based on lessons learned during monitoring processes.
- Address performance issues relating to compliance with this policy.

Clinical staff

- Ensure their work practices are consistent with the key principles for clinical handover.

Clinical Handover: Procedures.

BACKGROUND

About this document

Clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a patient/s to another person or professional group on a temporary or permanent basis.
Clinical handover does not just happen at the change of shift. It happens within and between teams constantly and is considered a time of risk for patients, where gaps in information transfer can impact patient safety. Examples include:

- Escalation of the deteriorating patient
- Patient transfers:
    - to another unit/clinic or facility
    - for a test, procedure or appointment
    - to, from and within Community settings, including Residential Aged Care
    - involving other teams (e.g. Ambulance, patient transport)
- Shift to shift change over
- Multidisciplinary team handover

Key definitions

Patient/family/carer	Includes guardian or those nominated to advocate on the patients behalf
Journey board	Indicates a board or portal that provides information about patients which directly relates to care coordination
Briefing	A tool, which can be used before or after clinical handover, for teams to summarise the key concerns, anticipate changes and to assign accountability
Huddle	A tool which, when used in this context serves the same function as a briefing and can be scheduled before or after clinical handover

KEY PRINCIPLES FOR SAFE AND EFFECTIVE CLINICAL HANDOVER

The seven (7) key principles provide a framework to guide the structure and process for safe clinical handover.

Patient/Family/Carer involvement

- Emphasise a culture where patients and their family/ carer are partners in care.
- Support patients and their family/ carer to be involved in clinical handover, in line with the wishes of the patient (e.g. patient/ family/ carer is given the opportunity to lead their clinical handover where appropriate).
- Establish the patient's care goals, preferences and needs regarding their admission/presentation/illness.

- Ensure there is a system for the early identification of Aboriginal and Torres Strait Islander patients and a process in place for including the Aboriginal Liaison Support Officer or Aboriginal Health Worker (where appropriate).
- Identify individual patient needs for example, Culturally and Linguistically Diverse (CALD) patients or those with communication challenges such as hearing or vision impairment.

Leadership

- Nominate a leader at each clinical handover.

Handover participants

- Handover is attended by relevant members of the multidisciplinary team who:
  - When handing over, arrive prepared with current information and knowledge of the patient's clinical situation.
  - Are provided the opportunity to ask questions and to seek clarity.

Handover time

- Schedule an agreed time and duration for clinical handover to occur.
- Ensure the clinical handover process remains interruption free (with the exception of emergencies).
- Have in place strategies to reinforce punctuality.
- Provide sufficient time for family/carer involvement by notifying them of clinical handover times.

Handover place

- Set an agreed location for clinical handover aiming for minimal interruption.
- Ensure access to all clinical results and healthcare records.
- Occurs in the patient's presence where possible.

  Face-to-face handover is preferred, although it is recognised that many handovers involve telephone or telehealth communication, especially in community or clinic settings. Any written information is to be supplementary only, that is, it must not replace verbal handover. Voice recorded handover is never permitted. When handover occurs and the patient is not present, processes must ensure that the patient/family/carer is aware of who will be taking over their care.

Handover process

Include tools such as electronic clinical communication tools, flow charts and scripts to help keep clinical handover relevant, succinct and consistent. A documented and approved approach must include:

1. A 'journey board' meeting, huddle or briefing is held prior to or after bedside handover
2. Introduction of team members and their roles and the patient/ family/ carer
3. Confirmation of the patient's identity using at least three (3) approved patient identifiers

- Summary of relevant clinical history and current clinical situation, including infectious status, diet/fluid/supervision requirements, invasive or implanted devices and medications

4. Review of the most recent recorded set of observations noting any trends, recent clinical review and/or rapid response calls and resultant management plans

5. Assessment of recent test results which require follow-up, for example, scans, x-rays and blood tests
6. Identification of timeframes and requirements for transition of care/discharge
7. Cross-check information in the patient's health care record/s including medications and observations to support the handover communication
8. Respond to patient/family/carer concerns
9. Acceptance of responsibility for the care of the patient by the clinician receiving handover.

Documentation

- Document findings and include changes in clinical condition and feedback from patient/ family/ carer regarding ongoing care requirements; update management/care plans.

  Cross-check documentation has occurred in the electronic medical record and on paper when using hybrid systems.

EVALUATION

All Public Health Organisations must collect and monitor data to evaluate the implementation of clinical handover based on the key principles. The results of data analysis will be provided to clinical units, facility, Local Health District/ Specialty Network quality and safety committees in a timely manner.

Scheduled reviews of clinical handover audit results and incidents should form the basis of the organisation's evaluation plan. Although not exhaustive, examples of supplementary data, to complement the scheduled audits, are outlined below.

Data source	What to look for
Incident Management data/Root Cause Analysis review/other case review protocols	- Readmissions due to gaps in handover of care - Medication incidents due to gaps in communication - Number of complaints/compliments about clinical handover - Number of RCAs where clinical handover was identified as a contributing factor
HIE data	- Readmissions where patients were not able to be cared for at home or care was impacted by ineffective clinical handover
Mortality and Morbidity meetings/mortality review	- Readmissions that were due to inability to be cared for at home, according to patient/family/carer wishes, during the last days of life, where clinical handover was identified as a contributing factor
Patient Experience Survey	- Review the results in relation to how patients/family/carer perceive the communication between themselves and the multi-disciplinary team (MDT) and between members of the MDT

APPENDIX 1: OBSERVATION AUDIT

- Observational clinical handover audits must occur annually, as a minimum, or more frequently as clinical incidents relating to clinical handover are identified, and based on audit outcomes.
- Audits must be completed at the point-of-care, in real time, and be undertaken by a clinician with a good understanding of the clinical handover policy.
- The following audit/criteria has been developed in line with the key principles of the policy
- It can be adapted to reflect care settings and patient cohorts.

Select type (including format) of clinical handover being observed

☐	Shift-to-shift in a hospital setting (record start times in the spaces below)
☐	Intra-facility - the handover of care from one area to another within a facility
☐	Other (please specify) (for example; telephone, telehealth)

For shift-to-shift clinical handover

Record *planned* start time of clinical handover __:__

Record *actual* start time of clinical handover __:__

Multidisciplinary team members in attendance

☐	Nursing/Midwifery Staff	☐	Medical staff
☐	Nursing Unit Manager/Midwifery Unit Manager/Nurse/Midwife in Charge	☐	Allied Health Staff
☐	Management/Executive	☐	Non-clinical staff
☐	Other (provide details)		

Preparation

	Yes	No	N/A
There is a nominated leader	☐	☐	■
A briefing or huddle is held prior to or after bedside handover	☐	☐	☐
Patients/family/carer from CALD background or with communication challenges (such as hearing or vision impairment) are identified and information needs met	☐	☐	☐
Aboriginal Liaison Support Officer or Aboriginal Health Worker services involved for patients who identify as Aboriginal and Torres Strait Islander. Document here if the service is not available. _____	☐	☐	☐

12. MEDICAL CARE 12.275

Handover – Key Principles

	Yes	No	N/A
Patient present at the handover (if No or N/A, state reason in space below)	☐	☐	☐
At the commencement of clinical handover the patient/family/carer is introduced to staff taking over their care	☐	☐	☐
The patient/family/carer is invited to be involved in clinical handover (eg, asked to repeat back or contribute to relevant information)	☐	☐	☐
The patient is given the opportunity to lead their clinical handover, where appropriate	☐	☐	☐
At least three (3) approved patient identifiers are used to confirm the patient's identity (e.g. patient name, MRN, DOB)	☐	☐	☐
Involve Patient/family/carer in the patient identification process	☐	☐	☐
Allergies are noted and confirmed with the patient/family/carer	☐	☐	☐
An approved, documented, standardised tool is used to guide clinical handover	☐	☐	☐
Relevant clinical history is provided, such as: infectious status, invasive or implanted devices, medications, most recent observations and test results	☐	☐	☐
A summary of the clinical assessment including care needs (e.g. cultural, linguistic, diet/fluid/supervision requirement) and risks (e.g. falls, pressure injury, vulnerability, sexual safety) is provided	☐	☐	☐
The patient's risk factors for suicide attempts are included where applicable	☐	☐	☐
The patient's risk factors for violence are included where applicable	☐	☐	☐
At conclusion of clinical handover the patient/family/carer is provided the opportunity to ask questions	☐	☐	☐

Process

Indicate if there were any interruptions during the clinical handover (tick all that apply)

☐	None
☐	Patient's hygiene needs
☐	Procedures and/or observations
☐	Staff member/s moves away to discuss other patients' issues
☐	Ward rounds/other clinical staff review of the patient
☐	Other (please provide details)
Details:	

Record actual finish time of clinical handover __:__

	Yes	No
Handover occurred within the agreed time-frame	☐	☐
Health care record reflects that clinical handover and transfer of responsibility/accountability of care has occurred with all findings and changes in the patient's clinical condition documented	☐	☐

NSW PALLIATIVE CARE STRATEGIC FRAMEWORK (PD2010_003)

PURPOSE

The *NSW Palliative Care Strategic Framework* builds on and replaces the *NSW Palliative Care Framework (*2001*)*.

The *Strategic Framework* is aligned with the goals of the *National Palliative Care Strategy.* The *Strategic Framework* sets out five priority areas for strengthening palliative care services in NSW.

The Statewide Centre for Improvement of Palliative Care (SCIP) has been established to provide leadership for palliative care service planning and to support the implementation of the *Strategic Framework*. This work will be aided by the Palliative Care Service Development Officer Network (SDO). A Service Development Officer position has been established in each AHS. These positions were approved in 2006 with recurrent funding.

MANDATORY REQUIREMENTS

The *Strategic Framework* sets out the priority areas for strengthening palliative care services in NSW. The values and operating statements articulate the way forward, and are supported by five planning priorities.
Priority 1: Improving NSW palliative care service planning & delivery
Priority 2: Implementing the Standards for Providing Quality Palliative Care for all Australians
Priority 3: Improving the palliative care workforce capacity
Priority 4: Improving palliative care data
Priority 5: Strengthening evidence based practice

Area Health Services are required to develop *Palliative Care Service Plans*, with support and guidance from SCIP. Each Area *Palliative Care Service Plan* should reflect the priorities of the *NSW Palliative Care Strategic Framework*. Areas must lodge their plans with SCIP, which will review them as necessary in partnership with the Department of Health to ensure they align with the *Strategic Framework*.

SCIP will also take a lead role in developing the *NSW Palliative Care Service Development Plan* and work in partnership with the Children's Hospital at Westmead on the *NSW Paediatric Palliative Care Service Development Plan*. The *NSW Palliative Care Service Development Plan* for paediatric and non paediatric patients will also be used to align *Area Health Service Palliative Care Service Plans*.

IMPLEMENTATION

The *Strategic Framework* will be implemented through the *NSW Palliative Care Service Development Plan* and the *NSW Paediatric Palliative Care Service Development Plan*. Strategies from these plans will be incorporated into *NSW Area Health Service Palliative Care Service Plan*s. Implementation at an AHS level is being supported by the Palliative Care Service Development Officer Network.

The Palliative Care Advisory Group (PCAG) will provide advice during the implementation process, and the *Palliative Care Strategic Framework* will be reviewed in 2013.

The document is available at http://www.health.nsw.gov.au/policies/pd/2010/PD2010_003.html

SAME GENDER ACCOMMODATION (PD2022_042)

PD2022_042 rescinds PD2015_018 .

POLICY STATEMENT

In NSW Health all patients, families, and carers will feel welcome, safe, and respected. Staff need to recognise and be responsive to each person's rights and needs, as well as able to provide empathy and sensitivity in their care for all patients.

NSW Health organisations must ensure the privacy and dignity of patients during all stages of their healthcare experience. Every effort must be made to be sensitive in the delivery of their care to all patients, and responsive to each person's rights and needs.

SUMMARY OF POLICY REQUIREMENTS

There are some exceptional clinical circumstances, such as highly specialised or urgent care, which may take priority over gender specific accommodation. When this does occur, it must be in the interest of all the patients affected.

Admission to hospital must not be delayed when same gender accommodation is not available. Staff must make it clear to patients and carers that mixed gender accommodation is not normal practice.
Mixed gender accommodation in critical care and short stay units may take priority over gender specific accommodation.

For many children and adolescents, clinical need, age and stage of development will usually take precedence over single gender ward allocation. Many children and adolescents take comfort from sharing with others of their own age and this may outweigh any concerns about mixed gender accommodation.

Staff must never make assumptions about a patients' sexual characteristics, gender, sexuality or body. If not informed, staff are to ask patients for their name, pronouns or how they would like to be addressed. All patients must be assured that asking questions is to ensure that every patient is able to receive the health care they need.

1. BACKGROUND

Patients who are staying overnight in hospitals must not have to sleep in the same room, ward or bay as a different gender to their own, use mixed bathroom facilities or pass through different gender wards to reach their own facilities, except in exceptional clinical circumstances. These only apply in Critical Care and Short Stay Units.

1.1 About this document

The aim of this document is to provide direction to NSW Health organisations and staff on the importance of providing same gender accommodation in hospitals. This is so that patients and carers experience healthcare in environments that are safe, comfortable, and culturally appropriate.

1.2 Key definitions

Aboriginal patients	The word Aboriginal is used in this document in line with the NSW Health Guideline *Communicating Positively: A Guide to Appropriate Aboriginal Terminology* [2]. The word Indigenous is used in this document only when referring to a Commonwealth document.
Exceptional clinical circumstances	Providing specialised or urgent care takes priority over ensuring gender specific accommodation. This is applies in Critical care and Short Stay Units.
Children and Adolescents	A person under the age of 16 years. The borderline between childhood and adulthood is not distinct: clinical need and stage of development will need to be considered.
Critical care units	Intensive Care Units (ICUs), Coronary Care Units (CCUs), Emergency Departments (EDs), Recovery Units
Short stay units	Emergency Department Short Stay Units (EDSSUs) and inpatient Short Stay Units
Sexual characteristics	Physical parts of the body that are related to body development/regulation and reproductive systems. Primary sex characteristics are gonads, chromosomes, genitals and hormones.
Gender	One's sense of whether they are a man, woman, non-binary, agender, genderqueer, genderfluid, or a combination of one or more of these definitions.
Intersex people	People who are born with anatomical, chromosomal and hormonal characteristics that are different from medical and conventional understandings of female and male bodies.
Cisgender/Cis	A term used to describe people who identify their gender as the same as what was presumed for them at birth (male or female).
Transgender and gender diverse	These are inclusive umbrella terms that describe people whose gender is different to what was presumed for them at birth. Transgender people may position 'being trans' as a history or experience, rather than an identity, and consider their gender identity as simply being female, male or a non-binary identity.
Non-binary	An umbrella term for any number of gender identities that sit within, outside of, across or between the spectrum of the male and female binary. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender.
Patient flow systems framework	A whole of health approach to managing patient flow and improving patient experience. The framework is used in conjunction with the NSW Health Patient Flow Portal. For more information please access the NSW Health website http://www.health.nsw.gov.au/pfs/Pages/default.aspx or contact the MoH Patient Flow Portal team at MOH-patientflow@health.nsw.gov.au.

Note: Some definitions for terminology covering sexual characteristics and gender have been sourced from Child Family Community Australia and TransHub. Further information and definitions can be found at these websites.

2. SAME GENDER ACCOMMODATION

2.1 Same gender accommodation cannot be provided in the short term

When same gender accommodation is not immediately available, every reasonable effort must be made to ensure transfer to a same gender room or bay occurs as soon as possible and within 24 hours.

When not in same gender accommodation, NSW Health staff must ensure patients' privacy is maintained in sleeping areas and bathroom facilities. Patients and carers must also remain informed about what is being done to address the situation and when same gender accommodation will be provided.

2.2 Mixed gender accommodation

There are exceptional clinical circumstances, such as highly specialised or urgent care and managing clinical circumstances such as infectious diseases, which may take priority over gender specific accommodation. In Critical Care Units mixed gender rooms or ward bays may be considered clinically appropriate.

In Short Stay Units same gender rooms or ward bays may be sometimes unachievable due to the specialised and rapid care received in these units.

Decisions are to be made on the needs of each individual patient and their clinical needs must take priority. Decisions are to be re-evaluated as the patient's condition improves and must not be based on the constraints of the environment or staff convenience.

2.3 Same gender bathrooms

Every effort must be made to provide patients with access to a same gender bathroom. Patients must not have to walk through a different gender area to reach their own bathroom.

If same gender bathrooms cannot be provided, patients and carers must be told what is being done to address the situation and the bathroom options available. Staff must make it clear that NSW Health considers mixed bathroom facilities to be the exception and not normal practice. When mixed bathroom facilities are unavoidable, each patient must have their privacy and dignity constantly maintained.

2.4 Nightingale wards

Nightingale wards are long rectangular wards with a row of beds on each side. Every effort must be made to separating genders on these wards, using fitted partitions or bedside curtains as a minimum. This is intended to maintain patient privacy and dignity, as well as protect patients from exposure, including casual overlooking or overhearing.

2.5 Child and adolescent units

Respecting the privacy and dignity of children and adolescents at all times during their health care experience involves the assumption that they do not have to sleep in the same room or ward bay as adult patients or share bathroom or recreational facilities.

Adult patients must not have to pass through children and adolescent units to reach their own facilities. Similarly, children and adolescents are not to be asked to pass through an adult ward to access facilities. This is intended to protect children and adolescents from unwanted exposure, including casual overlooking or overhearing.

Where possible adolescent patient preference must be sought, recorded and where possible respected. Bathroom facilities do not need to be designated as gender specific as long as they accommodate only one patient at a time and can be locked by the patient (with an external override for emergency use only).

2.6 Aboriginal patients

An important factor to achieve a culturally safe experience for Aboriginal patients in hospital is through providing same gender accommodation where possible. Mixed gender accommodation is considered culturally inappropriate for many of communities.

Providing same gender accommodation will minimise Aboriginal patients discharging against medical advice.

It is also recommended that Aboriginal patients and their families be provided access to an Aboriginal Health Worker and a designated waiting room or other culturally safe space as part of this process. Ongoing professional development for hospital staff to further support Aboriginal patients to feel culturally safe is strongly supported.

Local processes to develop same gender accommodation for Aboriginal patients need to be implemented in all hospitals for patients identifying as Aboriginal.

The Australian Commission on Safety and Quality in Health Care's report *Vital signs 2015: The State of Safety and Quality in Australian Health Care* outlines that episodes of incomplete care may be an indication of 'how safe, welcome and understood an Indigenous person feels and an indirect indicator of the extent to which services respond to an Indigenous patient's needs'.

The Bureau of Health Information (2016) 'Patient Perspectives – Hospital care for Aboriginal people' found that there were 'gaps' in experiences of care between Aboriginal and non-Aboriginal patients. It also found that there were differences in Aboriginal patients' experiences of care across the state.

2.7 Transgender and gender diverse patients

Transgender and gender diverse patients are people whose gender does not match their assigned sexual characteristics at birth. For staff to deliver effective care to transgender and gender diverse patients it is important that staff are well informed about the diversity of genders, bodies and sexualities.

All staff must be educated and trained on these areas so that they are capable and confident in working with the diversity of patients they meet.

When caring for patients, it may not always be appropriate or necessary to ask a person's gender. When a patient does share their gender, this must be respected, even if this conflicts with staff perceptions or what has been recorded in legal documents.

Staff are to make accommodation arrangements led by the needs of each patient. Given some transgender and gender diverse people have experienced stigma, discrimination and trauma in health settings, all staff should be guided by insights and advice that patient's chose to share, and by checking on their sense of safety and comfort.

2.8 Intersex patients

NSW Health staff are to understand who intersex people are and have an awareness of their health needs, experiences with health care, and potential sensitivities in health settings.

Intersex people are born with anatomical, chromosomal and hormonal characteristics that are different from medical and conventional understandings of female and male bodies. Intersex people therefore may have been assigned a gender at birth which is incorrect.

It is important to acknowledge that many people with intersex variations have undergone medical interventions associated with their intersex variation/s. In some cases, these interventions are undertaken in adulthood, while in other cases they are undertaken in infancy or childhood.

When providing care to intersex patients and placing them in a gendered space, ask the patient if they feel comfortable with that placement and work with them to meet their needs, sense of safety and comfort.

3. REFERENCES

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RECOGNITION AND MANAGEMENT OF PATIENTS WHO ARE DETERIORATING
(PD2020_018)

PD2020_018 rescinds PD2020_010

POLICY STATEMENT

All NSW public health organisations are to have local systems, structures and process in place to support the recognition, response to and appropriate management of the physiological and mental state deterioration of patients.

In this policy, public health organisations include local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.

SUMMARY OF POLICY REQUIREMENTS

All NSW public health organisations are to:

- Have a clearly defined governance system to oversee the management and continuous improvement of the local Deteriorating Patient Safety Net System.
- Use standard clinical tools and approved local clinical management guidelines/pathways as part of the local Deteriorating Patient Safety Net System to assess and monitor patient deterioration, including the NSW Health standard observation charts (paper or electronic) (unless an exemption from use of the charts has been granted).
- Formalise and implement a local Clinical Emergency Response System (CERS) that meets the requirements outlined in section 5 of this Policy Directive.
- Engage all patients, carers and families in a culturally appropriate manner to inform them about processes to escalate their concerns about patient deterioration, including who to contact and how to contact them.
- Have a local education program to support the local Deteriorating Patient Safety Net System that aligns with the Deteriorating Patient Education Strategy.
- Ensure that all staff are made aware of the local Deteriorating Patient Safety Net System (including how to activate their local CERS), and their roles and responsibilities under the system during orientation and/or ward induction.
- Ensure that all clinicians who provide direct patient care have completed the mandatory BTF Tier one and Tier two education and training prior to or during their induction to the health service, as outlined in the Deteriorating Patient Education Strategy.
- Implement a local measurement strategy that monitors the performance and effectiveness of the Deteriorating Patient Safety Net System, including the collection and reporting of mandatory quality improvement measures.
- Communicate data and information about the performance of the local Deteriorating Patient Safety Net System to key stakeholders, including patients, carers, families and clinicians/staff.

Recognition and Management of Patients who are Deteriorating: Procedures

1. BACKGROUND

Failure to recognise and appropriately manage patient physiological and mental state deterioration is a contributing factor in many adverse events in hospitals and health care organisations around the world.[1-6] Evidence derived from clinical incident reporting in NSW has demonstrated the same problem exists in NSW health services.[3]

Between the Flags was developed by the Clinical Excellence Commission in collaboration with clinical experts. It is based on research into patient clinical deterioration initiated in NSW and published in the international literature.[3, 6] Between the Flags provides the foundation for the NSW Deteriorating Patient Safety Net System, which is strengthened by the integration of other programs and frameworks, such as:

- Sepsis Kills
- End of Life
- Patient, carer and family escalation, known as R.E.A.C.H, and
- Take 2, Think, Do framework for diagnostic error.

The Deteriorating Patient Safety Net System has five components:

1. **Governance**: structures and processes to support implementation, management and quality improvement at Local Health District (LHD)/Specialty Health Network (SHN), facility, clinical service and clinical unit level
2. **Standard Clinical Tools:** including observation charts with standard calling criteria for clinical review and rapid response, and approved local clinical management guidelines/pathways that outline the Clinical Emergency Response System (CERS) response and support documentation
3. **Clinical Emergency Response System (CERS)**: a local system for the escalation of care that is used by staff, patients, carers and families
4. **Education:** tiered education for clinicians to develop and reinforce clinical and non-technical skills in recognising and responding to patients who are deteriorating
5. **Evaluation:** evaluation strategy that includes a family of measures (outcome, process and balancing measures) for monitoring the performance and improving the effectiveness of the Deteriorating Patient Safety Net System.

The Deteriorating Patient Safety Net System addresses criteria within the Australian Commission on Safety and Quality in Health Care's Recognising and Responding to Acute Deterioration Standard.

BTF addresses the Australian Commission on Safety and Quality in Health Care National Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care.[8-9]

1.1 Roles and responsibilities

Clinical Excellence Commission

- Identify and advise the NSW Ministry of Health and public health organisations (PHOs) on available strategies, standards and tools to support continued improvement of the NSW Health Deteriorating Patient Safety Net System.
- Support clinicians and relevant Executives/Directors of Clinical Governance (DCGs) to implement, monitor and improve the Deteriorating Patient Safety Net System across NSW.
- Monitor and evaluate the implementation of local Deteriorating Patient Safety Net Systems and provide advice to PHOs to make changes, as required.

Health Education and Training Institute

- Work in collaboration with the CEC on the development of education program content.
- State wide education and training and management of the learning pathways for the Deteriorating Patient Program.
- Provide advice on educational standards and governance of content in the state wide learning management system.

Local Health Districts & Specialty Health Networks

- Assign responsibility, personnel and appropriate resources to implement all the requirements of this Policy.
- Ensure the requirements of this Policy are effectively implemented, including system governance, standard clinical tools, CERS, education and evaluation.
- Work with NSW Ambulance in the development, implementation and monitoring of local CERS where the provision of CERS Assist is required.

HealthShare NSW

- Incorporate the core principles of Deteriorating Patient Safety Net System and clinical handover into non-emergency transport clinical practice, where appropriate.
- Support PHOs with the implementation of the Deteriorating Patient Safety Net System/s, where required.

NSW Ambulance

- Incorporate the core principles of the Deteriorating Patient Safety Net System and clinical handover into Ambulance clinical practice, where appropriate.
- Support PHOs with the implementation of the Deteriorating Patient Safety Net System, including the provision of CERS Assist, where required.

eHealth NSW

- Ensure that the design and build of electronic medical record functionality and clinical decision support tools align with the standards and principles outlined in this document.
- Ensure that relevant electronic medical record functionality and clinical decision support tools are maintained and continuously improved where required.
- Support PHOs, as required, to implement applicable electronic medical record functionality and clinical decision support tools that align with the standards and principles outlined in this document.

KEY TERMS

Acute alterations to calling criteria	Alterations made to calling criteria for a condition where the patient's observations will fall outside the standard parameters for a defined period of time, while treatment is taking effect. Acute alterations to calling criteria are set for a defined period of time (not longer than 12 hours), after which they revert back to standard calling criteria. Patients with acute alterations to calling criteria must have daily medical reviews to ensure their clinical progress aligns with the patient's treatment plan.
Additional criteria	Signs or symptoms of deterioration depicted on the standard observation chart that a patient may exhibit outside of, or in addition to, the standard calling criteria for vital sign observations.
Agreed signs of deterioration	Signs or symptoms of deterioration that a patient may exhibit outside of, or in addition to, the standard calling criteria and additional criteria that are agreed following engagement of the patient, carer and family, and tailored to the patient's specific circumstances.
Altered calling criteria	Changes made to the standard calling criteria by the AMO/delegated clinician responsible, to take account of a patient's unique physiological circumstances and/or medical condition. Alterations may be 'acute' or 'chronic'.

A-G systematic Assessment	A structured approach to physical assessment that considers a patient's **A**irway, **B**reathing, **C**irculation, **D**isability, **E**xposure, **F**luids, **G**lucose.
Attending Medical Officer (AMO) / Delegated clinician responsible	Senior medical practitioner who has primary or delegated responsibility and accountability for a patient on a temporary or permanent basis. For an inpatient, this is the named Attending Medical Officer (AMO) or another consultant, staff specialist or visiting medical officer with delegated responsibility. As defined in local guidelines and following a risk assessment, the delegated clinician responsible may also be a senior clinician such as a nurse practitioner. In the non-hospital/residential setting this may be the patient's general practitioner.
Balancing measure/s	A unit of data that measures whether changes to one part of a system have an impact on another part of the system and the size of the effect.
Behaviour change	Changes to the way a patient interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional state, such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.
Blue zone	A coloured zone on the standard clinical tools that requires an increase in the frequency of observation. Staff are to consider calling for an early clinical review.
Clinical Emergency Response System (CERS)	A formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit based responses (clinical review and rapid response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).
CERS Assist	A NSW Ambulance program whereby urgent additional clinical assistance is provided in response to a rapidly deteriorating patient (red zone observations or additional criteria) in a public health care facility.
Chronic alteration to calling criteria	Alterations to calling criteria where a patient has a chronic (lasting >3 months) health condition which causes their normal observations to fall outside standard parameters. Chronic alterations are set for the duration of the patient's episode of care and are reviewed during routine medical review and assessment of the patient.
Clinical Review	A review of a deteriorating patient undertaken within 30 minutes by the clinical team responsible for the patient's care, or designated responder/s, as per the local CERS protocol.
Clinical team responsible for the patient's care	The clinicians, led by the AMO/delegated clinician responsible, who are involved in, and responsible for, the care of the patient on a temporary or permanent basis. In most cases this is the medical team unless otherwise specified.
Clinical service	A health professional or group of professionals who work in co-operation and share common facilities or resources to provide services to patients for the assessment, diagnosis and treatment of a specific set of health-related problems/conditions in a facility or in the community.
Clinical unit	A subset of a facility or service with a special clinical function.

Clinician/s	Medical, nursing, midwifery and allied health professionals who provide direct patient care.
Deterioration in mental state	A negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.(7)
Deteriorating Patient Safety Net System	The NSW Health Deteriorating Patient Safety Net System refers collectively to the various individual programs and frameworks implemented by NSW Health facilities/clinical services or clinical units to support the recognition and appropriate management of patients who deteriorate.
End of life	Refers to the timeframe an individual is clearly approaching the end of their life and is living with and/or impaired by a life-limiting illness. This includes the patient's last weeks or days of life, when deterioration is irreversible and when a patient is likely to die in the next 12 months(10).
Facility	A building or structure where healthcare is provided by a public health organisation, such as a hospital, multi-purpose centre or office-based clinic.
Family of measures	A collection of outcome, process and balancing measures that monitor many facets of the system and provides a framework to understand the impact of changes.
Individualised monitoring and assessment plan	A plan for assessing and monitoring the patient's clinical situation that considers their diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological and behavioural observations to be monitored and the frequency of monitoring(7, 8).
ISBAR	An acronym for Introduction, Situation, Background, Assessment, Recommendation, a structured communication tool.
Last days of life	Refers to the last 24-72 hours of life when treatment to cure or control the person's disease has stopped and the focus is on physical and emotional comfort and social and spiritual support.
New onset confusion	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days)(11).
Outcome measure/s	A unit of data that measures whether changes to the system have an impact on the intended recipient and the size of the effect.
Palliative care	An approach that aims to prevent and relieve suffering and improve the quality of life of patients and their families who are facing the problems associated with life-threatening illness through early identification and assessment and treatment of pain and other physical, psychosocial and spiritual issues(10).
Process measure/s	A unit of data that measures whether the system is performing as it is intended to and that activities are occurring as planned, and the extent to which that is happening.
Public health organisation (PHO)	Local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.

Rapid response	An urgent review of a deteriorating patient by a rapid response team (RRT), or designated responder/s, as defined in the local CERS protocol.
R.E.A.C.H	An acronym for Recognise, Engage, Act, Call, Help is on its way. R.E.A.C.H is a CEC program for patients, carers and families to directly escalate concerns about deterioration through the local CERS.
Red zone	Coloured zone on the standard clinical tools that represent warning signs of deterioration for which a rapid response call (as defined by the local CERS protocol) is required.
Resuscitation Plans	A medically authorised order to use or withhold resuscitation measures (formerly called 'No CPR Orders'). Resuscitation Plans can also be used to document other time-critical clinical decisions related to end of life. A Resuscitation Plan is made: • With reference to pre-planning by patients (such as Advance Care Directives or plans) • In consultation with patients, carers and families • Taking account of the patient's current clinical status, as well as their wishes and goals of care. Resuscitation Plans are intended for use for patients 29 days and older in all NSW PHOs, including acute facilities; sub-acute facilities; ambulatory and community settings; and by NSW Ambulance (12).
Special Care Nursery	A clinical unit with space designated for the care of neonates who require additional support, or who need additional monitoring and/or observation(13,18).
Standard calling criteria	Signs and symptoms that a patient is deteriorating and may require review of their monitoring plan or escalation of care through the Clinical Emergency Response System to appropriately manage the deterioration. Standard calling criteria are depicted on standard observation charts as blue, yellow and red zones.
Standard clinical tools	A tool or resource that supports clinicians to recognise when a patient is deteriorating and outlines the appropriate response, such as the sepsis pathways; electronic fetal heart rate monitoring algorithm and labels; Comfort Observation and Symptom Assessment chart; and Resuscitation Plan, as well as the NSW Health standard observation charts.
Standard observation chart	Standardised observation chart approved for use by the NSW Ministry of Health. These have been developed for a variety of clinical settings.
Track and trigger tool	A tool, such as the standard observation chart, that records vital sign observations and allows them to be tracked over time to support identification of a change in the patient's condition that requires a review and/or change in management or frequency of observation.
Transfer of care	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Also known as clinical handover.
Yellow zone	Coloured zone on the standard observation charts and standard clinical tools that represent warning signs of deterioration for which a clinical review or other CERS call may be required.

3 GOVERNANCE

Public health organisations (PHOs) need to have a clearly defined governance system in place at LHD/SHN level and facility/clinical service/clinical unit level to oversee the management and continuous improvement of the local Deteriorating Patient Safety Net System.

At the LHD/SHN level, the governance system needs to:

- Provide leadership to support the management and continuous improvement of the Deteriorating Patient Safety Net System locally
- Establish and articulate clear objectives and expectations for the Deteriorating Patient Safety Net System that align with the standards and principles outlined in this policy
- Provide a framework, endorsed by the Director of Clinical Governance or other responsible senior executive, for determining exemptions for specialty clinical units where patients are appropriately monitored and care is escalated as required, such as intensive care units, coronary care units and operating theatres, from using the NSW Health Standard Observation Charts
- Delegate clear roles, responsibilities and accountabilities to personnel at facility/clinical service/clinical unit level to lead, manage and continuously improve the Deteriorating Patient Safety Net System
- Determine the education and training requirements for all staff involved in the management and continuous improvement of the Deteriorating Patient Safety Net System at a facility/clinical service/clinical unit level, including those with delegated roles, responsibilities and accountabilities for managing the system
- Review regular reports and monitor performance of the Deteriorating Patient Safety Net System across facilities, clinical services and clinical units
- Communicate with stakeholders, including patients, carers, families, clinicians and the Clinical Excellence Commission, to provide feedback on the performance and effectiveness of the Deteriorating Patient Safety Net System.

At the facility/clinical service or clinical unit level, the governance system needs to support the following functions:

- Facilitate collaboration between patients, carers and families, clinicians and managers to design, implement, monitor and continuously improve the Deteriorating Patient Safety Net System consistent with the objectives and expectations of the LHD/SHN, including a local CERS protocol that meets the requirements outlined in this Policy
- Support the development of organisational policies and procedures relevant to the Deteriorating Patient Safety Net System that reflect the role, capacity and capability of the facility/clinical service or clinical unit in hospital and non-hospital settings
- Delegate clear roles, responsibilities and accountabilities to appropriately skilled and trained personnel for managing and improving the local Deteriorating Patient Safety Net System
- Ensure clinicians with delegated roles, responsibilities and accountabilities under the local Deteriorating Patient Safety Net System are oriented to the system and demonstrate a clear understanding of their roles, responsibilities and accountabilities, including contracted staff, locums and clinicians on rotating rosters
- Provide opportunities for clinicians to complete the required education and training relevant to their delegated role in the local Deteriorating Patient Safety Net System and maintain records of completion
- Ensure that clinicians with delegated responsibilities under the local Deteriorating Patient Safety Net System are appropriately credentialed

- Support use of appropriate standard clinical tools/approved local clinical management guidelines or pathways as part of the local Deteriorating Patient Safety Net System, including approved NSW Health standard observation charts unless exempt
- Ensure that adequate resources (personnel and equipment), are allocated, available and fit-for-purpose to support the delivery of high-quality care as part of the Deteriorating Patient Safety Net System
- Collect and report data and information on the performance and effectiveness of the Deteriorating Patient Safety Net system to the LHD/SHN, relevant local committees, clinicians, patients, carers and families to facilitate quality improvement
- Monitor variation in practice against expected outcomes and provide feedback to clinicians on variation in practice and health outcomes to inform improvements in the Deteriorating Patient Safety Net System
- Regularly test the local Deteriorating Patient Safety Net System and/or processes through mock drills or simulated exercises where these events are infrequent or when there are significant changes to the context of service delivery.

Clinicians using, and/or with delegated roles, responsibilities and accountabilities under the Deteriorating Patient Safety Net System are to:

- Actively take part in the design, implementation, monitoring and improvement of the local Deteriorating Patient Safety Net System
- Understand and perform their delegated roles and responsibilities, as per their local Deteriorating Patient Safety Net System
- Participate in education and training related to the Deteriorating Patient Safety Net System, including education and training that focuses on culturally appropriate engagement of patients, carers and families and shared decision making
- Review their clinical practice and performance of their roles, responsibilities and accountabilities under the Deteriorating Patient Safety Net System and use the information to implement improvements to the system and changes to practice.

The allocation of roles, responsibilities and accountabilities under the Deteriorating Patient Safety Net System will vary depending on the health services' local context, availability of resources and models of care. Some examples of the key roles, responsibilities and accountabilities that might be allocated to personnel as part of a local Deteriorating Patient Safety Net System are outlined in Appendix 10.1.

4 ASSESSMENT OF DETERIORATION

4.1 Assessment

Assessment of a patient needs to, at a minimum, include a systematic A-G assessment and be documented in the patient's health care record, as per the requirements outlined in NSW Health Policy Health Care Records – Documentation and Management (PD2012_069). To establish the patient's baseline and agree on other patient-specific signs of deterioration initially, assessment needs to:

- Include a comprehensive systematic physical and mental state assessment
- Consider any pre-morbid conditions and where accessible, medical or clinical history documented in health care records
- Engage patients, carers, families and where appropriate, the patient's general practitioner, case manager or other clinicians familiar with their care.

Ongoing assessment is to involve the patient, their carer/s and family in monitoring changes in their physical and mental state and vital sign observations, as well as interpretation of clinical information and trends.

The frequency of assessment is to be increased above the minimum requirements outlined in Table 2 when:

- The patient's vital sign observations fall within a coloured zone on a standard observation chart
- Assessment identifies other signs and symptoms of deterioration
- A CERS call has been made.

Assessment is to be respectful of, and sensitive to, the cultural and religious needs of the patient, including their personal preferences, cultural values, language and kinship systems. Patients and carers are also to be given information and education of the importance of communicating concerns around signs of deterioration.

4.2 Standard clinical tools

Standard clinical tools support clinicians to assess patients, recognise when they may be deteriorating and outline the appropriate escalation of care.

The standard observation charts approved by the NSW Ministry of Health are standardised clinical tools designed using human factors principles. The charts incorporate colour-coded calling criteria and a 'track and trigger' format to alert clinicians to patients who are deteriorating, by graphically 'tracking' their vital sign observations over time and 'triggering' an appropriate escalation of care based on the coloured calling criteria. The charts also include a list of additional colour-coded escalation criteria that include other standard signs and symptoms of deterioration.

All NSW Health services are to use the approved standard observation charts as part of their Deteriorating Patient Safety Net System, unless they have an exemption issued by their LHD/SHN to use alternative charts. Specialty clinical units where patients are appropriately monitored and care is escalated as required, such as intensive care units, coronary care units and operating theatres, may be exempt from using the standard observation charts, as per section 3.

Where facilities or clinical services use electronic versions of the standard observation charts, processes must be in place to ensure documentation of vital sign observations can continue to be completed during system outages.

The standard observation charts have three colour-coded zones:

Blue zone: (where applicable) represents criteria for which increasing the frequency of observations and/or increased vigilance is required

Yellow zone: represents early warning signs of deterioration and the criteria for which a clinical review (or other CERS) call may be required

Red zone: represents late warning signs of deterioration and criteria for which a rapid response call is required.

Appendix 10.2 provides further details of required actions when each zone is triggered.

Other standard clinical tools, such as the sepsis pathways, electronic fetal heart rate monitoring algorithm and labels, Comfort Observation and Symptom Assessment Chart, and Resuscitation Plan, have been designed to align with the colour-coded calling criteria used on the standard observation charts. The coloured zones on the standard clinical tools outline the appropriate response and these are to be incorporated as part of the local CERS.

Local clinical management guidelines or clinical pathways may be developed for specialty areas or groups of patients with clinical indications for more or less frequent monitoring. Local clinical management guidelines and clinical pathways need to outline the criteria for escalation of care (coloured zones); be approved using the local governance system; and incorporated into the local CERS.

4.3 Minimum requirements for vital sign monitoring

The minimum set of vital signs and frequency of observations for different patient groups are outlined in Table 2 below.

In addition to the minimum requirements, a full set of vital sign observations must be taken and documented in the patient's health care record:

- At the time of admission or initial assessment (this excludes the brief clinical assessment conducted as part of the triage process on arrival to the Emergency Department)
- Within one (1) hour prior to discharge from a facility, clinical service or clinical unit.
- Prior to and following transfer of care between a facility, clinical service or clinical unit.
- A medical officer may only prescribe the frequency of vital sign observations below the minimum requirements following an assessment of the patient and with authorisation from the AMO/delegated clinician responsible for the patient's care.
- Where a medical officer is not available onsite, a registered nurse/midwife or allied health professional may vary the frequency of observations below the minimum frequency outlined in Table 2, with authorisation from the AMO/ delegated clinician responsible for the patient. This must be arranged via phone order and follow agreed local procedures.

Table 2: Minimum number and frequency for vital sign observations

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Adult inpatients	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Including pregnant women greater than twenty (20) weeks gestation and less than six (6) week post-partum admitted for a condition unrelated to pregnancy who are monitored on the Standard Maternity Observation Chart (SMOC).
Mental health acute and subacute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then daily thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Mental state assessment of patients within a mental health inpatient unit are to be completed in line with Engagement and Observation in Mental Health Inpatient Units PD2017_025.
Mental health non-acute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then monthly thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Patients with active comorbid physical health conditions or aged 65 years and over are to have observations no less than weekly and are to have a comprehensive systematic physical assessment completed at least monthly.

Hospital in the Home	At least once during each consultation/visit (17)	To be determined locally based on the models of care and assessment of risk	
Special Care Nursery	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, behaviour change*, pain score	
Newborn	**Before leaving the birthing environment** One (1) full set of vital signs observations and a newborn risk assessment completed If perinatal risk factors are identified and/or observations within the blue, yellow or red zone and/or additional criteria present, further observations must be recorded on a Standard Newborn Observation Chart (SNOC) six (6) times per day at four (4) hourly intervals.	Respiratory rate, oxygen saturations, heart rate and temperature	Newborns with low or no identifiable risk factors are to be monitored/assessed in-line with local protocols.
Paediatric inpatients	**Six (6) times per day at four (4) hourly intervals**	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Baseline blood pressure (BP) is required within 24 hours of admission. Additional BPs are to be taken as clinically indicated (PD2010_32)
Maternity/ antenatal inpatient	**Four (4) times per day at six (6) hourly intervals.**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*. For fetal heart rate monitoring requirements refer to Maternity – Fetal heart rate monitoring GL2018_025	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Maternity/ postnatal inpatient with no identified risk factors	**Before leaving the birth environment** **One (1) full set of vital signs observations and a maternity risk assessment completed.**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	If a woman has observations in a coloured zone or identified risk factors, vital sign observations are to be performed four times per day at six hourly intervals. Women receiving midwifery care in the home are to be monitored according to local protocol, refer to section 4.6.

Maternity/postnatal inpatient with risk factors	**Four (4) times per day at six (6) hourly intervals.**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Inpatient sub-acute/ long stay/ rehabilitation	**Twice a day at a maximum interval of 12 hours apart**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops an acute medical/ physiological problem the required frequency of observations reverts to a minimum of four (4) times per day at six (6) hourly intervals
Inpatient palliative care	Twice a day at a maximum interval of 12 hours apart	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops acute medical/physiological problems are managed in line with their goals of care and Resuscitation Plan
Residents in long term care facilities, such as a multipurpose service (MPS)	At least once per month	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	The frequency of observations may change depending on the resident's condition and will be determined locally by the AMO/delegated clinician responsible for the resident's care. Additional vital signs may be determined as clinically appropriate for the patient cohort cared for in these settings, such as weight, and monitored on a regular basis.

* Includes an assessment of the patient's behaviour in the context of their developmental age and/or baseline assessment, noting changes in their cognitive function, activity/tone, perception, or emotional state such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.

4.4 Individualised monitoring and assessment plans

It is recommended that patients with clinical needs which differ from approved clinical management guidelines have an individualised monitoring and assessment plan in place.

An individualised monitoring and assessment plan takes into account the patient's clinical situation, including their diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological/mental state observations to be monitored, and the frequency of monitoring.

Individualised monitoring and assessment plans, along with the rationale for the plan, are to be documented in the patient's health care record.

Patients, carers and families need to be engaged in the development of an individualised monitoring and assessment plan to ensure that it meets the patient's needs.

An AMO/delegated clinician responsible must authorise any individualised monitoring and assessment plan which varies the vital signs or other observations to be monitored below the minimum requirements outlined in section 4.3, Table 2. This includes when the delegated clinician responsible is a senior medical officer not employed or contracted by the PHO, such as the patient's treating general practitioner.

If a patient with an individualised monitoring and assessment plan has observations within the blue, yellow or red zone, care must be escalated according to the appropriate zone response unless an alternative response is stipulated in their Resuscitation Plan.

Following the initiation of a CERS call, the individualised monitoring and assessment plan need to be reviewed and the frequency of observations increased.

4.5 Alterations to calling criteria

Standard calling criteria (blue, yellow or red zone parameters) may be altered and/or other agreed signs of deterioration identified, based on assessment of the patient's condition and with input from patients, carers and families.

A medical officer may alter the standard calling criteria following assessment of the patient and engagement of patients, carers and families, and **in consultation with the AMO/delegated clinician responsible.**

If the AMO/delegated clinician responsible is not available onsite, a registered nurse/midwife or allied health professional responsible for vital sign observation monitoring may alter calling criteria when prescribed by the AMO/delegated clinician responsible and following assessment of the patient. This process needs to be outlined in the local CERS protocol, along with defined processes for altering calling criteria, as listed in section 5, below.

The local CERS protocol also needs to define processes for altering calling criteria, including:

- Documentation of the rationale for the new calling criteria in the patient's health care record
- Authorisation of the alterations by the AMO/delegated clinician responsible, including when the delegated clinician responsible is a senior medical officer not employed or contracted by the PHO, such as the patient's treating general practitioner
- The minimum timeframe for review of the altered calling criteria.
- Altered calling criteria are to only be used:
- To align the calling criteria with the patient's baseline vital sign observation parameters when they are above or below the standard calling criteria. Establishment of the patient's baseline is to be done in consultation with the patient, carers and/or family and based on assessment of the patient
- If the course of the patient's disease or condition, or recovery from a particular intervention, is expected to be above or below the standard calling criteria
- If the proposed changes to the standard calling criteria will improve detection of patient deterioration.

A 'chronic' alteration may be set to align the calling criteria with the patient's baseline vital sign observation parameters. A chronic alteration may be set for the duration of the patient's episode of care and needs to be formally reviewed by the clinical team responsible for the patient's care during routine assessments. A chronic alteration may be set for patients treated in non-hospital or residential care settings, however time limits for the duration of the alteration must be set at the time the alteration is ordered and documented in the patient's medical record.

An 'acute' alteration may be set to align the calling criteria with the expected progression of a patient's disease or condition. Acute alterations are set for a defined period of time, not longer than 8 hours, before reverting back to the standard calling criteria on the appropriate standard observation chart. Acute alterations are not intended to be used for patients who are cared for in a non-hospital or residential care setting.

Special treatment plans, such as a Resuscitation Plan, which may also alter the response to the red and yellow zone triggers, are to be documented in the patient's health care record.

4.6 Vital sign monitoring for patients in non-hospital/residential care settings

It is expected that patients who are receiving care outside of a hospital or in a residential care setting (such as outpatient clinics, community and primary health care services, midwifery care provided in the home or Hospital in the Home services) are monitored for signs of deterioration and that protocols are in place to escalate care as required.

For patients in these settings, monitoring of vital signs and other observations will depend on the:

- Patient's clinical needs, risks and proposed treatment
- Environment in which care is being delivered
- Scope of practice of the clinician providing care
- Resources available to monitor and document vital signs and other observations
- Capacity of the service to escalate care when required.

Non-hospital and/or residential care settings need to develop local protocols that establish clear expectations for monitoring physiological or mental state deterioration, including the vital signs and other observations that will be monitored, how frequently they will be monitored and the criteria for escalation of care (coloured zones).

Non-hospital and/or residential care facilities may implement a local clinical management guideline or pathway for cohorts of patients who are frequently cared for or based on the model of care that is provided. The minimum expectations for monitoring signs of deterioration need to consider clinical risks and be approved by the local governance system or relevant committee.

Non-hospital and/or residential care settings may also consider using individualised monitoring and assessment plans for each patient. Where individualised monitoring and assessment plans are used in non-hospital/residential care settings, the requirements outlined in section 4.4 apply.

4.7 Palliative care and last days of life

Patients admitted under palliative care services are to have an individualised monitoring and assessment plan and Resuscitation Plan that aligns with their goals of care. When it is identified that a patient under the care of any clinical service/clinical unit is dying or in their last days of life, the use of standard observation charts is not appropriate. The patient's individual monitoring and assessment plan and Resuscitation Plan are to be reviewed in consultation with the patient, carers and family to ensure comfort is observed and, where required, concerns escalated via the local CERS.

Clinicians are to refer to the CEC Last Days of Life Toolkit for appropriate resources to:

- Ensure comfort is observed in patients whose death is expected, such as the Comfort Observation and Symptom Assessment Chart; and
- Facilitate the accelerated transfer for the patient who wishes to die at home.

5 CLINICAL EMERGENCY RESPONSE SYSTEMS

A Clinical Emergency Response System (CERS) is a formalised system for obtaining prompt assistance from appropriately skilled and knowledgeable clinicians when a patient has signs and symptoms of physiological or mental state deterioration.

As the signs and symptoms of deterioration in mental state are often indicative of a physiological/organic condition and not necessarily a sign of an acute mental health condition, the CERS response to these are to be same as for physiological deterioration. Organic causes of deterioration are to be considered prior to accessing specialty expertise from a mental health service.

The CERS needs to:

- Operate 24 hours per day, 7 days per week
- Have the capacity to manage multiple calls at any given time;
- Have contingency plans to account for known or unexpected absences of key personnel;
- Be known and understood by all clinicians.
- Be able to be activated by staff, patients, carers or families.

NSW Health organisations are to develop and implement a local CERS across their organisation which includes:

- Procedures to enable patients, carers and families to directly escalate care within 30 minutes to a clinician who is not routinely involved in the patient's care. These procedures must clearly identify how patients, carers and families may initiate the escalation and what the expected response is. Refer to the CEC's R.E.A.C.H program[22]
- Procedures to systematically and proactively identify patients at increased risk of deterioration, with appropriate mitigation strategies
- Protocols that outline the actions to be taken to escalate care when a patient's observations breach a blue, yellow or red zone, including who will respond and how they are to be contacted
- Procedures to review the provisional diagnosis and/or differential diagnosis by a second clinician following a CERS call, or when deterioration has not been reversed
- Protocols for accessing secure clinical units or clinical services not physically co-located with an acute service that is responsible for responding to a CERS call within agreed timeframes
- Procedures for accessing specialty expertise in alignment with the facility, clinical service or clinical unit's service capability framework or referral network
- Protocols for intra- and inter-facility escalation that clearly identify who to refer to, how to contact them and how the transfer is to be conducted, consistent with the principles outlined in section 5.4
- Defined skills, education and training requirements for clinicians with assigned responsibilities as designated responders that align with the Deteriorating Patient Education Strategy
- Defined roles and responsibilities for team leaders and members of the rapid response team (RRT)
- An agreed set of minimum core emergency equipment and medication consistent with best practice guidelines that is readily available throughout the facility, clinical service or clinical unit in accordance with the organisation-wide risk assessment, and approved by the governance system or relevant committee
- Procedures for orientation and training of staff on how to access and use equipment for advanced resuscitation, including specialist equipment for paediatric, neonatal and maternity patients
- A structured clinical handover tool, such as ISBAR, to communicate critical information, outcomes, alerts and risks during the escalation of care between the clinicians involved
- Requirements for documenting a CERS call, including the outcome of the call, the subsequent medical management and monitoring plan, and a provisional and/or differential diagnosis in the patient's health care record
- Prompt communication with the patient, carers and families about the response to and outcome of any CERS calls.

For facilities, clinical services or clinical units that have a formal arrangement with the NSW Ambulance or who use 'CERS Assist' as part of their escalation framework, the point at which escalation to NSW Ambulance is required must be outlined in the relevant protocols and procedures.

5.1 CERS in specialty areas

Specialty areas with the internal resources to manage clinical emergencies may use a graded and tailored response protocol for patient deterioration that uses a combination of internal specialty expertise and external support to escalate care. Areas that may require a graded and tailored response protocol include emergency departments; maternity wards; neonatal intensive care or special care nurseries; and post-anaesthetic care units (recovery units).

Where a facility, clinical service or clinical unit requires a graded and tailored response protocol, the organisation wide CERS must identify and include these specialty area protocols. A specialty area's response protocol needs to:

1. Identify the area to which the protocol applies
2. Outline the types of deterioration that can be managed without external support and the point at which external support needs to be called
3. Define the roles and responsibilities of both internal and external designated responders in managing, and reversing, patient deterioration
4. Specify the minimum core emergency equipment and medication consistent with best practice guidelines that is to be readily available and the location of these (in accordance with the organisation-wide risk assessment), and approved by the governance system or relevant committee
5. Define the skills, education and training requirements for clinicians with assigned responsibility as a designated responder for that specialty area that align with the Deteriorating Patient Education Strategy
6. Include a structured clinical handover tool, such as ISBAR, to communicate critical information, outcomes, alerts and risks during the escalation of care between the clinicians involved.

5.2 Clinical review process

Prompt and effective clinical review is essential in managing patients who are deteriorating and is to be undertaken (or supervised) by experienced staff.

If a patient's observations enter the yellow zone (based on vital sign observations and/or additional criteria), the yellow zone response instructions on the appropriate standard observation chart, standard clinical tool or approved local clinical management guideline/pathway are to be followed. Unless specified otherwise, the decision to call a clinical review (or other CERS call) is to be made in consultation with the nurse/midwife-in-charge or relevant clinical supervisor. The decision to escalate (or not) is to be documented in the patient's health care record.

For patients in hospital settings, a clinical review is to be undertaken by the clinical team responsible for the patient's care (or another designated responder) within 30 minutes.

Depending on the local CERS protocol, the clinical review may be undertaken by a medical officer on call or an appropriately experienced registered nurse/midwife (RN/RM), preferably First Line Emergency Care Course (FLECC) accredited, or post graduate qualifications in emergency/critical care nursing, or credentialed in the procedures of the relevant specialty.

For patients in non-hospital or residential care settings, initiation of a clinical review must follow local procedure. The timeframe for review, the clinician most appropriate to undertake the review and other related responses need to be locally determined in line with the implemented model of care and based on clinical risks associated with the delivery of care. In these settings, the decision to initiate a clinical review also needs to be made in consultation with a clinical supervisor and documented in the patient's health care record.

5.3 Rapid response process

If a patient's observations enter the red zone (based on vital sign observations and/or additional criteria), the red zone response instructions on the appropriate standard observation chart, standard clinical tool or approved clinical management guideline are to be followed, and a rapid response is to be activated as per the local CERS protocol.

For patients in hospital settings, the nurse/midwife-in-charge or equivalent relevant clinical supervisor must be informed that a rapid response call has been made, and the instructions outlined on the appropriate standard observation chart, standard clinical tool and/or approved local clinical management guideline/pathway need to be followed.

Where a rapid response is called for a patient who is on an end-of-life pathway, and the appropriate level of escalation is unclear, the AMO/delegated clinician responsible is to be called, as well as the patient's carer and/or family.

The RRT members or designated responder/s must urgently attend a rapid response call, assess the patient, treat the underlying cause of deterioration and/or provide interventions to resuscitate the patient.

In small or rural health services, the designated responder may be an appropriately experienced registered nurse/midwife (RN/RM), preferably First Line Emergency Care Course (FLECC) accredited or with post graduate qualifications in emergency/critical care nursing, or credentialed in the procedures of the relevant specialty, or a paramedic who attends as a result of a CERS Assist call.

When responding to the deterioration of a maternity, paediatric or neonatal patient, at least one member of the RRT or designated responder needs to be credentialed in the advanced resuscitation techniques and procedures of that specialty.

A facility, clinical unit or clinical service may implement a graded rapid response process based on the:

- Severity of the patient's condition and the reason for the call. For example, patients with an immediately life threatening condition, such as cardio-respiratory arrest, airway obstruction, stridor, or are unresponsive, are prioritised to a rapid response team, and patients with red zone observations or additional criteria that are not immediately life threatening are attended by a senior registrar or equivalent in the first instance
- Skills required to support a tailored response to a specialty area. For example, a maternity emergency managed by obstetric and midwifery staff who require additional airway support for immediate management and ICU support post-intervention.

This graded response needs to be risk assessed and approved by the relevant local committee/senior management, and clearly defined in the local CERS protocol.

For patients in non-hospital or residential care settings, the initiation of a rapid response must be in accordance with the local procedure. The actions to be taken when a red zone response is triggered need to be locally determined in line with the implemented model of care and based on the clinical risks associated with the delivery of care. In most cases, this will usually mean calling triple zero (000) for NSW Ambulance.

5.4 Patient transfer processes

5.4.1 Intra-hospital transfer processes

Patients with observations in the red or yellow zone can **only** be transferred between clinical units when:

1. The transferring responsible clinician approves the transfer
2. There is an individualised monitoring and assessment plan in place, which may include altered calling criteria
3. The receiving clinical team responsible for the patient's care is advised of the individualised monitoring and assessment plan
4. They have appropriate clinical support during transportation.

5.4.2 Inter-facility transfer processes

For patients requiring transfer for specialist care, the processes for requesting and arranging transfers are outlined in the following documents:

PD2011_031 – *Inter-facility Transfer Process for Adults Requiring Specialist Care*

PD2018_011 – *Critical Care Tertiary Referral Networks & Transfer of Care (ADULTS)*

PD2019_024 – *Adult Mental Health Intensive Care Networks*

PD2019_020 – *Clinical Handover*

PD2019_053 – *Tiered Networking Arrangements for Perinatal Care in NSW*

GL2017_010 - *NSW Paediatric Service Capability Framework*

PD2010_030 – *Critical Care Tertiary Referral Networks (Paediatrics)*

PD2010_031 – *Children and Adolescents Inter-facility Transfers*

GL2016_018 – *NSW Maternity and Neonatal Service Capability Framework*

PD2018_002 – *Service Specifications for Transport Providers, Patient Transport Service*

5.4.3 Transferring patients from non-hospital/residential care settings

Patients in non-hospital or residential care settings who require escalation of care will usually be referred to their general practitioner or an acute health care facility; this may involve transfer via ambulance or other patient transport service.

Staff in non-hospital or residential care settings are to refer to and follow their locally determined procedure for escalating care. Staff must support the transfer process by communicating relevant clinical information to the receiving health care professional or facility through written documentation provided to the patient, carer or family, documenting notes in the patient's health care record or verbally during clinical handover.

This does not include patients who are cared for in the community as an admitted patient of a Hospital in the Home (HITH) service. HITH patients who deteriorate are to be managed as per the requirements outlined in GL2018_020 Adult and Paediatric Hospital in the Home.

6 EDUCATION

This section is to be read in conjunction with the CEC Deteriorating Patient Education Strategy which outlines the minimum training requirements for clinicians who provide direct patient care.

All facilities/clinical services/clinical units are to have a documented local education program that:

- Incorporates patients, carers and families in the co-design and delivery of locally provided deteriorating patient education and training
- Ensures all staff are aware of and know how to activate the local CERS, including contracted staff, locums and clinicians on rotating rosters
- Describes the skills, knowledge, education and training requirements for all clinicians to understand how to engage and partner with patients, carers and families in the recognition and management of deteriorating patients, including cultural awareness and cultural competency training
- Identifies appropriate education and training programs for clinicians to complete that align with the Deteriorating Patient Education Strategy
- Describes the minimum skills, knowledge, education and training requirements on the recognition and management of the deteriorating patient for all clinicians providing direct patient care, including completion of basic life support training

- Describes the skills, experience, education, training and credentialing requirements for clinicians who are members of the RRT or are designated responders, including advanced life support training
- Details the resources allocated to support clinicians to complete the required education and training, including protected time off
- Identifies specialty units that require clinicians to respond to and manage clinical emergencies within their own clinical service/clinical unit, and describe the skills, experience, education and training and credentialing requirements for these clinicians, including team training and the non-technical skills component of the BTF Tier Three Framework
- Outlines the system for ensuring regular educational updates are provided for existing clinicians, and the orientation and training of new clinicians on the recognition and management of the deteriorating patient
- Incorporates the components of the BTF education into other educational activities/opportunities, including: signs of physiological and mental state deterioration; systematic A-G assessment, synthesising assessment findings and observations to guide clinical decision making; expected trajectory of illness; appropriate escalation of care and the appropriate management of the deteriorating patient; structured communication, handover and team work
- Outlines processes to reinforce structured communication techniques and systematic patient assessment in daily clinical practice
- Identifies appropriate performance measures for monitoring satisfactory completion of required education and training
- Describes the roles and responsibilities for the governance of the local education program, including responsibility for developing, implementing and monitoring the program.

7 EVALUATION

All PHOs need to have a measurement strategy in place to monitor the performance and effectiveness of local Deteriorating Patient Safety Net Systems. The measurement strategy is to outline a selection of outcome, process and balancing measures, including the collection and reporting of mandatory quality improvement measures:

- Rapid response call rate per 1,000 acute separations
- Cardio-respiratory arrest rate per 1,000 acute separations.

Advice on collection and reporting of mandatory quality improvement measures, including definitions and methods for collection, is provided by the NSW Ministry of Health as part of the LHD/SHN service agreements. Mandatory quality improvement measures are available on the CEC Quality Improvement Data System (QIDS).

The outcome, process and balancing measures selected as part of the PHO's measurement strategy are to facilitate continuous quality improvement of local Deteriorating Patient Safety Net Systems. Details on developing a measurement strategy are provided in the Deteriorating Patient Measurement Strategy Guide.

A list of example measures that could be used as part of a measurement strategy are provided below. However, these are not exhaustive and facilities/clinical services/clinical units are to select the most meaningful measures for their context.

Outcome measures:

- In-hospital mortality rates
- Percentage of patients surveyed who report a positive experience

Process measures:

- Rates/count/number of clinical review (yellow zone) calls
- Rates/count/number of rapid response (red zone) calls
- Rates/count/number for patient, carer and family (REACH) escalation calls
- Percentage of patients, carers and family members surveyed that know how to raise their concerns and if required make a patient, carer and family escalation (REACH) call
- Percentage of patients with a full set of observations completed at the required minimum frequency
- Percentage of patients with a full set of observations completed at initial assessment and prior to departure from a facility, clinical service or clinical unit
- Percentage of patients that have an increase in their observation frequency following triggering of a coloured zone and/or a CERS call
- Percentage of red zone triggers escalated to a rapid response call
- Percentage of yellow zone triggers escalated to a clinical review (or other CERS) call
- Percentage of patients with a Resuscitation Plan
- Percentage of patients transferred to a higher level of care following a CERS call
- Percentage of patients with alterations to calling criteria
- Percentage of clinical staff that provide direct patient care who have completed their Deteriorating Patient mandatory training

Balancing measure:

- In-hospital length of stay
- ICU length of stay
- ICU admission rates/occupancy rates
- Re-presentation rates.
- When selecting measures to form their measurement strategy, PHOs are to:
- Consider the care provided by the facility, clinical service or clinical unit, the usual patient cohort/s and the patients goals of care
- Ensure measures align with the aims and objectives of the system and any changes/improvements made to it
- Engage with patients, carers and families to consider what factors are meaningful to measure from a patient's perspective.

Performance reports are to be communicated to the LHD/SHN; clinicians and managers; patients, carers and families; and other key stakeholders and include an analysis of the data identifying improvement opportunities and the impact of any improvements implemented by the facility, clinical service or clinical unit/s.

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9 RELATED DOCUMENTS

National

Australian Commission on Safety and Quality in Health Care

National Safety and Quality Health Service (NSQHS) Standards (second edition)

National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration (second edition)

Recognising and Responding to Deterioration in Mental State: A Scoping Review

National Consensus Statement: essential elements for safe high quality end of life care

National Consensus Statement: Essential elements for safe high quality paediatric end-of-life care

Delirium Clinical Care Standard

NSQHS Standards User guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium

NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health

NSQHS Standards User Guide for Health Service Providing Care for People with Mental Health Issues

NSQHS Standards User Guide for Measuring and Evaluating Partnering with Consumers

NSQHS Standards (second edition) User Guide for Governing Bodies

NSW Health

Clinical Excellence Commission – Between the Flags Project: The Way Forward

Clinical Excellence Commission – R.E.A.C.H Toolkit

PD2012_069 Health Care Records – Documentation and Management

GL2016_018 NSW Maternity and Neonatal Service Capability Framework

GL2018_025 Maternity Fetal Heart Monitoring

GL2018_016 Maternity – Resuscitation of the Newborn Infant

GL2017_018 Maternity - Prevention, Detection, Escalation and Management of Postpartum Haemorrhage (PPH)

IB2008_002 Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training

PD2019_053 Tiered Networking Arrangements for Perinatal Care in NSW

PD2017_025 Engagement and Observation in Mental Health Inpatient Units

PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services

PD2015_004 Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint

GL2017_010 NSW Paediatric Service Capability Framework

PD2010_034 Children and Adolescents: Guidelines for Care in Acute Care Settings

PD2010_032 Children and Adolescents – Admission to Services Designated Level 1-3 Paediatric Medicine and Surgery

PD2010_031 Children and Adolescents – Inter-Facility Transfers

GL2014_007 NSW Rural Paediatric Emergency Clinical Guidelines Second Edition

PD2010_030 Critical Care Tertiary Networks (Paediatrics)

PD2011_038 Children and Infants – Recognition of a Sick Baby or Child in the Emergency Department

PD2018_011 Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS)

PD2011_031 Inter-Facility Transfer Process for Adults Requiring Specialist Care

GL2020_004 Rural Adult Emergency Clinical Guidelines

PD2014_030 Using Resuscitation Plans in End of Life Decisions

GL2005_057 End-of-Life Care and Decision-Making

GL2005_056 Advance Care Directives (NSW) – Using

GL2018_020 Adult and Paediatric Hospital in the Home Guideline

PD2018_002 Service Specifications for Transport Providers, Patient Transport Service

PD2019_020 Clinical Handover

IB2018_048 2018-19 KPI and Improvement Measure Data Supplement

GL2018_025 Maternity – Fetal Heart Rate Monitoring

PD2018_010 Emergency Department Patients Awaiting Care

PD2014_025 Departure of Emergency Department Patients

10 APPENDICES

10.1 Example roles and responsibilities for the Deteriorating Patient Safety Net System

AMO/delegated clinician responsible (i.e. consultant / staff specialist / VMO) are to:

- Provide leadership to the clinical team responsible for the patient's care, to ensure they respond as per the local CERS
- Support processes for, and awareness of, patient, carer and family escalation
- Ensure every patient, taking their diagnosis and proposed treatment into account, has an individualised assessment and monitoring plan specifying the vital sign observations and other relevant observations to be recorded and the frequency of these
- Involve patients, families and carers in the development and review of documented individualised assessment and monitoring plans, medical management plans and resuscitation plans, to ensure they align with the patient's goals of care
- Ensure any alterations to calling criteria are reviewed for appropriateness, formally authorised, and documented in the patient's health record
- Ensure that a medical management plan (including the monitoring plan) is reviewed and documented for all patients following a CERS call (clinical review or rapid response).

Members of the clinical team responsible for the patient's care are to:

- Inform patients, carers and families of processes available to escalate their concerns about deterioration
- Involve patients, carers and families in the establishment of baseline observation parameters for patients to inform individualised assessment and monitoring plans and potential alterations to calling criteria
- Involve patients, carers and families in the establishment of their communication preferences and needs
- In consultation with the AMO/delegated clinician responsible, document a clear individualised assessment and monitoring plan that specifies the vital signs and other relevant observations to be recorded and the frequency of the observations
- Identifies patients at increased risk of deterioration and deploys strategies to mitigate the risks
- Discuss with, and seek authorisation from, the AMO/delegated clinician responsible for any alterations to calling criteria and document the rationale for these alterations in the patient's health care record
- Review and confirm the provisional diagnosis and/or proposed differential diagnosis and medical management plan, including an individualised assessment and monitoring plan, for all patients following a clinical review or other CERS call, and communicate critical
- information about a patient's care to the AMO/delegated clinician responsible and other clinicians, as appropriate
- Communicate critical information, outcomes, alerts and risks to patients, carers and families following a clinical review and/or rapid response in a timely manner
- Escalate care as per the local CERS.

Nursing/Midwifery Unit Manager/supervisor or delegate (i.e. nurse/midwife-in-charge) is to:

- Support processes for, and awareness of patient, family and carer escalation
- Provide leadership in monitoring compliance with the minimum requirements of the Deteriorating Patient Safety Net System, such as completion of vital sign observations at the required frequency
- Determine the need for a clinical review for patients whose vital sign observations are in the yellow zone, when additional yellow zone criteria is present or when clinicians, patients, carers or family are concerned about a patient's deterioration, and call for a clinical review or other CERS call as required
- Continue to escalate care as per the local CERS in the event that a clinical review is not attended by the clinical team responsible for the patient's care, or designated responder, within 30 minutes
- Work in partnership with, and communicate critical information to, the RRT during a rapid response call
- Support staff to complete relevant deteriorating patient education programs, including the allocation of protected time to attend required training
- Identify opportunities to reinforce structured communication techniques and systematic patient assessment as covered in the BTF education program during routine clinical practice
- Provide feedback to the local Deteriorating Patient governing committee(s) regarding implementation of the five elements of the Deteriorating Patient Safety Net System.

Nursing/midwifery/allied health staff (within the related scope of practice) are to:

- Be aware of, and know how to activate, the local CERS
- Inform patients, carers and families about how to escalate their concerns about deterioration
- Conduct a systematic patient assessment, including documenting a full set of vital signs observations on an approved standard observation chart, at the frequency specified in their individual monitoring plan. In the absence of an individual monitoring plan, refer to the appropriate approved local clinical management guideline/pathway, or the minimum requirements outlined in Table 2 of this policy.
- When a coloured zone is triggered, follow the relevant coloured zone response instructions on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Increase the frequency of observations and initiate appropriate clinical care when a patient's systematic assessment triggers a blue zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Promptly notify the Nursing/Midwifery Unit Manager or delegated nurse/midwife-in-charge when a patient's systematic assessment triggers a yellow zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Initiate a rapid response call and notify the Nursing/Midwifery Unit Manager or delegated nurse/midwife-in-charge when a patient's systematic assessment triggers a red zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, or serious concern exists about a patient's deterioration
- Document actions taken in relation to recognition, and management of deterioration in the patient's health care record
- Work in partnership with, and communicate critical information to, the RRT during a rapid response call
- Communicate critical information, outcomes, alerts and risks of any clinical review or rapid response calls to the Nursing/Midwifery Unit Manager or delegated nurse/midwife-in-charge, and the clinical team responsible for the patient's care, if/when they are not involved in the process.

Rapid response teams are to:

- Ensure patients are attended to urgently when required as part of the local CERS
- Work in partnership with, and communicate critical information to the clinical team responsible for the patient's care during a rapid response call
- Ensure all rapid response calls are documented in the patient's health care record and outcomes are handed over to the clinician and the clinical team responsible for the patient's care
- Communicate critical information, outcomes, alerts and risks to patients, carers and families following a rapid response in a timely manner
- Have a process to challenge or confirm the provisional diagnosis and/or proposed differential diagnosis, medical management and monitoring plan for all patients following a rapid response.

10.2 Response instructions on the standard observations charts for hospital settings

10.2.1 Blue zone response

If a patient has any observations which breach the blue zone on a standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, clinicians are to:

- Initiate appropriate clinical care
- Increase the frequency of observations, as indicated by the patient's condition.

If a clinician is worried or unsure whether to initiate a CERS call, consult with the nurse- /midwife-in-charge or relevant clinical supervisor to decide whether a CERS call is to be made, considering the following:

- What is usual for the patient and are there documented alterations to calling criteria?
- Does the abnormal observation reflect deterioration in the patient?
- Is there an adverse trend in observations?

10.2.2 Yellow zone response

If a patient has any observations or additional criteria which breach the yellow zone observations or additional criteria on a standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, clinicians are to:

- Initiate appropriate clinical care
- Repeat and increase the frequency of vital sign observations, as indicated by the patient's condition
- Consult promptly with the nurse /midwife-in-charge or relevant clinical supervisor to decide whether a clinical review (or other CERS) call is to be made.

Together with the nurse/midwife-in-charge or relevant clinical supervisor, consider the following:

- What is usual for the patient and are there documented alterations to calling criteria?
- Does the trend in observations suggest deterioration?
- Is there more than one yellow zone observation or additional criterion?
- Are you concerned about your patient?

If a clinical review is called:

- Reassess the patient and escalate according to the local CERS if the call is not attended within 30 minutes or there is increasing concern

- Document a systematic A-G assessment, reason for escalation, treatment and outcome in the patient's health care record
- Inform the AMO/delegated clinician responsible that a call was made as soon as it is practicable.

Where required, outcomes of the clinical review are to be documented into any relevant NSW Health, LHD/SHN or local database for capturing key performance indicators.

A structured communication tool, such as ISBAR, is to be used when providing clinical handover to the AMO/delegated clinician responsible and/or the designated responder(s).

The patient, carer and family are to be informed that a clinical review was activated and the outcome of this review.

10.2.3 Red zone response

If a patient has any red zone observations or additional criteria on a standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, a rapid response call needs to be made. In addition, the clinicians are to:

- Initiate appropriate clinical care
- Inform the nurse/midwife-in-charge or relevant clinical supervisor that a rapid response call has been initiated
- Repeat and increase the frequency of vital sign observations, as indicated by the patient's condition
- Document a systematic A-G assessment, reason for escalation, treatment and outcome in the patient's health care record
- Inform the AMO/delegated clinician responsible that a call was made as soon as it is practicable.

Members of the RRT or designated responder(s) are to attend urgently (as per the local CERS protocol) to assess the patient; treat the underlying cause of deterioration and/or provide interventions to resuscitate the patient.

The RRT leader is responsible for ensuring the outcome of the rapid response and the resultant medical management plan is entered into the patient's health care record.

Where required, outcomes of the rapid response call are also to be entered into any relevant NSW Health, LHD/SHN or local database for capturing key performance indicators.

A structured communication tool, such as ISBAR, is to be used when providing clinical handover to the AMO/delegated clinician responsible and/or the designated responder(s).

The patient, carer and family are to be informed that a rapid response was activated and the outcome of this response.

INTER-FACILITY TRANSFER PROCESS FOR ADULTS REQUIRING SPECIALIST CARE
(PD2011_031)

PURPOSE

The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW.

A seamless and integrated network of clinical services that best meets the needs of such patients is the aim of this document.

In order to achieve an efficient transfer of patients between primary, secondary and tertiary centres, a streamlined process must exist. Once the specialist care has been delivered a similarly efficient return transfer is essential. This preserves a hospital's ability to provide specialist service to others in need, and ensures the most appropriate care can be delivered in the most appropriate location.

MANDATORY REQUIREMENTS

Access to urgent specialist care and inpatient specialist care should be coordinated by a senior clinician and the Patient Flow Units within the nominated tertiary referral centre where clinical referral pathways do not exist.

Each Local Health District (LHD) must have a process in place by June 2011, outlining policy and operational guidelines on inter-LHD transfer for patients requiring access to specialist care.

IMPLEMENTATION

Roles and Responsibilities

Chief Executive (CE) LHD

- Has the direct responsibility for ensuring the implementation of the policy directive and in the delegation of a single point of arbitration as per section 5.0 of the policy directive.

LHD

- Formalise intra-LHD and inter-LHD referral systems and inter-state (if appropriate) for patients requiring referral for specialist care.
- Align inter-LHD networks for patient transfers within the existing critical care services adult tertiary referral networks, and clearly identify designated tertiary facilities according to the specialist services provided.
- Meet the needs of patients within the LHD, including the provision of clinical advice and access to appropriate treatment prior to transfer and on return to local LHD facility.
- Ensure clinical referral and support processes are clear and effectively communicated to all staff to ensure patients can access required specialist care in an appropriate time frame.

LHD and Facility Patient Flow Units:

- Establish a process whereby Patient Flow Units preferentially use all clinically appropriate options for placement of patients within the originating LHD.

- Develop LHD specific referral pathways utilising designated in-LHD specialist referral facilities.
- Ensure robust processes are in place to facilitate the co-ordination, communication and effective clinical handover of patients transfers within and across the LHDs.
- Develop and publish escalation pathways in the event of delay or disagreement regarding transfer.

NSW Ambulance Service:

- Support public health organisations with the implementation of the Inter-facility transfer process.

PURPOSE

About this document

The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW.

A seamless and integrated network of clinical services that best meets the needs of such patients is the aim of this document.

In order to achieve an efficient transfer of patients between primary, secondary and tertiary centres, a streamlined process must exist. Once the specialist care has been delivered a similarly efficient return transfer is essential. This preserves a hospital's ability to provide specialist service to others in need, and ensures the most appropriate care can be delivered in the most appropriate location.

This policy does not override:

1. Current referral networks established within the adult, paediatric or perinatal critical care referral network policy directives:
   - *PD2010_021 Critical Care Tertiary Referral Networks and Transfer of Care (Adults)*
   - *PD2010_030 Critical Care Tertiary Referral Networks (Paediatrics)*
   - *PD2010_031 Children and Adolescents - Inter Facility Transfers*
   - *PD2010_069 Critical Care Tertiary Referral Networks (Perinatal)*

2. Current established intra- and inter-Local Health District (LHD) referral pathways which have been established and enable timely access to specialist care. However, where referral pathways do not exist or delays in the transfer of care are experienced, this policy designates a nominated referral pathway to an appropriate facility to manage timely access to specialist care

3. Existing memorandums of understanding governing the transfer of mental health patients between facilities and LHDs.

The following table provides a summary of the referral process, contact pathways and responsibilities for staff when coordinating a patient transfer. Of note is the differentiation between PD2010_021 and PD2011_031.

Clinical Condition	Urgency of Transfer	Refer To	First Phone Call To	Responsibility for Bed Finding and Clinical Advice	Responsibility for Initiating Transport
Critical Care Tertiary Referral Networks and Transfer of Care (Adults) PD2010_021	Patient has a time-urgent clinical condition needing transfer in the shortest time possible. Patient's condition is not time-urgent	Linked Tertiary Hospital Linked Tertiary Hospital	AMRS 1800 650 004 Linked Tertiary Hospital via documented LHD referral pathway	Patient is automatically transported to the linked Tertiary Referral Hospital. Linked Tertiary Hospital using Critical Care Resource System Patient Flow Unit AMRS if problems	AMRS 1800 650 004 Referring clinician contacts AMRS
Inter-facility Transfer Process for Adult Patients Requiring Specialist Care **PD2011_031**	Patient requires transfer for urgent specialist care (within 24hrs) Inpatient requiring specialist care (within 24-72hrs)	Linked LHD or Tertiary Hospital Linked LHD or Tertiary Hospital	Receiving specialty clinician via documented LHD referral pathways Receiving specialty clinician via documented LHD referral pathways	Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found. Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found.	Patient Flow Unit Patient Flow Unit

Key definitions

In this document the term:

- **Must** - indicates a mandatory action that must be complied with
- **Should** - indicates a recommended action that should be followed unless there are sound clinical reasons for taking a different course of action
- **Urgent specialist care (<24hrs)** - indicates where patients require specialist intervention to prevent or manage further deterioration within a short time frame (immediate to within 24 hours).
- **Inpatient specialist care (24-72hrs)** - indicates where patients require specialist investigations or management of care not available at originating site (requires transfer within 24 to 72hrs).
- **Patient Flow Units** - represents dedicated patient flow units for the LHD or a facility or the person(s) responsible for patient flow depending on the resources within a given facility. This includes facility Bed Managers and After Hours Nurse Managers.
- **Senior Clinician** - A senior medical officer such as a Consultant, (Staff Specialist or VMO) or Senior Registrar

KEY PRINCIPLES

Each LHD must have a clear and readily available policy incorporating the following principles:

- **Good Communication and clinical handover** - between referring and receiving Senior Clinicians that involves the Patient Flow Units, resulting in the coordination of timely and safe patient transfer for ongoing care within medically agreed timeframes.

- **Patient Flow Responsibility** - all facilities have personnel tasked with coordinating patient flow, available 24/7 at all sites (e.g. Patient Flow Manager, After Hours Nurse Manager, Bed Manager).
- **Inter LHD Transfers** - where clinically appropriate patient transfers to occur within the LHD.
- **Existing Clinical Referral Networks** - where existing historical clinical referral networks are working well, these should be continued to facilitate timely access to specialist care. As part of the development of the new LHD Health Care Plans, formalised clinical networks will be determined.
- **Nominated Referral Centres** - accessing the nominated tertiary referral centre where existing clinical referral networks don't exist or where time is delaying the patient's access to ongoing specialist care as per Appendix 2.
- **Direct to inpatient bed** - the patient should be admitted directly to an inpatient bed and avoid the Emergency Department (ED) where possible unless deterioration in the patient's condition requires assessment in the ED.
- **Return Transfers -** on completion of specialist care patients are returned to the originating or other clinically appropriate facility within 24hrs or one working day.
- **Timely Escalation** - immediate escalation is to occur with the appropriate service managers for decision making, when an issue regarding patient transfer arises which will impact on the patient accessing safe and timely care within the medically agreed timeframe.

IMPLEMENTATION

Roles and responsibilities

Chief Executive (CE) LHD:

- Has the direct responsibility for ensuring the implementation of the policy directive and in the delegation of a single point of arbitration as per section 5.0 of the policy directive.

LHD:

- Formalise intra-LHD and inter-LHD referral systems and inter-state (if appropriate) for patients requiring referral for specialist care.
- Align inter-LHD networks for patient transfers within the existing critical care services adult tertiary referral networks, and clearly identify designated tertiary facilities according to the specialist services provided.
- Meet the needs of patients within the LHD, including the provision of clinical advice and access to appropriate treatment prior to transfer and on return to local LHD facility.
- Ensure clinical referral and support processes are clear and effectively communicated to all staff to ensure patients can access required specialist care in an appropriate time frame.

LHD and Facility Patient Flow Units:

- Establish a process whereby Patient Flow Units preferentially use all clinically appropriate options for placement of patients within the originating LHD.
- Develop LHD specific referral pathways utilising designated in-LHD specialist referral facilities.
- Ensure robust processes are in place to facilitate the co-ordination, communication and effective clinical handover of patients transfers within and across the LHDs.
- Develop and publish escalation pathways in the event of delay or disagreement regarding transfer.

NSW Ambulance Service:

- Support public health organisations with the implementation of the Inter-facility transfer process.

ACCESSING THE LEVEL OF CARE REQUIRED

LHDs are required to establish a single telephone contact number within 6 months of implementation. The purpose of this contact number is to provide all clinicians with clinical support and advice on clinical care and access to appropriate care and clinical referral pathways.

Patients who require transfer for specialist treatment fall broadly into two categories:
1. Those who require urgent specialist care (<24hrs) not available at the originating site
2. Those who require inpatient specialist care (24-72 hrs) not available at the originating site

The decision to transfer and determination of the urgency of transfer (medically agreed timeframe) must be made through discussion between the senior clinician at the referring site and a senior clinician from the specialist service at the receiving facility.

Patients and their representatives must be kept informed of any decisions to transfer a patient between facilities.

Delays in transfer of urgent patients must be minimised. If a bed is not available at the receiving hospital within a clinically relevant time or there is a disagreement regarding transfer, LHD policy must provide clear and immediate escalation pathways in advance of the transfer. This should not delay the transfer.

Escalation pathways should involve senior clinicians, facility and LHD executive and Patient Flow Units.

Should the senior clinician at the nominated *receiving* facility not support the patient transfer, they then have a clinical and professional responsibility to assist with patient placement to an appropriate alternative location for treatment and care.

Ongoing delays must be escalated to executive staff of the referring hospital. Communication amongst each facility executive may be required to assist with escalation processes. Such events should be routinely subject to audit and review.

Paramount to all communication between clinicians is the provision of adequate clinical information regarding the patient, sufficient to enable clinicians to make clinical decisions on the most appropriate care for the patient.

It is imperative that facility and LHD Patient Flow Units are involved in the discussions coordinating the patient transfer, and that the Bed Board Tool within the Patient Flow Portal is used to log transfer requests and facilitates good communication. This will allow for streamlined coordination of inter-hospital transfers.

LHDs must ensure a transfer checklist is in place. The use of an inter-facility transfer checklist will assist in standardising practice and ensuring an adequate level of information is provided, assisting clinical handover of the patient. (See Appendix 1 for an example of an inter-hospital transfer checklist.)

For urgent specialist care (<24hrs)

Transfer of patients for urgent specialist care must occur within 24 hours. The transfer of these patients requires a coordinated approach between the referring and accepting senior clinician (or their representative) and the receiving and sending Patient Flow Units. **Direct transfer to an appropriate inpatient bed should be the first preference**.

Prior to transfer, the referring senior clinician must:

1. Determine transfer urgency in consultation with the receiving senior clinician (the Patient Flow Unit at the facility should be working with the Clinicians to identify a transfer timeframe that best meets the patient's needs.
2. Contact the person responsible for allocating beds at the receiving hospital. (Bed Manager, After Hours Nurse Manager, Patient Flow Unit)
3. Ensure the transfer is made in a timeframe that is appropriate to the patient's clinical condition and provide an accurate estimated time of arrival.
4. Determine the appropriate form of clinical transportation and level of supervision for the patient in consultation with the receiving senior clinician
5. Provide copies of appropriate documentation with the patient which must include the patient's clinical notes, medication chart, current investigation results and referring and receiving doctor contact details.

A patient who is at risk of deterioration should be considered for early transfer to a facility where their care could be managed more effectively. At any time should the patient's condition deteriorate and become critical, PD2010_021 *Critical Care Tertiary Referral Networks and Transfer of Care (Adults)* should be utilised to ensure the patient has access to the appropriate level of care required in a timely manner.

Patients should be transferred directly to their allocated inpatient bed or a clinically appropriate area on arrival to the receiving facility (irrespective of time of day). It is the responsibility of the accepting team to conduct a timely review. If a patient's condition has deteriorated en route to the receiving facility, assessment may be required in the Emergency Department. The Emergency Department senior clinician should be notified, if this is required, and provided with a clinical handover prior to arrival at the receiving facility.

For Inpatient specialist care (24-72 hrs)

Transfer of inpatients for specialist care should occur within business hours wherever possible. The transfer process must be coordinated between the referring senior clinician, the accepting senior clinician and the Patient Flow Unit, and include agreement on timelines around the transfer.

In hours

Patients who are being transferred from a hospital ward/unit for the purpose of ongoing specialist care do not generally require clinical assessment or treatment by Emergency Department staff at the receiving facility unless the patient has deteriorated en route. Their admission should be managed by inpatient specialist teams in appropriate inpatient/ward areas. This assessment should be carried out in a similar timeframe to transfers from the emergency department.

Out of hours

Outside business hours, and where specialist inpatient teams are not available within a reasonable time frame, local policy should clearly state arrangements regarding:

1. The specific location within the facility where the patient will be transferred for specialist assessment and management
2. The process for conducting the initial assessment and management.

Patient safety should guide the decision on where the patient is most appropriately placed.

For return transfer of care post specialist assessment review or intervention

All patients that require specialist care must be transferred with the understanding that when the specialty services are no longer required, care of the patient will be transferred back to the originating hospital, or a hospital with an equivalent level of care capability close to the patient's geographical home location.

This ensures that specialist services are available for others in need and that care is delivered to the patient in the most appropriate setting. The treating specialist team is responsible for initiating return transfers of care and should liaise with the admitting team at the receiving facility to negotiate the plan for transfer. The Patient Flow Unit must be included in the discussions and transfer information including contact details of individuals logged in the Bed Board application within the Patient Flow Portal.

LHD policy must clearly outline the return referral process. The policy must reinforce that:

1. The specialist hospital must notify the receiving hospital that the patient is ready for return transfer and provide a clinical handover informing them of the patient's clinical condition and management
2. Relevant details must be entered onto NSW Bed Board via the Patient Flow Portal
3. The receiving hospital should give the returning patient priority in bed allocation and avoid return transfer through the emergency department
4. The planned inter-facility return transfer should occur within 24 hours or 1 working day of notification
5. Transfers to rural areas must consider the availability of a medical officer to admit the patient back into a facility and relevant clinical health support when coordinating the patient transfer.
6. Escalation pathways should be in place to address transfer delays outlining the person(s) responsible for managing the escalation and action to be taken.

GOVERNANCE

The Chief Executive (CE) of the receiving LHD is responsible for ensuring coordination of inter-facility transfers for patients requiring access to specialist care.

If a situation arises where issues are encountered in coordinating appropriate care for patients requiring specialist care or return transfer patients, these issues are to be escalated via the hospital's and LHDs organisational management structure. In the event that a resolution cannot be reached the issues are then to be escalated to a position delegated by the CE LHD of no less than tier 2 level. The CE LHD or delegate is required to ensure a process is in place to:

I. Activate the nominated tertiary referral hospital pathway
II. Implement return patient transfer pathway

Resolutions of issues are to be managed at the CE LHD to CE LHD level to ensure policy compliance results in patient accessing safe and timely specialist care.

THE TRANSFER NETWORK

Due to the variety of indications for transfer for specialist review, specific clinical conditions cannot be described here. Transfer of patients may need to occur within LHD (intra-LHD transfer) and between LHDs (inter-LHD transfer). LHD Policy should reflect the need for intra-LHD and inter-LHD transfer of patient to access specialist care. Operational guidelines should include clear processes that link the transfer to an accepting clinician, Patient Flow Manager and transport at the same time.

In line with the PD2010_021 *Critical Care Tertiary Referral Networks and Transfer of Care (Adults)* the CE LHD or delegate is responsible for ensuring the appropriate referral arrangements are in place for all non-critical patients requiring referral for specialist care. Formalised specialist clinical referral networks and referral processes must be in place to guide and assist clinicians to ensure appropriate and timely patient referrals.

Where cross-jurisdictional border arrangements are in place i.e. Victorian, Queensland, Australian Capital Territory and South Australian borders, this policy supports existing arrangements. However where delays occur in accessing timely care for patients, transfer to the nominated referral hospital must be considered. These clinical referral networks are as per, PD2010_021 NSW Critical Care Tertiary Referral Networks & Transfer of Care (Adults), which defines the links between LHDs, and tertiary referral hospitals for specialist clinical care. (Appendix 2)

Justice Health does not have acute health care facilities, but seeks acute services from LHDs where necessary, generally through emergency departments. Liaison with Justice Health is critical prior to transfer of care back to Justice Health, to ensure ongoing care needs are met.

Intra LHD transfers

LHDs are responsible for developing intra LHD links to assist clinicians in transferring patients that require specialist care.

LHD policy must clearly identify

- The process for coordinating the transfer (which includes the Patient Flow Units)
- The facilities responsible for accepting particular patient cohorts by speciality need.

Inter LHD transfers

If intra LHD specialist services are not available it will be necessary to escalate the transfer to a facility in another LHD.

Local policy should indicate who is responsible for coordinating inter LHD transfer and reflect the following steps.

1. Unless an alternative clinically appropriate transfer is agreed, inter LHD transfers should follow the nominated clinical referral networks used for critically ill or injured patients to tertiary referral centres
2. If the nominated tertiary referral hospital has issues accepting the patient, and the patient has an urgent condition, transfer must not be delayed: LHD escalation pathways must be activated to ensure the patient has timely access to specialist care.
3. If a patient can receive equivalent and effective specialised care in a less acute facility within the tertiary referral LHD, the tertiary referral centre will arrange treatment in that facility.
4. Any patient transfer should take into account the receiving hospital's distance from the patient's home and the impact this may have on the patient's relatives and carer(s).
5. The final decision must be made by the receiving senior clinician in consultation with the referring senior clinician and the Patient Flow Units.
6. If an alternative provider cannot be found within an appropriate time frame, the nominated tertiary hospital must accept the patient.

FEEDBACK

LHDs should incorporate feedback loops into inter-facility transfer procedures. This should manifest in a monthly or more frequent teleconference or face to face meetings with the LHD's Patient Flow Managers.

There must also be a well documented and immediate escalation process if issues arise at any stage, whether it is in forward or return transfers.

A post implementation checklist (Appendix 7.3) is to be completed at 3 and 6 months after Policy Directive implementation and be forwarded to the Director, Health Services Performance Improvement Branch.

ATTACHMENTS

Appendix 1 EXAMPLE of an Inter-hospital Transfer Checklist

FOR MEDICAL RECORD USE ONLY -MEDICAL RECORD COPY – **South Eastern Sydney Illawarra Area Health Service** **INTERHOSPITAL TRANSFER SUMMARY**	SURNAME: MRN: OTHER NAMES: DOB: SEX: AMO: AFFIX ADDRESSOGRAPH LABEL HERE Original to remain in patient's medical records, Copy to transfer with patient.

Transfer Details

Transfer Date: ____/____/____ Transfer from: _____ To: _____
Diagnosis: _____
Patients current condition: _____
Accepted by Dr _____
Mode of transport: SVH Transport □ NSW Ambulance □ NSW PTS □ Air Ambulance □ Wingaway□ SHSEH Transport □
Bed availability confirmed by receiving facility: yes □ no □ date: ___/___/___ time: _____hrs

Management/ Intervention/ Assessments

Oxygen therapy: yes □ no □ Specify: _____	**IV therapy:** yes □ no □ Type: _____ Site: _____
Dietary requirements: NBM: yes □ no □ NGT/PEG: yes □ no □ Type: _____ TPN: yes □ no □	**Mobility Issues:** yes □ no □ Falls risk score: _____ Walking aid: yes □ no □ type _____
Incontinent: yes □ no □ Specify: _____ Urinary Catheter: yes □ no □ Specify IDC □ SPC□ Other: _____	**Risk of cross infection:** no □ yes □ → precautions: _____ Contact □ Droplet □ Airborne □ **Infection (Type):** _____

Assessment prior to transfer

	Yes No	Comments
Patient ID bands in place	□ □	
Alert Bands in place	□ □	
Pain management on route	□ □	*Score: /10, last dose given at: ,Pain medication due:*
Observations		*Obs on discharge: Time:*
		T P Resp BP
Glasgow coma scale if required	□ □	*Score:*
Blood sugar level if required	□ □	*Current BSL: Next due:*
Wound care chart Pressure Ulcer Assessment	□ □	*Waterlow score:*
Dentures	□ □	
Prosthesis	□ □	
Communication deficit	□ □	
Personal / Valuables / Spectacles	□ □	
X-rays/ scans (pts own)	□ □	
Appropriate Sustenance provided	□ □	*Sandwiches and drinks required for road travel outside metro Sydney*

Handover of Patients condition

Nursing Mangement: _____

EXAMPLE ONLY

REVISION Date: Page 2 of 3
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Appendix 2 HD and Nominated Tertiary Referral Centres for Urgent and Non Urgent Specialist Care

Metropolitan NSW LHDs

LHD	Central Coast	Illawarra Shoalhaven	Nepean Blue Mountains
Nominated Tertiary Referral Centre	Royal North Shore	St George	Nepean
Hospital	Gosford Long Jetty Woy Woy Wyong	Bulli Coledale David Berry Kiama Milton Ulladulla Port Kembla Shellharbour Shoalhaven Wollongong	Blue Mountains Hawkesbury Lithgow Portland Springwood
LHD	**Northern Sydney**	**South Eastern Sydney**	**South Western Sydney**
Nominated Tertiary Referral Centre	Royal North Shore	Prince of Wales St George Royal Hospital for Women	Liverpool
Hospital	Greenwich Hornsby Macquarie Manly Mona Vale Neringah Royal Rehabilitation Ryde	Calvary Healthcare Gower Wilson (Lord Howe Island) Sutherland Sydney & Eye Hospital War Memorial	Bankstown Lidcombe Braeside Bowral Camden Campbelltown Fairfield
LHD	**Sydney**	**Western Sydney**	
Nominated Tertiary Referral Centre	RPAH/Concord	Westmead	
Hospital	Balmain Canterbury	Auburn Blacktown Mount Druitt St Josephs	

Rural LHDs

LHD	Hunter New England	Mid North Coast	Murrumbidgee
Nominated Tertiary Referral Centre	John Hunter	John Hunter	Prince of Wales St George St Vincent's
Hospital	Armidale Barraba Belmont Bingara Boggabri Bulahdelah Cessnock Denman Guyra Inverell Kurri Kurri Maitland Manilla Merriwa Moree Murrurundi/Wilson Muswellbrook Narrabri Tomaree Community (Nelson Bay) Calvary Newcastle Mater Quirindi Scone Singleton Tamworth Warialda Wee Waa Werris Creek Wingham	Bellingen Coffs Harbour Dorrigo Kempsey Macksville Port Macquarie Wauchope	Albury[42] Balranald Barham Koondrook Batlow Berrigan Boorowa Deniliquin Coolamon Cootamundra Finley Griffith Gundagai Hay Henty Hillston Holbrook Jerilderie Junee Leeton Lockhart Murrumburrah-Harden Narrandera Temora Tocumwal Tumbarumba Tumut Urana Wagga Wagga West Wyalong Young

[42] Albury is networked with clinical services in Victoria however referral to a NSW facility may be required due to clinical need.

LHD	Northern[43]	Southern[44]	Western	Far West
Nominated Tertiary Referral Centre	John Hunter	The Canberra/Prince of Wales*	Royal Prince Alfred	Royal Prince Alfred
Hospital	Ballina Bonalbo Byron Casino Coraki Grafton Kyogle Lismore Maclean Mullumbimby Murwillumbah Nimbin Tweed Urbenville	Bateman's Bay Bega Bombala Braidwood Cooma Crookwell* Delegate Goulburn* Moruya Pambula Queanbeyan Yass	Baradine Bathurst Blayney Bourke Brewarrina Canowindra Cobar Collarenebri Cudal Dubbo Dunedoo Eugowra Forbes Gilgandra Gulgong Lake Cargelligo Lightning Ridge Molong Mudgee Narromine Nyngan Oberon Orange Tottenham Trangie Trundle Tullamore Wellington	Broken Hill[45] Ivanhoe Menindee Tibooburra Wilcannia

Sydney Children's Hospital Network
Randwick Westmead *(State-wide referral role)*

[43] Northern LHD maintains a clinical referral with Queensland
[44] Murrumbidgee, Southern maintains a clinical referral network between The Canberra Hospital and the following hospitals: Bateman's Bay, Batlow, Bega, Bombala, Boorowa, Braidwood, Cooma, Delegate, Moruya, Pambula, Queanbeyan, Tumut, Yass and Young.
[45] Broken Hill maintains clinical referral networks with South Australia

Post Implementation Checklist

Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
4. Evidence of documented clinical referal pathways established across and between the Local Health Network	❑	❑	❑
	Notes:		
5. Establishment of a single point of telephone contact providing support to clinicians with issues relating to access of appropriate care and clinical referral pathways	❑	❑	❑
	Notes:		
6. Single LHD arbitrator designated for the resolution of escalated patient inter-facilty transfer issues	❑	❑	❑
	Notes:		
7. Number of patients requiring arbitration at tier 2 level to successfully occasion an inter-facility transfer to a higher level care facility	❑	❑	❑
	Notes:		
8. Number of patients breaching >24hr for a return transfer time at 3 and 6 months	❑	❑	❑
	Notes:		

PATHWAY FOR ACUTE CORONARY SYNDROME ASSESSMENT (PACSA)
(IB2023_009)

IB2023_009 replaced GL2019_014

PURPOSE

This Information Bulletin advises NSW Health organisations of the publication of the updated *Pathway for Acute Coronary Syndrome Assessment (PACSA)*.

KEY INFORMATION

The *Pathway for Acute Coronary Syndrome Assessment (PACSA)* is a set of documents that outline how to assess and manage patients with suspected acute coronary syndrome (ACS).

The PACSA has been designed to standardise practice throughout the variety of health services operating in NSW and supports practice in rural, remote and tertiary clinical environments. It is not designed to be a comprehensive review of the assessment and management of ischaemic heart disease and should be used in conjunction with other clinical resources.

The PACSA consists of four documents:

- *PACSA Flowchart (NH700422)*
- *PACSA Checklist (NH700420)*
- *PACSA STEMI Reperfusion Flowchart (NH700423)*
- *PACSA STEMI Reperfusion Checklist (NH700421)*.

The *PACSA Flowchart* and *PACSA STEMI Reperfusion Flowchart* outline each step of management with corresponding colour-coded details on the right-hand side. Each Flowchart has a corresponding Checklist.

The *PACSA Flowchart*, the *PACSA STEMI Reperfusion Flowchart* and corresponding Checklists are available from the NSW Health state forms catalogue. The product numbers are listed above for each flowchart/checklist. NSW Health staff can order and print forms via Stream Solutions (a division of Toll).

More information for NSW Health staff is available on the HealthShare NSW intranet.

People outside of NSW Health are able to purchase the resources by contacting Stream Solutions directly on 1300 786 075.

ABORIGINAL EAR HEALTH PROGRAM GUIDELINES (GL2011_013)

PURPOSE

The purpose of this document is to provide Local Health Districts with a range of suggested strategies developed by the NSW Otitis Media Expert Advisory Committee to:

Reduce the number of young Aboriginal children being adversely affected by otitis media by reducing lifestyle risk factors amongst parents, carers and their extended families.

Improve the level of awareness about otitis media amongst the Aboriginal community, health and education professionals, thereby supporting a preventive approach and improved early identification.

Improve the effectives of services which lessen the impacts of otitis media on health and learning outcomes.

KEY PRINCIPLES

The primary aim of the attached guidelines are to encourage Local Health Districts to move away from, screening-only approaches, which have been found to be ineffective at reducing prevalence rates and to instead focus on prevention using a broad public health approach.

Effective primary prevention strategies outlined in the attached NSW Aboriginal Ear Health Program Guidelines include improving nutrition and the home environment, increasing breastfeeding and reducing passive smoking.

USE OF THE GUIDELINE

Local Health Districts developing local and regional responses addressing otitis media are asked to consider the directions and suggested strategies contained herein which place priority on prevention through a broad public health approach incorporating existing child health surveillance and health care programs (rather than universal-style screening).

To download or view the Guidelines go to
http://www.health.nsw.gov.au/policies/gl/2011/GL2011_013.html

NUTRITION CARE (PD2017_041)
PD2017_041 rescinds PD2011_078

PURPOSE

Local Health Districts, Specialty Health Networks and other NSW public health organisations have a responsibility to provide nutrition care for all their admitted patients.[30] This Policy directive sets out the NSW Health framework for a strategic and coordinated approach to nutrition care for admitted patients, including weight and height/length assessment, from admission to transfer of care.

MANDATORY REQUIREMENTS

This Policy applies to all NSW Local Health Districts, Specialty Health Networks and other NSW Health organisations which provide services to admitted patients including, but not limited to hospitals and emergency departments, Day stay centres (e.g. renal dialysis, chemotherapy etc.), Multipurpose services, Mental Health facilities and Hospital in the home.

Where these facilities provide food and nutrition care services to admitted patients, consumers and residents, the nutrition care processes described in this policy directive including weight and height/length assessment **must** be in place.

IMPLEMENTATION

Chief Executives are responsible for:

- Implementing the Nutrition Care Policy, within their respective facilities.
- Ensuring governance structures are in place for all sites within the Local Health District or Network.
- Assigning responsibility, personnel and resources to meet the requirements of the Policy.
- Ensuring a staff/volunteer education and training program for nutrition care is in place.
- Ensuring systems for nutrition risk screening, nutrition assessment, and weight and height assessment using appropriate equipment and validated tools are in place.
- Ensuring clinician work practices are consistent with the requirements of the Policy.
- Ensuring systems to evaluate the nutrition care and weight and height assessment processes are in place.
- Reporting on the implementation and evaluation of the requirements of the Policy.
- Ensuring providers of food services comply with the requirements of this Policy.

Nursing/Midwifery Unit Managers (or Nurse/Midwifery Managers where appropriate) are responsible for:

- Enabling and monitoring systems to ensure patients, consumers and residents receive appropriate nutrition care.

The Agency for Clinical Innovation is responsible for:

- Providing support to NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations for the implementation of the Nutrition Care Policy.
- Monitoring and evaluating implementation of the Policy within NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations in collaboration with the NSW Ministry of Health and key stakeholders.

[30] When the term 'patient' is used throughout this Policy it refers to all patients, consumers, and residents admitted to a NSW Health facility for care.

- Reporting on the implementation and evaluation of the Policy to the NSW Ministry of Health Nutrition and Food Committee. This includes recommendations for amendments to the Policy and other relevant documents such as nutrition standards and diet specifications.

Food Service Providers (including HealthShare NSW and contracted providers) are responsible for:

- Ensuring the standards set out in this Policy and other related policies are incorporated into all food service provision activities for admitted patients, including menu planning and design, and food service system design and delivery in NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations.
- Ensuring appropriate consultation and communication with NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations.

Health Education and Training Institute

- Provides educational resources to support the implementation of this Policy.

NUTRITION CARE PROCEDURES

1 BACKGROUND

1.1 Food and nutrition in health

Good nutrition is vital for everyone, particularly for those who are frail, ill or suffering from injury. The provision of good nutrition care is an integral aspect of health care and is associated with better patient outcomes.[31] Hospital patients rely on the hospital to provide foods which are nourishing and acceptable to the patient in terms of their developmental, cultural and psychosocial needs. To achieve the best outcomes for the patient other issues such as patient access to foods and the provision of assistance with eating need to be addressed.

Food is not only essential for physical health, childhood growth and development, mental health and general well-being but also essential to an individual's sense of self. Food has strong psychological connotations associated with nurturing. In the hospital environment, meal times provide a welcomed routine to the day. Eating may be one of few opportunities many patients have to regain independence, make choices and ultimately take control over an aspect of their care, providing a positive milestone on the road to recovery.[32] Familiar foods are also important and can provide comfort and security in unfamiliar situations.

All hospital food services have a duty of care to meet the nutrition requirements and the developmental, cultural and psychosocial needs of each patient. All staff can contribute to making the mealtime environment pleasant and can assist patients in accessing and enjoying their meals.

Assessment of a person's nutritional status is important for identifying their nutritional risk during admission, as well as for promoting longer-term health and wellbeing. Along with nutrition screening, weight and height/length assessment is an important component of identifying patients who may benefit from additional nutrition care.

1.2 Malnutrition in hospital

The term malnutrition can be used to describe any nutritional imbalance and includes over and under-nutrition. However, for the purpose of this Policy, malnutrition refers solely to **protein-energy under-nutrition.**

[31] Correia et. al., 2014

[32] Segaran, 2006

A primary concern for acute, chronic, and transitional care settings is the recognition and treatment of malnutrition.[33] Malnutrition may be present in a person who is a normal weight, overweight or obese, not just those who are underweight. Many patients are malnourished on admission to care, or are at nutritional risk. If not addressed, the nutritional status of patients may worsen during the course of admission. This may result from impaired intake, impaired digestion and/or absorption, poor food choices, poor eating behaviours, altered metabolic states and unusual nutrient requirements. Early identification, documentation and management of malnutrition is critical.

1.3 Overweight and obesity in hospital

The prevalence of overweight and obesity among Australians has been steadily increasing over many years and health problems related to excess weight impose substantial economic burdens on individuals, families and communities.[34]

Long-term management is required for people who are overweight or obese. Interventions need to be individualised and supported by self-management principles and regular review by a healthcare professional.

The hospital setting provides an opportunity to identify people who are affected by overweight and obesity, and to initiate appropriate care including nutrition advice, weight management strategies or pathways where appropriate.

However, people who are overweight or obese and develop a severe acute illness or experience a major traumatic event are at risk of malnutrition and frequently need and benefit from intensive nutrition intervention.[35]

1.4 Consequences of poor nutrition

Unless systematic efforts are made to identify and manage patients at nutritional risk, the above conditions may go undetected and unmanaged during the person's admission and on transfer of care. If untreated, they can cause a wide range of adverse outcomes for the person and the health system. These include:

For the individual:

- Delayed wound healing
- Increased risk of falls and pressure injuries
- Muscle wasting and weakness
- Increased prevalence of both adverse drug reactions and drug interactions
- Infection
- Dehydration
- Impaired mobility
- Diarrhoea, constipation
- Impaired metabolic profiles
- Apathy and depression.

Consequences for paediatric inpatients can also include:

- Faltering growth and poor weight gain

[33] White et. al., 2012
[34] National Health and Medical Research Council, 2013
[35] White et. al., 2012

- Excess weight gain for length or height
- Impaired neurodevelopment
- Delayed achievement in developmental milestones. This may include some or all of the following aspects of development: physical (fine & gross motor skills), emotional, cognitive, social, language, and cultural.

For the health system:

- Increased lengths of stay
- Increased rates of readmission
- Increased costs
- Greater antibiotic use
- Increased complications
- Increased clinical intervention
- Increased staff time per patient

1.5 Key definitions

The following terms apply in this document

Malnutrition	Malnutrition due to starvation, disease or ageing can be defined as "a state resulting from lack of uptake or intake of nutrition leading to altered body composition (decreased fat free mass) and body cell mass leading to diminished physical and mental function and impaired clinical outcome from disease"[36]
Must	Indicates a mandatory action
Nutrition Care	A coordinated multidisciplinary approach to the provision of nutrition that adapts to the consumer/patient's individual needs and preferences throughout the healthcare journey. It encompasses interventions, monitoring, and evaluation designed to facilitate appropriate nutrient intake based upon the integration of information from the nutrition assessment. This includes access to safe, acceptable and appropriate food services, nutrition supplements and/or enteral and parenteral nutrition.[6,37]
Nutrition Screening	'A process of identifying patients with characteristics commonly associated with nutrition problems who may require comprehensive nutrition assessment and may benefit from nutrition intervention.'[38]
Nutrition Assessment	'A comprehensive approach to gathering pertinent data in order to define nutritional status and identify nutrition-related problems. The assessment often includes patient history, medical diagnosis and treatment plan, nutrition and medication histories, nutrition-related physical examination including anthropometry, nutritional biochemistry, psychological, social, and environmental aspects' [10]
Nutrition Support	The provision of nutrients to make up the shortfall between the patient's nutrient requirements and their oral intake. Supplementary nutrition can be given in the form of additional foods and/or fluids, enteral feeds or parenteral nutrition (PN).

[36] Sobotka 2012 and Cederholm et. al, 2015
[37] American Dietetic Association, 1994
[38] Watterson et. al, 2009

Overweight and Obesity	Abnormal or excessive fat accumulation that may impair health.[39] For adults, the World Health Organization (WHO) defines overweight and obesity as follows: • overweight is a Body Mass Index (BMI) greater than or equal to 25kg/m^2; and • obesity is a BMI greater than or equal to 30kg/m^2. For children (2-18 years), the Centre for Disease Control (CDC) and Prevention BMI for age charts (2000)[40] are used: • above a healthy weight (overweight) is BMI for age: 85th centile to below 95th centile • well above a healthy weight (obesity) is BMI for age: 95th centile and above. For children under 2 years, monitor for evidence of excess weight gain using WHO Child Growth Charts.[41] For example, where the percentile documented on the weight-for-age chart is higher than the percentile documented for the length-for-age chart, and especially if the difference is increasing.
Should	Indicates a recommended action that is to be followed unless there are sound reasons for taking a different course of action.
Underweight	For adults, the World Health Organization (WHO) defines below a healthy weight (underweight) as: • a Body Mass Index (BMI) less than 18.5kg/m^2 For children (2-18 years), the Centre for Disease Control (CDC) and Prevention BMI for age charts (2000)[42] are used: • below a healthy weight (underweight) is defined as a BMI for age below the 5th centile For children under 2 years, monitor for evidence of inadequate weight gain or poor growth using WHO Child Growth Charts.[43]
Weight and height/length assessment	The process of 1. Measuring and documenting a person's height (or length in children under 2 years) and weight, 2. Using the measurements to calculate a BMI, and 3. Using the appropriate BMI for age chart (in children) and BMI cut-off values (in adults) to inform clinical decision making and care.

1.6 Related NSW health policies and guidelines

PD2010_049	Multipurpose Services - Policy and Operational Guidelines
PD2011_015	Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals
PD2012_042	Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients
PD2012_069	Health Care Records – Documentation and Management
PD2014_004	Incident Management Policy

[39] World Health Organization, 2016
[40] National Center for Health Statistics, 2000
[41] World Health Organisation, 2006
[42] National Center for Health Statistics, 2000
[43] World Health Organisation, 2006

PD2017_001	Responding to the needs of people with disability during Hospitalisation
PD2017_033	Physical Health Care within Mental Health Services
GL2005_057	End-of-Life Care and Decision-Making – Guidelines
GL2017_012	Healthy Food and Drink in NSW Health facilities for Staff and Visitors Framework
GL2017_019	Physical Health Care of Mental Health Consumers
GL2017_021	Growth Assessment in Children and Weight Status Assessment in Adults
IB2012_024	Metabolic Monitoring Clinical Documentation Module
IB2013_039	Foodborne Listeriosis Control in Health Care Institutions

Agency for Clinical Innovation

- Nutrition Standards and Diet Specifications available at http://www.aci.health.nsw.gov.au/resources/nutrition/nutrition-food-in-hospitals/nutrition-standards-diets
- ChOICES: The Patient Menu Selection process available at: https://www.aci.health.nsw.gov.au/resources/nutrition/nutrition-food-in-hospitals/nutrition-policy
- Palliative and End of Life Care – A Blueprint for Improvement available at: https://www.aci.health.nsw.gov.au/palliative-care-blueprint

1.7 Other related sites

- NSW Department of Primary Industries Food Authority http://www.foodauthority.nsw.gov.au/industry
- Australian Commission on Safety and Quality in Health Care http://www.safetyandquality.gov.au/
  - This policy aligns with the National Safety and Quality Healthcare Standards
- The Healthy kids website www.healthykids.nsw.gov.au
  - general information on healthy eating and physical activity information for children and parents
- Healthy kids for professionals website https://pro.healthykids.nsw.gov.au/
  - for NSW health professionals, focusing on lifestyle management in children.
- The Go4Fun program www.go4fun.com.au
  - a free, community-based referral program for children who are above a healthy weight, and their families
- The Get Healthy Service www.gethealthynsw.com.au
  - a free, phone-based lifestyle coaching service for NSW residents 16 years and older.

2 GOVERNANCE

A strategic and coordinated approach is required by Local Health Districts, Specialty Health Networks and other NSW public health organisations to ensure a high standard of nutrition care is provided to patients.

Governance structures should include consumer, clinical and corporate representation. Each Local Health District and Specialty Health Network should have a governance structure for food and nutrition that includes representatives from the following groups:

- Senior management
- Medical staff
- Nursing/midwifery
- Consumers and their carers
- Nutrition and Dietetics
- Food services
- Other allied health staff (e.g. speech pathology, occupational therapy) as required
- Other disciplines should be consulted as needed.

The role of local governance structures should include the following activities:

- Implementation of this Policy
- Operational policy/procedure development, endorsement and review
- Effective communication of policies and procedures to staff
- Ensuring nutrition care is considered in the planning and development of new services
- Monitoring implementation of agreed standards and related procedures
- Monitoring performance against agreed standards
- Review, management and reporting of nutrition care incidents
- Evaluation of nutrition care which includes the consideration of feedback received from consumers, staff and key stakeholders
- Providing feedback to staff and consumers about performance against the Policy.

A governance group at each health facility should be considered.

3 WEIGHT AND HEIGHT/LENGTH ASSESSMENT

Assessing weight and height/length is the first step in identifying and developing a care plan for patients according to their current weight status and clinical condition.

Weight and height/length assessment requires measurement of the patient's actual (not estimated) weight and height/length.

All patients under the age of 18 years **must** have their weight and height/length measured and documented within 24 hours of admission and weight should continue to be measured and documented at least weekly in the acute setting and at least monthly in long stay facilities. Head circumference should also be measured and documented from birth to at least two years of age on admission.

All patients 18 years and older should have their weight and height measured and documented within 24 hours of admission and weight should continue to be measured and documented at least weekly in the acute setting and at least monthly in long stay facilities (e.g. multipurpose services, rehabilitation centres, mental health facilities).

Measurement of weight and height/length, and assessment of weight status, is to be performed and documented according to the NSW Health Guideline: Growth Assessment in Children and Weight Status Assessment in Adults.

There may be a small number of patient populations where measuring weight and height/length is not clinically appropriate and this decision will need to be made at a specific service-level.

4 NUTRITION SCREENING

Nutrition screening is key to early identification of patients with nutritional problems which may go unrecognised and therefore remain untreated.

There are many factors that may prevent a patient from eating and/or drinking adequately and safely. These include, but are not limited to, physical difficulties, medical conditions, behavioural difficulties, age, stage of development, cognitive impairment, and changes to sense of taste as a result of treatment/illness or loss of appetite.

Nutrition screening is a rapid, simple and general procedure used by nursing, medical or other clinical staff to detect patients at risk of malnutrition. It is applicable in the hospital, outpatient, community and ambulatory care settings as well as long stay facilities such as multipurpose services and residential aged care.

NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations **must** have in place a system for nutrition screening using a validated tool. The choice of tool and subsequent action pathway is dependent on the patient population and the staff resources available. Ideally the tool should be quick simple, accurate and reliable.

Examples include but are not limited to: the Malnutrition Screening Tool (MST), the Mini Nutrition Assessment (MNA), the Malnutrition Universal Screening Tool (MUST) and the Paediatric Nutrition Screening Tool (PNST).

Nutrition screening should occur:

- within 24 hours of admission and then weekly during the patient's episode of care
- at least monthly in long stay facilities (e.g. multipurpose services, some rehabilitation centres, some mental health facilities)
- if the patient's clinical condition changes.

Patients whose score is 'at risk' on a validated screening tool or whose clinical condition is such that their treating team identifies them as at nutritional risk should be referred to a dietitian for a full nutrition assessment and nutrition support as appropriate.

There may be a small number of patient populations where nutrition screening is not clinically appropriate and this decision will need to be made at a specific service-level. For example people with eating disorders and people receiving palliative care.

5 NUTRITION ASSESSMENT

Patients should have a full nutrition assessment if they have been identified as at risk by nutrition screening. Nutrition assessment determines an individual's nutritional status and helps identify appropriate nutrition interventions. Early detection of malnutrition and implementation of appropriate nutrition support reduces the risk of patients' nutrition status deteriorating during an episode of care.

Local Health Districts, Specialty Health Networks and Public Health Organisations **must** have in place a system for nutrition assessment for the diagnosis of malnutrition. The nutrition assessment **must** be undertaken by a dietitian and an appropriate validated tool **must** be used to support the diagnosis of malnutrition.
Examples of validated assessment tools include but are not limited to the Subjective Global Assessment (SGA) Tool, Subjective Global Nutrition Assessment in Children (SGNA) Full Mini Nutritional Assessment (Full-MNA) and Patient Generated Subjective Global Assessment (PG-SGA).

Patients requiring nutrition assessment should be seen by a dietitian within two working days of referral.

If there is no dietitian available, a protocol that outlines the management of the patient until a nutrition assessment can be completed **must** be in place and communicated to staff. Strategies such as telehealth could be considered for facilities where access to a dietitian on-site is limited.

Nutrition assessment should be discussed with the treating doctor and multidisciplinary team and **must** be documented in the patient's medical record.

6 NUTRITION CARE PLANNING

Individuals identified as malnourished or at nutritional risk **must** have an appropriate nutrition care plan developed by a dietitian and documented in the patient's medical record.

The patient's overall nutrition care plan **must** be documented and incorporate the recommendations made by the multidisciplinary team involved in the patient's care. This would include, but is not limited to, recommendations made by Dietitians, Speech Pathologists, Occupational Therapists, Nurses/Midwives and the medical team.

This nutrition care plan should contain clearly documented nutrition interventions to attain identified goals of treatment. Good patient care may require help with feeding, recording of food and fluid intake, modified menus, additional dietetic advice and oral nutrition supplements and/or oral, enteral or parenteral nutrition support. Patients, carers and/or relatives should have input into the nutrition care plan and communicate any issues with these plans with a member of the multidisciplinary care team. Referral to the appropriate clinician(s) should follow where required.

Nutrition care plans should be:

- reviewed regularly and documented to reflect changes
- monitored to ensure goals are met with further action taken as necessary
- communicated appropriately to the patient and care givers.

Changes in a patient's clinical condition that may impact on their nutrition should be monitored and appropriate action taken. Action may include re-screening, re-assessment and changes to care plans.

6.1 Transfer of care

Patients who require ongoing nutrition care on transfer of care **must** have a clear nutrition care plan documented. The plan should be communicated to the patient and/or carer as well as to any receiving facility and the patient's general practitioner and other members of the community-based health care team. On transfer, the care plan should include information about:

- weight status
- nutrition status
- special dietary requirements
- key messages for achieving and maintaining a healthy weight, where required
- provision/purchase and preparation of specialised nutrition support products and relevant equipment where required
- arrangements for referral and follow-up.

Arrangements should be in place for continuing care. This could include but is not limited to, primary care, community-based care, private practitioners or an outpatient service.

If the patient has an ongoing need for specialised nutrition support items the patient should have access to, or be provided with, an adequate supply of these items while waiting for their own supply where required (e.g. enteral formula or equipment, thickened fluids, thickener).

7 PLANNING AND DELIVERY OF FOOD AND FLUIDS

Patients are more likely to eat a meal and receive the appropriate balance of nutrients it provides when the meal and presentation is pleasing and appetising. Meals should be delivered to the wards or respective dining areas and served promptly to maintain the nutrition content, temperature and quality.

Effective multidisciplinary communication is vital for the efficient provision of food in hospital and to ensure that patients' nutrition requirements are met while minimising waste.

Patients/carers should be provided on admission with information about meal services and the importance of nutrition in an easy-to-read format.

7.1 Menus

The menu **must** meet the nutrition requirements of patients in accordance with the Nutrition Standards and Diet Specifications available at http://www.aci.health.nsw.gov.au/resources/nutrition/nutrition-food-in-hospitals/nutrition-standards-diets

Patients should be:

- given the opportunity of selecting food and fluids from the menu
- assisted with menu selection, as required, by an appropriate member of staff. This will range from staff with general knowledge of the menu and available food items to those with the skills and knowledge to guide a patient/carer to choose from the menu according to the patient's therapeutic diet order and/or the dietitian's nutrition care plan.
- able to make their menu selections no more than one day ahead of the day of service. This has been shown to enhance oral intake.

Relatives/carers can provide assistance to patients who are unable to make their own menu selections, by either making menu choices on the patient's behalf or informing staff of the patient's food preferences.

7.2 Provision of food and fluids

The diet ordering and the meal delivery systems should be efficient, timely and safe. The diet ordered for the patient should be explained to the patient and/or carers.

The number of meal occasions (mealtimes) should meet the needs of the local population and be spread out to cover most of the hours spent awake. Food should be available for patients who are admitted out of normal hours, or who are not present at ward mealtimes.

All food provided by the facility or service must comply with relevant legislative standards, including those pertaining to food safety. Systems must be in place to cater for patients at risk of sentinel events including those with dysphagia, allergies and those who are severely immunocompromised.

Where clinically possible, patients' nutrition requirements should be provided by food in accordance with endorsed nutrition standards. Appropriate access to fluids, particularly drinking water, must be provided for all patients, as clinically appropriate. Oral supplements should not substitute for, or be relied upon, to enhance the provision of food and fluid unless there are clear clinical indicators.

The following patients should be considered for oral, enteral or parenteral nutrition support:

- patients who cannot consume adequate nutrition orally to meet their nutrition requirements, including those patients on texture-modified diets,
- patients with inadequate intestinal function
- patients who are designated as 'Nil-By-Mouth' for more than three days.

Strategies **must** be in place to minimise fasting including clear guidelines outlining the specific minimum and maximum fasting times required for procedures (including when fasting is not required).

Specific nutrition concerns related to end-of-life issues should be considered according to GL2005_057 End-of-Life Care and Decision-Making – Guidelines.

8 THE MEALTIME ENVIRONMENT

Hospital routines, clinical procedures and ward rounds can disrupt mealtimes and significantly reduce patients' nutrition intake. A relaxed and pleasant mealtime environment enhances patients' enjoyment of their meals and can influence the amount of food and fluids they consume.

All staff should focus on creating a mealtime environment conducive to eating and providing feeding assistance where required during mealtimes. This includes:

- minimising interruptions to the patients' meal times such as ward/medication rounds, teaching and diagnostic procedures
- preparing patients for eating prior to the meal delivery (e.g. appropriate seating, positioning, toileting, hand washing, accessing dentures and or glasses and clearing of over-bed trolleys)
- providing patients who are able the opportunity to sit out of bed to eat their meals
- ensuring patients are able to access their food and open packaging.

For some patient groups access to a dining room for meal times may be appropriate e.g. mental health facilities and multipurpose services.

9 PROVISION OF ASSISTANCE TO EAT AND DRINK

Many patients require some form of assistance or supervision with eating and drinking. This ranges from assistance with opening packages, meal supervision to fully assisted feeding. If assistance with eating and drinking is not provided when required, patients' nutritional status may be compromised.

Independence with eating and drinking should be promoted in a safe and supportive way.

Patients should be:

- treated with respect and dignity at all times when being prepared for and receiving food and fluids
- given adequate time (at least thirty minutes) to consume their meal before the tray is collected
- provided with appropriate modifications to their meal to assist them with accessing and/or eating the meal
- provided with equipment/utensils to meet their individual needs including adaptive aids, cutlery and drinking devices.

Carers, relatives and volunteers can be involved in assisting patients to eat if deemed safe by the clinical staff and if any necessary training has been provided.

Paediatric patients (particularly the very young) require direct supervision during meal times, monitoring total intake and safe consumption. This may be provided by a parent/carer.

Wards and dining areas should be adequately staffed at mealtimes and the importance of providing timely and individualised assistance with eating and drinking should be recognised in work allocations.

A system for the development and assessment of new food products, packaging, dinnerware and cutlery for ease of accessibility and useability by patients should be in place. Such a system **must** include consultation with appropriate stakeholders (e.g. consumers).

10 STAFF EDUCATION AND TRAINING

Training and education programs enhance an understanding of the link between good nutrition care, identifying those at risk of poor nutrition, preventing malnutrition and delivering better patient outcomes.

All staff involved in nutrition care should:

- understand their role and responsibilities, and receive appropriate education and training on the key aspects of nutrition care relevant to their patient demographic, the diets available and the purpose of these diets if responsible for ordering diets
- be aware of the role of food and nutrition supporting a patient to achieve optimal nutrition, prevent malnutrition, and maximise patients' clinical outcomes and quality of life
- be aware that patients who are overweight or obese may also be malnourished
- be aware of their role in measuring and monitoring patients' weight and acting on identified risks.

Education programs on weight status assessment, nutrition care and malnutrition should be provided annually and additionally as required. Training could be provided locally or via Health Education and Training Institute.

11 EVALUATION

NSW Local Health Districts, Speciality Health Networks and other NSW public health organisations **must** have a system to evaluate the nutrition care provided. The system **must** include monitoring and reporting of the following:

- audit of weight and height/length documentation
- audit of nutrition screening and nutrition assessment
- patient experience and satisfaction with food and nutrition care
- regular feedback to staff and consumers on compliance with the Policy.

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ATTACHMENT 1: NUTRITION CARE POLICY SELF-ASSESSMENT CHECKLIST

Element	Examples of evidence	Available Resources	COMPLIANCE			Actions required	Assigned to	Target Completion date
			Not compliant	In progress	Compliant			
The LHD/SHN/Organisation has an effective nutrition care governance structure that has clinical, consumer and corporate representation in place that is appropriate for each facility.	- Terms of Reference - Minutes and Action plans - Communication to staff and consumers about the governance structure. - Clear protocols for nutrition care including weight and height/length measurement and documentation	- Templates for Terms of Reference and Agenda's: ACI Nutrition and Mental health toolkit - Engaging consumers and carers: ACI Nutrition and Mental health toolkit - Growth assessment in children and weight status assessment in adults						
There is a system in place to ensure patients undergo nutrition screening within 24 hours of admission to care and weekly using a validated nutrition screening tool (or monthly for long stay facilities e.g. multipurpose services, some rehabilitation centres, some mental health facilities).*	- Appropriate screening tool(s) are in use and supported by clear protocols. - Monitoring and evaluation plan - Audit results and action plans	- NSW Health Adult Admission form - Evidence based practice guidelines						

Appropriate equipment (such as scales, height/length measures and specialised feeding equipment) is functional, well positioned and available in clinical areas.*	- List of available equipment - Equipment audits, reports and action plans - Evidence of routine calibration							
Patients have their weight and height/length measured and documented within 24 hours of admission to care and then - weight measured weekly in the acute setting.* - weight measured monthly in long stay facilities (e.g. multipurpose services, some rehabilitation centres, some mental health facilities)	- Audits, reports and action plans - Local policy or protocol	- Adult and Paediatric Admission forms - Physical Health Care of Mental Health Consumers (GL2009_007) - NSW Health Metabolic monitoring module - Evidence based practice guidelines - Age appropriate growth charts for boys and girls						
There is a system in place to ensure patients at nutritional risk are referred to a dietitian for a full nutrition assessment. The nutrition assessment occurs within two working days of referral to the dietitian.*	- Clear referral pathways and protocols - Appropriate nutrition assessment tool(s) are in use and supported by clear protocols. - Documentation audit results, reports and action plans	- Evidence based practice guidelines						

The menu provided to patients meets the needs of the local population	The menu development and review process has considered: o Average length of stay o The demographic and cultural profile of consumers o Feedback from stakeholders including consumers (via surveys, focus groups, participation in processes etc.)	- ACI Nutrition Standards - ACI Nutrition Standards Menu review tool - ACI Nutrition Care and Food Service Data Checklist: ACI Nutrition and Mental health toolkit						
There are systems in place to ensure patients have the opportunity to select their own meals where appropriate	- Clear protocols in place - Information is provided to patients/carers about the food service - Audits, reports and action plans	- ACI ChOICES: The Patient menu selection process - ACI Food and Nutrition brochure						
Patients who need assistance with eating and drinking are identified and the level of care they need is provided.*	- Systems in place and supported by clear protocols - Audits, reports and action plans - Feeding assistance program in place	- ACI Dementia and Delirium Care Volunteer implementation and training resource - NSW Health Admitted Patient survey results (Bureau of Health Information)						
Nutrition care requirements are included in care plans, and appropriately communicated on transfer of care	- Systems in place and supported by clear protocols - Audits, reports and action plans							
There is a system in place to identify and train relevant staff in nutrition care.	- Clear protocol in place - Training program available - Training audits, reports and action plans	- HETI eLearning module: Nutrition screening for malnutrition - Weight4Kids online modules						

Nutrition care is evaluated by a range of stakeholders and the process includes: • Patient experience and satisfaction with food and nutrition care. • Multidisciplinary incident review and management	- Surveys, audits, focus groups - Meal time observations - Reports and action plans - Incident investigation or analysis	- NSW Health Admitted Patient survey results (Bureau of Health Information) - HealthShare Food Service patient satisfaction survey results - Data from Incident Management Systems						
Routine feedback is provided to staff and consumers on compliance with the Nutrition Care Policy	- Local intranet and / or internet page - Evaluation results are shared with consumers and staff and used to improve services (e.g. via newsletters, meetings, intranet sites, publications, information for consumers/ carers)							

*This element requires regular audit as part of evaluation.

NSW ABORIGINAL HEALTH PLAN 2013-2023 (PD2012_066)

PURPOSE

The NSW Aboriginal Health Plan 2013-2023 (the Plan) is the result of the NSW Government's commitment toward closing the gap in health outcomes for Aboriginal people.

Over the next ten years the Plan provides unique opportunities for NSW Health to re-examine the best ways of working together and redesigning health services to achieve health equity.

The Plan has been developed to help guide how health systems are planned, delivered, and monitored over the next decade in relation to Aboriginal health. The success of these reforms will be dependent upon working in partnership and utilising the expertise of Aboriginal people in shared leadership arrangements and innovative collaborations.

MANDATORY REQUIREMENTS

Compliance with this policy is mandatory for all staff of Local Health Districts, Specialist Health Networks, Pillars and other NSW health related statutory authorities.

Six strategic directions have been identified to drive the changes needed in the health system to improve Aboriginal health. They are:

1. Building trust through local partnerships.
2. Building the evidence and implementing what works.
3. Ensuring integrated planning and service delivery.
4. Strengthening the Aboriginal workforce.
5. Ensuring culturally safe work environments and health services.
6. Strengthening performance monitoring, management and accountability.

To support achievement of these strategic directions, several strategic actions that support each of the strategic directions require implementation. Please refer to these actions on pages 10-16 in the Plan.

IMPLEMENTATION

The Plan adopts a systems reform approach to improve health equity for Aboriginal people, and will support the NSW health system to achieve the *NSW 2021: A plan to make NSW number one* targets to:

- Reduce smoking rates by 4% for Aboriginal people.
- Reduce the rate of smoking by 2% per year for pregnant Aboriginal women.
- Halve the gap between Aboriginal and non-Aboriginal infant mortality rates by 2018.
- Reduce the age-standardised rate of potentially preventable hospitalisations by 2.5% for Aboriginal people by 2014-15.

Local Health Districts, Specialist Health Networks and the Pillars will be required to implement and report on achievements over the life of the Plan.

The Plan's strategic directions will be implemented through NSW Health funding and performance management structures. Inclusion of key performance indicators in LHD and SHN Service Agreements and Service Compacts will provide a mechanism to ensure engagement and support of the Plan by NSW Health service providers.

All Service Agreements will explicitly require services to provide a proportion of interventions for Aboriginal people.

The health of the Aboriginal people of NSW: Report of the Chief Health Officer, 2012 has been released in conjunction with the Plan. This report will be used as a baseline of the health status of Aboriginal people and health system performance. It will be reproduced every three years to identify where improvements have been made. Also, annual progress meetings will be held with the Aboriginal Community Controlled Health Services sector and NSW Health to showcase the progress made against the strategic directions and actions contained in this Plan.

To download the document please go to http://www.health.nsw.gov.au/policies/pd/2012/PD2012_066.html

NSW HEALTH & AGEING AND DISABILITY AND HOME CARE (ADHC) JOINT GUIDELINE (GL2013_001)

Supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital.

PURPOSE

The aims of the Guideline are:

1. To ensure that staff working in hospitals and disability accommodation support services are aware of their respective roles and responsibilities to people with disability before, during and after transfer of care from hospital.
2. To provide a framework for best practice for health care staff and disability support staff/nurses so together they can:
   - Identify areas of risk that could compromise a person with disability's capacity to achieve the best health outcomes and their safety and/or dignity during a hospital stay;
   - Agree on what additional supports are required to reduce identified risks; and
   - Negotiate responsibility and resources for the provision of agreed additional support.
3. To link and reference each agency's policies rather than replicating them (staff should refer to relevant policies where indicated in this Guideline).

This Joint Guideline (the Guideline) has been endorsed by ADHC and NSW Health and was developed in consultation with key stakeholders across health and disability sectors.

KEY PRINCIPLES

The following general principles underpin the Guideline:

- Person Centred Approach
  An approach that places the person at the centre of decision making and treats natural networks of support and service providers as partners. A philosophical background based on the value of human rights, independence, choice and inclusion.
- Patient Centred Approach
  An approach that is geared towards using resources to develop a culture where the patient is both the heart of the system and the driver behind every decision.
- Communication
  Good communication between the person, their family/guardian, hospital staff and the disability support staff and sharing information about the persons health and disability support needs makes a positive difference to a person's health outcomes

- Sharing Information
  Key information that hospital staff need to know about the person and their support needs should be provided in a universally consistent format and travel with the person around the hospital for ease of access.
- Sharing Expertise
  Sharing expertise to ensure that people with disability achieve the best health care outcome is central to this Guideline.
- Capacity to consent
  It is the responsibility of the treating practitioner to determine if the person is able to give consent for medical or dental treatment. Disability Support Staff cannot provide consent for medical treatment under any circumstances.

The document covers issues relating to workforce, care coordination and transfer of care, the key stages of planned and unplanned admission to hospital, resolution of issues arising during the hospital stay, local liaison mechanisms and implementation.

USE OF THE GUIDELINE

Local Health Districts should use this Guideline in conjunction with NSW Health Policy Directives - PD2011_015: *Care Coordination: Planning for Admission to Transfer Care in Public Hospitals* and PD2008_010: *People with Disability: Responding to Needs During Hospitalisation*.

Some Local Health Districts (LHDs) and ADHC Regions have developed local protocols which provide the framework for effective support of ADHC clients during a hospital stay. This Guideline aims to facilitate a higher level of compliance with existing NSW Health and AHDC policies.

As a minimum requirement, all local protocols need to comply with the general principles set out in this Guideline. Providing these principles are included in local protocols, all other protocol features can be negotiated, expanded and adapted to meet existing local needs.

The implementation of the Guideline should be reported through the Local Health District's Disability Action Plans.

Use of the Jointly Agreed Hospital Support Plan Part 1 & 2 (Appendix 1)

The Hospital Support Plan may be inserted into the plastic sleeve of *My Health Record*. Part 1 of the Hospital Support Plan contains all relevant personal, consent, health/medical and disability support information necessary to help hospital staff provide safe and effective health care and will be completed by the disability support staff. It will be presented to hospital staff at every pre admission/admission and a copy be kept with the person at all times including all transfers of care.

Part 2 of the Hospital Support Plan is designed to facilitate the sharing of clinical and disability support expertise. It provides the framework to negotiate the range and level of support the person will require during hospitalisation to ensure they achieve the best health outcomes and maintain their safety and dignity.

Part 2 of the Hospital Support Plan is completed in partnership with disability support staff/nurses, the nurse in charge of the unit/ward, the person and, if the person agrees, the family/guardian, at a pre admission meeting or as soon as the person is settled following an unplanned admission to hospital.

To download the Guidelines please go to http://www.health.nsw.gov.au/policies/gl/2013/GL2013_001.html

SNAKEBITE AND SPIDERBITE CLINICAL MANAGEMENT GUIDELINES 2013 – THIRD EDITION (GL2014_005)

PURPOSE

Clinical resource document to advise on the management of patients with actual or suspected snakebite or spiderbite, and the appropriate levels, type and location of stored antivenom in NSW health facilities. These are clinical guidelines for best clinical practice which are not mandatory but do provide essential clinical support.

KEY PRINCIPLES

Determination of antivenom stock requirements is best done at a regional level, either for a whole Local Health District (LHD) or important regions within a Local Health District in collaboration with local Critical Care Clinicians based a review of risks, facilities, past usage and other practical considerations using the following principles:

- Geographic location and degree of isolation.
- Local snake and spider distribution.
- History of envenoming cases.
- Referral role of regional, rural and metropolitan hospitals.

Whilst, the definitive management of snake envenoming can only occur in a hospital with a laboratory that can do an INR/aPTT and there is sufficient nursing care; antivenom treatment can (and should) be given to obviously envenomed patients in smaller hospitals without laboratory services prior to retrieval.

Specifically, the guidelines recommended that at a minimum ALL hospitals in NSW should have:

- One (1) vial of brown snake antivenom.
- One (1) vial of tiger snake antivenom.
- One (1) vial of polyvalent antivenom should be kept in larger regional and referral hospitals, retrieval services across NSW, and in larger hospitals west of the Great Dividing Range for mulga snake.
- Two (2) vials of funnel-web spider antivenom should be kept in all hospitals where the spider occurs.

USE OF THE GUIDELINE

The guidelines should be used as a clinical resource document to assist in the assessment, decision making and clinical management of patients with confirmed or suspected snakebite or spiderbite, and the appropriate levels, type and location of stored antivenom in NSW health facilities.

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_005.html

INSERTION AND MANAGEMENT OF URETHRAL CATHETERS FOR ADULT PATIENTS (GL2021_015)

GL2021_015 rescinded GL2015_016

GUIDELINE SUMMARY

This Guideline provides best practice principles for inserting and managing urethral catheters for adult patients in NSW Health Organisations (HOs) with the aim of reducing unnecessary catheterisation and minimising the risk of catheter-associated urinary tract infection (CAUTI).

This document will support trained and credentialed health workers (HW) who are competent in urinary catheter practice for acute care settings.

KEY PRINCIPLES

To minimise the risk of a patient acquiring a CAUTI, clinicians are to ensure that indwelling urethral catheters are always:

- Inserted only if clinically indicated
- Inserted and maintained using aseptic technique
- Removed as soon as the clinical need has been resolved.

Catheter insertion, routine care and catheter removal are to be documented in the patient's healthcare record.

USE OF THE GUIDELINE

The Chief Executives of NSW HOs are responsible for the implementation of this Guideline within their services/facilities to ensure that local protocols or operating procedures are in place, aligned and consistent with the Guideline.

All clinicians working in adult acute care settings and who are involved in the care of patients with catheters should be aware of the Guideline and actively participate in its implementation.

The Clinical Excellence Commission will have responsibility for producing resources for NSW HOs to support the implementation of this Guideline.

The Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_015

339(31/08/21)

COMPACKS PROGRAM GUIDELINES (GL2016_023)

PURPOSE

The ComPacks Program Guideline is a resource for frontline Local Health District staff and ComPacks Service Provider staff to facilitate the implementation of the Program.

KEY PRINCIPLES

ComPacks was developed specifically for people in NSW Public hospitals who need immediate support to return home safely using a combination of community case management and non-clinical community services. A ComPacks package may include assistance with personal care, domestic assistance, transport and social support, and is available for up to six weeks from the time of discharge from hospital.

The ComPacks Program Guidelines outline the key components of the ComPacks program, including eligibility, referrals, services, assessment, stakeholder responsibilities and coordination and performance management.

USE OF THE GUIDELINE

In 2010 a resource tool kit was implemented for the ComPacks Program. The ComPacks Program Guidelines is an extension of this toolkit and is designed as a resource for frontline Health staff, Local Health District Relationship Managers, ComPacks Service Provider Case Managers and Relationship Managers. It was developed in consultation with representatives from these groups.

The Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2016_023

315(26/09/16)

CARDIAC MONITORING OF ADULT CARDIAC PATIENTS IN NSW PUBLIC HOSPITALS (IB2022_027)

IB2022_027 replaced GL2016_019

PURPOSE

This Information Bulletin is to notify NSW Health that the *Cardiac monitoring of adult cardiac patients in NSW public hospitals* document has been revised and is now available on the Agency for Clinical Innovation website as a clinical practice guide.

KEY INFORMATION

The Agency for Clinical Innovation Cardiac Network has revised the *Cardiac monitoring of adult cardiac patients in NSW public hospitals* document in line with contemporary evidence and it has been published as a clinical practice guide.

The revised document provides further clarification on:

- The role for, limitations of, and institutional resources to support ST segment and QT interval monitoring.
- Lead selection according to indication.
- Advice on avoidance of inappropriate monitoring in low-risk patients.
- Advice on avoidance of inappropriate monitoring in low-risk patients.
- Safe adjustment of alarm parameters to reduce alarm fatigue and the expectations for reviewing and documenting cardiac monitoring alarms.
- The skills within the advanced escort skill set that are patient-dependent.
- The capacity for senior nurses with advanced cardiac skills to act as delegate decision makers about cardiac monitoring.
- The revised monitoring requirements for clinically stable patients awaiting pacemakers or internal cardioverter defibrillator implantation and for patients receiving inotropes as supportive care at the end of life.

NSW CLINICAL SERVICE FRAMEWORK FOR CHRONIC HEART FAILURE
(GL2017_006)

PURPOSE

The NSW Clinical Service Framework for Chronic Heart Failure (CHF) provides nine evidence-based standards to support clinicians in community and hospital environments to provide best-practice care in the prevention, diagnosis and management of people with CHF across the continuum of care.

Compliance with the Framework will improve patient outcomes and experience and reduce length of stay and re-hospitalisation.

KEY PRINCIPLES

- Management of people with CHF should align with the nine evidence-based standards described in the Framework.
- The document may be used by general practitioners, nurses, doctors, allied health staff and Aboriginal health service providers.
- The Framework provides guidance for a range of clinical settings including Primary Health Networks (PHNs) and general practices, Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Medical Services (AMS), community health services, hospitals and Local Health Districts (LHDs).
- Health services for people with chronic and complex conditions need to be reconfigured to be more integrated, coordinated and patient focused throughout the continuum of care.
- People with CHF often have multiple comorbidities and physiological and psychosocial needs that change over time. Access to different levels of care at various stages of the disease trajectory is needed to reduce presentations to hospital.
- The General Practitioner (GP) or other primary care provider plays a central coordinating role in the person-centred medical home model where care is delivered in partnership with a multidisciplinary team. The GP may be able to reduce unplanned admissions by early identification of patients with increasing care needs and planned admission for rapid assessment and treatment rather than an emergency hospital presentation.
- Supported self-management underpins the aims of services, therefore, clinical team members should be trained in health behaviour change to deliver the service in partnership with the patient, their family and carers who are central to decision making and setting patient-centred achievable goals.

USE OF THE GUIDELINE

Chief Executives
- Should provide the document to staff working in areas where patients may present for example, emergency departments, cardiac and medical wards

Directors of Clinical Governance and Patient Flow Managers
- Should monitor the implementation of the Framework and its impact on patient experience, outcome and patient flow within their facilities

Nurse Unit Managers
- Should support their staff to implement the Framework

Nursing Staff
- Should provide evidence-based care as recommended in the protocol

Medical Staff (including GPs working in mainstream and Aboriginal Health Services)
- Should assess, risk stratify and manage patients using the 12 evidence-based minimum standards described in the protocol.

The NSW Clinical Service Framework for Chronic Heart Failure Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_006

GROWTH ASSESSMENT IN CHILDREN AND WEIGHT STATUS ASSESSMENT IN ADULTS (GL2017_021)

PURPOSE

To support core patient care, this document describes the following:

- A standardised approach to measuring weight and height in children and adults, and to measuring length and head circumference in younger children.
- Interpreting and recording these measurements as part of determining weight status.
- Key equipment and patient considerations around taking these measurements.

KEY PRINCIPLES

Weight and height measurement of children and adults – or weight, length and head circumference measurement of younger children – should be performed on a regular basis as part of providing good clinical care. For example, it is necessary to measure weight, height and head circumference in order to monitor children's growth. It is also necessary to measure weight and height (or length) to determine weight status in children and adults.

Standardised measurement and interpretation of weight, height, length and weight status, will improve the accuracy and usefulness of measurements over time and across facilities, and support clinical decision making.

USE OF THE GUIDELINE

This guideline helps clinicians perform weight, height, length, or head circumference measurements of their patients, and to use these measurements to assess their patients' weight status.

This guideline also helps managers design and establish workflow practices that enable routine measurements.

The Growth Assessment in Children and Weight Status Assessment in Adults Guideline is available at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2017_021

YOUTH HEALTH AND WELLBEING ASSESSMENT GUIDELINE (GL2018_003)

PURPOSE

This guideline presents the current best evidence for conducting a youth health and wellbeing Assessment. Its purpose is to inform practice for healthcare providers to achieve the best possible care in NSW.

This guideline is primarily for clinicians caring for young people (12-24 years old) in a paediatric, adolescent or adult healthcare setting.

This guideline supports NSW Health's commitment to implement appropriate psychosocial assessment tools, such as HEEADSSS, to assess and respond to the holistic health and wellbeing needs of young people outlined in the *NSW Youth Health Framework 2017-2024* (PD2017_019).

KEY PRINCIPLES

Youth health and wellbeing assessments are important to assist clinicians to identify and respond early to areas of concern in a young person's life that might affect their health and wellbeing.

The youth health and wellbeing assessment is not a diagnostic tool. It is a holistic, flexible approach designed to build rapport and engage with a young person in a clinical setting. The information gathered can then be used to directly address any concerns and/or refer a young person for a specialist response.

The most widely used youth health and wellbeing assessment tool in Australia and internationally is known as a HEEADSSS assessment.

Each letter of HEEADSSS reflects a major domain of a young person's life. Capturing information in each domain helps reveal risks, behaviours and protective factors. It helps to identify areas of intervention where the clinician can work with the young person to achieve better health outcomes.

- **H** Home
- **E** Education and Employment
- **E** Eating and Exercise
- **A** Activities, Hobbies and Peer Relationships
- **D** Drug Use (cigarettes, alcohol)
- **S** Sexual Activity and Sexuality
- **S** Suicide, Self-Harm, Depression, Mood, Sleeping Patterns
- **S** Safety and Spirituality

In general, a youth health and wellbeing assessment (12-24 years old) should be conducted with every young person who attends a health service or hospital. Where appropriate young people in an adult or paediatric inpatient area within a hospital should have a youth health and wellbeing Assessment completed in conjunction with other screening assessment/admission processes.

Clinical judgement should be used to determine the appropriateness of the assessment for 12-24 year olds. This includes considering the young person's health condition, maturity, the environment and health service context (for example, sufficient time or privacy may not be available in an Emergency Department context).

In general an assessment is done through conversation with a young person. On some occasions, where it is more appropriate a young person can be asked to complete the Youth Health and Wellbeing Assessment Chart (Appendix 1).

It is essential that clinicians/healthcare workers read and understand this guideline in particular Sections 6 to 11 of the Guideline.

- Section 6 Issues covered by a youth health and wellbeing assessment
- Section 7 When to conduct a youth health and wellbeing assessment
- Section 8 Youth health and wellbeing assessment flow diagram
- Section 9 Self-completed assessment using Youth Health and Wellbeing Assessment Chart
- Section 10 Setting up and concluding the assessment
- Section 11 Contraindications and cautions

USE OF THE GUIDELINE

This guideline should be considered when conducting Youth Health and Wellbeing Assessment with young people (12-24 years old) who attend a health service or hospital.

This document outlines the -

- approach that should be taken by NSW Health staff when conducting a youth health and wellbeing assessment (Sections 7 - 10)
- issues to consider when implementing the youth health and wellbeing assessment within different health settings and with different age groups (Sections 11 - 12)

A range of resources for workers are available to support Youth Health and Wellbeing Assessment when needed (Appendices 1 – 4).

The document should not be seen as a prescriptive set of rules to be applied without the clinical input and discretion of the managing health professionals. Each patient should be individually evaluated and a decision made as to appropriate management in order to achieve the best clinical outcome.

The Youth Health and Wellbeing Assessment: Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_003

325(01/02/18)

ESTABLISHING A SUBCUTANEOUS IMMUNOGLOBULIN (SCIG) HOSPITAL PROGRAM (GL2020_024)

GUIDELINE SUMMARY

NSW Health's commitment to providing world class clinical services, enhancing the quality of life of its patients and empowering patients to be partners in their care underpin the matter covered in this Guideline.

This Guideline outlines the principles for establishing a SCIg hospital program to train and support suitable, SCIg-eligible patients to treat themselves at home in familiar surroundings and at a time that suits them. Trained patients will not have to travel to hospital for regular intravenous infusions of immunoglobulin and will be able to pick up their treatment product as close to their home as possible.

333(27/11/20)

KEY PRINCIPLES

This Guideline applies to all NSW Health staff involved in the establishment and running of a SCIg hospital program.

Local Health Districts (Districts) involved in the planning of a SCIg hospital program are encouraged to promote the collaboration of clinical specialty areas to ensure equity of patient access to the program. In addition, consideration should be given to patients being able to access training and product as close to their homes as possible.

The hospital General Manager must approve the provision and resourcing of SCIg clinical services by facilities in their hospital.

SCIg may be managed (ordered, receipted, stored and released for dispensing) by a facility's pathology/transfusion medicine laboratory or by the facility's pharmacy department. The unit/facility that manages SCIg must be registered as an Approved Health Provider (AHP). If the unit/facility that manages SCIg is different from the unit/ facility that normally manages blood and blood products, a second AHP registration will be required.

The NSW Ministry of Health's Office of the Chief Health Officer must be advised of the following by the hospital General Manager:

1. approval has been given to commence providing subcutaneous immunoglobulin therapy at the health facility;
2. health facility has all the necessary processes and resources in place to support service provision; and
3. in the event that a second AHP has been arranged, provide confirmation that the Local Health District Blood Management Committee and Drug and Therapeutics Committee (or their equivalents) will be responsible for oversighting the governance of SCIg in the facility.

BloodSTAR must be used by treating clinicians to obtain authorisation for patients to receive government-funded subcutaneous immunoglobulin. Before entering patient details into BloodSTAR the treating clinician must obtain the patient's consent to do so.

In addition, patient consent is required before the patient is treated with SCIg. BloodNet must be used to order SCIg, to replenish SCIg imprest, to receipt the product and to record SCIg dispensing episodes.

There is no prescriptive dispensing arrangement for SCIg but the product must be dispensed by a pharmacist and recorded by them in iPharmacy. The dispensing arrangement that a facility proposes to adopt must be endorsed by the District Drug and Therapeutics Committee and the Blood Management Committee (or their equivalents) and approved by the District Director of Pharmacy (or equivalent).

It is NSW Health policy that hospital pharmacies can charge a dispensing fee for SCIg in line with the Pharmaceutical Benefits Scheme (PBS) fee. Chief Executives may waive the fee either by a local directive or on a case-by-case basis. If patients are charged a dispensing fee for SCIg they must be charged a single fee, regardless of the duration of supply and the number of different vial sizes and doses prescribed.

Public hospitals can dispense SCIg to a community patient who has a prescription from a private authorised prescriber.

Establishing a SCIg hospital program guideline is available at
https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2020_024

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL'S NATIONAL GUIDELINES FOR DRINKING ALCOHOL (IB2021_001)

PURPOSE

The National Health and Medical Research Council (NHMRC) released '2020 Australian Guidelines to Reduce Health Risks from Drinking Alcohol'.

These Guidelines replace the NHMRC's 2009 Australian Guidelines to Reduce Health Risks from Drinking Alcohol.

This Information Bulletin informs all NSW Health entities to update resources, programs, policies, guidelines and public health messages that reference the Australian guidelines, calling attention to the changes since 2009.

KEY INFORMATION

The Guidelines have been developed from a rigorous review of evidence over a four-year period. They are backed up by extensive analysis of systematic reviews of the health effects of drinking alcohol and data on Australian drinking patterns which is available at https://www.nhmrc.gov.au/health-advice/alcohol

The NHMRC was guided by a group of independent health experts including doctors, medical and public health professionals, researchers and consumer representatives on an Alcohol Working Committee. The Guidelines were reviewed and endorsed by NHMRC Council which included Chief Medical Officers of the Commonwealth, each State and Territory, together with leaders in health, research and ethics. All Australians could comment whilst the Guidelines were being drafted, including the alcohol industry.

Main changes to the revised guidelines are:

Guideline 1: Adults

To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.

The less you drink, the lower your risk of harm from alcohol.

Guideline 2: Children and people under 18 years of age

To reduce the risk of injury and other harms to health, children and people under 18 years of age should not drink alcohol.

Guideline 3: Women who are pregnant or breastfeeding

A. To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol.
B. For women who are breastfeeding, not drinking alcohol is safest for their baby.

CLINICAL PRINCIPLES FOR END OF LIFE AND PALLIATIVE CARE (GL2021_016)

GUIDELINE SUMMARY

This Guideline outlines the clinical principles and key actions that will support good quality, evidence-informed practice and improvement in the provision of end of life and palliative care (EoLPC) in NSW. This Guideline aligns with the *NSW Health End of Life and Palliative Care Framework 2019-2024* (the Framework).

The key actions described in this Guideline have been identified as meaningful, measurable and achievable priority actions that can be implemented locally to drive state-wide, coordinated efforts to address the priority areas of the Framework.

KEY PRINCIPLES

The objectives of this Guideline are to identify overarching key principles which guide provision of EoLPC, identify key actions which will contribute to achieving the state-wide priorities of the Framework and communicate expectations regarding alignment with published 'standards' for the delivery of EoLPC to all people across NSW.

All NSW Health services providing EoLPC are to ensure they have evidence-informed, locally developed model/s of care that meet the needs of their community and, at a minimum:

- address the five priority areas of the Framework
- incorporate the nine key actions from this Guideline
  - Screening and identification
  - Triage
  - Comprehensive assessment
  - Care planning
  - Open and respectful communication
  - Symptom management
  - 24/7 access to support
  - Place of death
  - Grief and bereavement support.
- ensures reference with applicable nationally agreed standards for the provision of EoLPC
- ensures use of appropriate, evidence-based tools and resources
- articulates pathways to ensure access is available to multidisciplinary services
- integrates the use of clinically appropriate virtual care modalities to support the provision of integrated care
- improves equitable access for priority and underserved populations.

USE OF THE GUIDELINE

NSW Local Health Districts (Districts) and Specialty Health Networks (Networks) are responsible for ensuring their services and facilities meet the requirements of this Guideline. It is recommended that local governance mechanisms are in place to oversee the implementation of the Guideline.

All staff and services who provide end of life care and/or palliative care (includes, but is not restricted to, specialist palliative care services) are to be aware of this Guideline and actively participate in its implementation.

This Guideline is applicable across all care settings including community settings, nonadmitted settings, admitted settings, or other settings in which NSW Health services are providing care. It is relevant to all people (neonates, infants, children, adolescents, young adults, adults and older adults) who have a life-limiting illness or are identified as approaching the end of life.

Districts and Networks are to use this Guideline to:

- develop, implement and monitor strategies aligned to the key actions specified in this Guideline
- understand the expectations of NSW Health regarding alignment with relevant nationally agreed standards for EoLPC
- ensure locally developed model/s of care reflect appropriate, evidence-informed tools and resources
- assist in meeting accreditation requirements.

The Guideline is available at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_016

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https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_016

339(06/09/21)

DOMESTIC VIOLENCE ROUTINE SCREENING (PD2023_009)

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

347(03/04/23)

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning. All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

The full Domestic Violence Routine Screening policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_009

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

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SECLUSION AND RESTRAINT IN NSW HEALTH SETTINGS (PD2020_004)

PD2020_004 rescinds PD2012_035 and PD2015_004

POLICY STATEMENT

NSW Health's commitment to preventing seclusion and restraint aims to improve safety for people accessing public health services and staff.

This Policy Directive outlines the principles, values and procedures that underpin efforts to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint in NSW Health settings.

SUMMARY OF POLICY REQUIREMENTS

This Policy applies to all NSW Health staff working in all NSW public health settings.

Seclusion and restraint must only be used as a last resort, after less restrictive alternatives have been trialled or considered. The principle of least restrictive practice is common across all settings. It means NSW Health staff will maximise a person's choices, rights and freedom as much as possible while balancing healthcare needs and safety for all.

The safety of staff must be maintained at all times, including during the planning, initiation, undertaking, monitoring and cessation of the seclusion and restraint of a person.

NSW Health services must have systems that:

- minimise and, where possible, eliminate the use of seclusion and restraint
- govern the use of seclusion and restraint in accordance with legislation
- report use of seclusion and restraint to the governing body.

All local health districts, specialty health networks and NSW Ambulance must have local procedures in place that are consistent with the principles and requirements identified in this policy by July 2020.

NSW Health districts and networks and NSW Ambulance must develop, implement and annually review a service level action plan to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint, in collaboration with staff, those accessing health services, carers and families.

Seclusion and Restraint in NSW Health Settings: Procedures.

1 BACKGROUND

1.1 About this document

NSW Health is committed to minimising and, where safe and possible, eliminating the use of seclusion and restraint.

The aim is to maintain and protect the safety of all people accessing services, staff and visitors.

It is not unusual for staff or others to raise concerns that safety will be compromised if seclusion and restraint are reduced. Current evidence indicates that reducing seclusion and restraint will minimise physical and psychological harm experienced by people accessing services and staff. This policy aligns with the National Safety and Quality Health Service Standards (2nd edition) requirements for minimising harm.

It articulates principles that apply to all NSW Health settings. It describes mandatory requirements and how these are tailored for specific healthcare contexts.

Section 3.9 outlines additional requirements for specific settings.

The principle of least restrictive practice is common across all settings. It means NSW Health staff will maximise a person's choices, rights and freedom as much as possible while balancing healthcare needs and safety for all. This requires leadership committed to:

- protection of human rights
- maintaining a safe workplace
- a just and learning culture
- a prevention approach to reducing seclusion and restraint
- respectful behaviours and interactions at all service levels
- recognising and addressing potentially traumatising or triggering environments and behaviour
- adequate staffing and resources, including training and supervision
- collaboration and co-design with those directly affected by the practices of seclusion and restraint.

1.2 Key definitions

NSW Health recognises that language has an impact on people and the use of inclusive and contemporary terms can minimise stigma.
This Policy is informed by current practice and consultation with people accessing NSW Health services and service providers. Key definitions for seclusion and restraint align with the National Safety and Quality Health Service Standards (2nd Edition).

Definitions may vary for legal purposes. Where there is variation, practice must be consistent with applicable legislative definitions and requirements. **In some cases, practices that do not meet the policy definition of restraint used in this document will still require appropriate consents.**

Given the scope of this Policy, the words 'person', 'people' or 'individuals' have been used to refer to anyone accessing NSW Health services

Word/Term	Definition	Additional notes
Acute Sedation	Acute sedation is the temporary use of medication to reduce agitation, irritability and ASBD for the purpose of assessment and treatment.	Acute sedation is not considered chemical restraint when it allows for assessment to be continued and treatment for the underlying condition to be commenced. NSW Health recognises that acute sedation may be experienced or perceived as coercive by people accessing services, carers, families and others. It is important that this practice is safely managed by expert clinical decision making around the level of sedation and by adherence to current clinical guidelines. The aim is to achieve an appropriate and safe level of sedation quickly with sufficient medication to manage ASBD and to facilitate an accurate assessment and appropriate management of the person's underlying condition. The level of sedation should ensure the person is drowsy but they must be rousable.
Acute Severe Behavioural Disturbance (ASBD)	Behaviour that puts the person or others at immediate risk of serious harm. This may include threatening or aggressive behaviour, extreme distress and self-harm.	Examples of indicators of ASBD may include: aggression, hostility, physical and verbal intimidation, hitting, spitting, cutting, kicking, throwing objects, damaging equipment, using weapons or objects as weapons, and highly disinhibited behaviours, including sexual disinhibition. While behavioural concerns associated with issues such as acquired brain injury, dementia or cognitive impairment may be longstanding, the use of the word 'acute' signals the need to address the behavioural concern now.
Carer	Carer is used to describe a person who provides ongoing unpaid support to a family member or friend who needs help because of disability, medical condition (terminal or chronic), mental illness or ageing. Carers may support their family member or friend when accessing NSW Health services.	Carer is defined under the NSW Carers (Recognition) Act 2010. Consent and information provision to a carer must be in line with the relevant legislation. Depending on legislation, such as Mental Health Act 2007, different terms include: Representative; primary care-giver; primary carer; person responsible; designated carer; principal care provider.
Chemical Restraint	The use of a medication or chemical substance for the primary purpose of restricting a person's movement.	The definition of chemical restraint is a challenging issue. This is partly due to the need to attribute a purpose to the use of the medication. Medication (including PRN) prescribed for the treatment of, or to enable treatment of, a diagnosed disorder, a physical illness or a physical condition in line with current clinical guidelines is not considered chemical restraint.

Least Restrictive Practices	Practices that maximise the autonomy, rights, freedom, wellbeing and safe care of the person as much as possible while balancing healthcare needs and safety for all.	Environments should be safe, supportive and least restrictive. Staff must not withhold access to spaces or items unnecessarily, unless there are safety reasons for people accessing services, staff and others.
Mechanical Restraint	The application of devices to a person's body to restrict their movement. This is to prevent the person from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.	Mechanical Restraint devices must be authorised/approved by designated staff for use in each setting and for each occurrence of use and must be used only by authorised and trained staff. The use of furniture or other equipment solely for the purpose of restraining a person's freedom of movement is considered mechanical restraint. The application of limb restraints on both arms and legs at once is known as a four-limb restraint and requires a high level of observation. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury (for example, a splint to treat a fracture) is not considered mechanical restraint. In these instances, the appliances are the treatment. This is different from a device to restrain a person to ensure treatment is provided. Safety practices that are consistent with developmental norms, such as the use of cots, prams or high chairs for infants and toddlers, are not considered mechanical restraint. The use of wheelchairs or postural devices to assist mobility are not considered mechanical restraint. The use of bedrails as a safety mechanism to reduce the risk of a person accidentally falling out of bed is not considered mechanical restraint for the purpose of this policy, except in the circumstances associated with physical restraint as outlined in the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (see Section 3.8) and the Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019. An individual in a NSW Health aged care facility or hospital may specifically request to use a restrictive item to provide them with an enhanced feeling of safety or security. Where this is an informed decision, this individual’s choice should be acknowledged, monitored and documented in their Health Care Record. An informed decision would require that other options have already been discussed with the person.
Physical Restraint	The application by staff of ‘hands-on’ immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to	While restraint is often used when people exhibit ASBD, the definition also includes the use of physical restraint while administering medical procedures (e.g. blood tests) and to facilitate some treatments (e.g. inserting nasogastric tubes, anaesthetics, intubation).

	ensure that essential medical treatment can be provided.	Physically guiding or supporting a person, with their permission, to manage the same clinical procedures safely and effectively is distinguished from physical restraint by the degree of force applied and intention.
Restraint	The restriction of an individual's freedom of movement.	The scope of restraint in this policy is mechanical, physical and chemical restraint. These types of restraint are separately defined in this section for the purposes of this policy. Aged care legislation defines restraint as any practice, device or action that interferes with a person's ability to make a decision or restricts an individual's freedom of movement.
Seclusion	The confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.	The intended purpose, duration and location are not relevant in determining what is or is not seclusion. Seclusion applies even if the person agrees or requests the confinement. However, if voluntary isolation is requested by a person and they are free to leave at any time then this does not meet the definition of seclusion. The person's awareness that they are confined alone and denied exit is not relevant to the definition of seclusion. The structure and dimensions of the area to which the person is confined are not relevant. For example, if a person is confined alone and prevented from leaving a courtyard, safe assessment room, their bedroom or other area, this meets the definition of seclusion. If a staff member (or other) is with the person, this does not meet the definition of seclusion. For residential aged care, seclusion is considered an 'extreme restraint' and must not be used.

1.3 Legal and legislative framework

There needs to be a lawful purpose to restrain any person or to use seclusion.
All staff must understand relevant consent processes and legislative requirements for the use of seclusion and restraint in their setting.

The lawful basis will depend on the circumstances. In some cases, there will be consent.

This will often occur where restraint is an incidental part of treatment and the person, or their substituted decision maker, has given consent to the treatment and there is express or implied consent to the restraint. There may be a legislative basis underpinning the restraint or seclusion, such as restraint used to provide involuntary treatment to people detained under the Mental Health Act 2007. Where a person lacks capacity and there is a need to use seclusion or restraint, the Civil and Administrative Tribunal of NSW has the power to authorise a guardian to approve the use of restrictive practices.

Seclusion or restraint may be used as an act of self-defence to defend oneself or another person during an assault which is likely to continue or to prevent a threatened and imminent assault. In such cases, the person carrying out the restraint or seclusion must believe that it is:

- necessary to defend him or herself or another person, or to protect property, and
- a reasonable response to the circumstances.

In these circumstances, restraint or seclusion must only be carried out as a last resort and occur only until the risk has passed.

In all cases, no more force is to be used than is reasonable and proportionate in the circumstances and necessary to deal with the risk of harm.

A public health facility owes a duty of care to any person they restrain or seclude and is to take all reasonable steps to minimise harm and provide and maintain a safe workplace. Staff must be trained in the use of seclusion and restraint and must be aware of the impacts of such practices.

Local health districts (LHDs), specialty health networks (SHNs) and NSW Ambulance must adhere to legal, privacy and consent requirements, particularly in relation to:

- Aged Care Act 1997 (Cth)
- Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019
- Children and Young Persons (Care and Protection) Act 1998
- Carer Recognition Act 2010
- Drug and Alcohol Treatment Act 2007
- Guardianship Act 1987
- Health Records and Information Privacy Act 2002
- Mental Health Act 2007
- Mental Health (Forensic Provisions) Act 1990
- National Disability Insurance Scheme Act 2013 (Cth)
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth)
- Quality of Care Principles 2014 (applies to Aged Care)
- Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019
- Work Health and Safety Act 2011.

Staff are encouraged to read this policy in conjunction with other NSW Health and Commonwealth policies, guidelines and reports (see Attachment 2). 327(06/03/2020)

2 PRINCIPLES AND VALUES

NSW Health is committed to carrying out the principle of least restrictive practice in line with a human rights based approach and the PANEL principles of Participation, Accountability, Non-discrimination, Empowerment, Legality. The principles of prevention and trauma informed care also apply to this policy.

Application of these principles is supported by NSW Health's CORE values of Collaboration, Openness, Respect and Empowerment.

Principle	Applying the principle
Prevention	NSW Health services use a proactive and multicomponent approach and structured quality improvement to reduce seclusion and restraint. The Six Core Strategies to Reduce Seclusion and Restraint Use is an example of a multicomponent prevention approach. Services strengthen a culture of mutual respect, quality and safety and provide adequate resourcing to support the prevention of seclusion and restraint. Prevention occurs at both a system level (therapeutic programs, models of care, built environment) and an individual level (risk assessment, safety planning, positive behaviour support).
Least restrictive	NSW Health services maximise a person's choices, rights and freedom as much as possible while balancing safety (of people accessing services, staff and others) and healthcare needs. Environments should be safe, supportive and respect a person's dignity and privacy.
Participation	NSW Health services take a person-centred approach and collaborate with people accessing services and their carers and family regarding their care and treatment.
Accountability	NSW Health services have governance arrangements to authorise and review the use of seclusion and restraint.
Non-discrimination	NSW Health services respect the rights and dignity of all people. Services pay attention to the needs of particular groups that have faced barriers to realising their rights. This includes but is not limited to Aboriginal people, people with disabilities, children and young people, older people, refugees, lesbian, gay, bisexual, transgender, intersex (LGBTI) people, culturally and linguistically diverse (CALD) groups.
Empowerment	NSW Health services work in partnership with people and their carers and families. Collaboration and co-design happen at an individual and a service level. Services promote hope and build trust.
Legality	NSW Health services comply with relevant legislation, understand the human rights implications of restrictive practices and continually consider the principles of fairness, respect, equality, dignity and autonomy, as well the safety of people accessing services, staff and others.
Trauma informed	NSW Health services understand and respond to the prevalence and impacts of trauma, supporting care that does not traumatise or re-traumatise the person. Services provide care that is person-centred and recovery-oriented and upholds human rights. Services recognise that seclusion and restraint can be very traumatic for many people and may increase distress, re-traumatise and trigger memories from past trauma. Trauma informed care is applied in all health settings. Services recognise and address provocative and triggering practices and behaviour. NSW Health services also recognise and respond effectively to the risk of trauma for staff. NSW Health services recognise that many Aboriginal people have experienced and continue to experience significant intergenerational and other trauma. They take this into account when designing and providing care. Services consider cultural obligations (e.g. Aboriginal family and community roles) and personal backgrounds of staff when allocating roles during a seclusion or restraint episode.

3 KEY REQUIREMENTS

NSW Health organisations must recognise that while the use of seclusion and restraint as a last resort may be necessary to keep people safe, it can also be traumatic and harmful for staff, people accessing services, carers and families and must be minimised.

Particular attention must be given to:

- Aboriginal people and families
- people with disabilities
- people with mental health issues or substance misuse
- people with medical conditions (including pregnancy)
- people with identified trauma
- children and young people
- older people, especially those with cognitive impairment or behavioural and psychological symptoms of dementia (BPSD)
- refugees
- LGBTI people
- CALD groups
- people who are at risk of self-harm or suicide
- staff at risk of vicarious trauma.

3.1 Prevention

NSW Health organisations must develop and implement a service level action plan to reduce and where safe and possible prevent seclusion and restraint, in collaboration with staff, people accessing services, carers and families.

In addition, NSW Health organisations must have local protocols and procedures outlining prevention strategies to reduce, and where possible, eliminate the use of seclusion and restraint.

NSW Health organisations must ensure adequate staff numbers, peer support and appropriate skill mix to maintain a safe workplace for people accessing services, staff and others.

Proactive approaches that take steps to address the person's needs (e.g. communication strategies, sensory preferences, positive behaviour support plans) are encouraged.

NSW Health staff must collaborate with the person, their carers and families (as applicable), to understand potential triggers which may cause the person to become distressed and unsafe. Safety planning is intended to identify individual strengths, self-soothing techniques and helpful strategies for staff to use to attempt to de-escalate potential risk. Trauma informed care principles must guide the prevention of seclusion and restraint.

NSW Health organisations must ensure staff have appropriate access to mandatory training to prevent and respond to potential and actual aggression and violence in line with PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations. This includes understanding the key causes and components of difficult, challenging or disturbed behaviour, prevention and de-escalation.

3.2 Use of seclusion and restraint

NSW Health organisations must develop local protocols to guide the use of seclusion and restraint.

3.2.1 Least restrictive

NSW Health staff must only use seclusion and restraint:

- where there is a legal basis to do so
- as a last resort to prevent serious harm, usually associated with ASBD
- to allow administration of lawful medical treatment
- after less restrictive alternatives, including prevention strategies, have been trialled or considered, where safe to do so
- proportionate to the risk of harm
- for the minimum duration necessary.

In considering alternatives, NSW Health staff are to assess and act on the need to withdraw to a safe place and call for assistance if faced with unsafe situations.

Health staff must not place themselves or others at unnecessary risk in carrying out their duties. In practice, there may be times when the duty of care to people accessing services may require intervention but at no time is the duty of care to override a staff member's right to safety.

3.2.2 Initiating seclusion or restraint

- The decision to use seclusion or restraint must be made using all available information. This includes assessing the known clinical history of allergies and adverse effects of medication(s) where acute sedation is used.
- The amount of force used during any restraint must always be the minimum amount necessary and proportionate to the risk.
- If seclusion and restraint is initiated, NSW Health staff must cease their use as soon as the reason for the intervention has ended and it is safe to do so.
- NSW Health staff must ensure that any interference with a person's privacy and dignity is kept to the minimum necessary to protect the safety of all, especially when restraint occurs in public areas and shared treatment areas or rooms.
- Placing people in the prone position entails a significantly increased risk of harm to the person. There have been instances of sudden death, often associated with the administration of parenteral medication while in prone restraint.
- NSW Health staff should avoid prone restraint. Safety Notice 003/16 must be followed if prone restraint is used.
- Staff are to avoid restraining in a way that interferes with the person's airways, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen or by obstructing the mouth or nose.
- Staff must avoid bending the person's head or trunk towards the knees if they are seated.
- The restraint of a patient or an individual in clinical care areas is the role of the clinical team, with supplementary support, if this is necessary, provided by security staff at the direction of clinical staff.
- Security staff may also be required to provide supplementary safety support during the seclusion of a person but must never be required to replace a clinical staff member where clinical observations are required.

3.2.3 Ratifying and subsequent clinical reviews of the use of seclusion and restraint

- Seclusion and restraint is often initiated at short notice, in response to an emergency situation.
- To ensure a robust clinical review, all use of seclusion and restraint must be ratified by a senior clinician as soon as possible, but not more than one hour after the practice was initiated. The outcome of the review will be to cease the practice or to ratify its continuation. The review must be documented in the Health Care Record.
- If seclusion or restraint has been ceased prior to ratification, the person is to be examined by a medical officer as soon as possible after the event.
- After the initial ratification, a senior clinician must review the person as frequently as possible but not less than every four hours, until the intervention is ceased.
- An additional review must take place at each shift handover.
- If seclusion or restraint continues for 24 hours or more, an additional review, which includes multidisciplinary involvement, must take place.
- The senior clinician ratifying or reviewing the practice must not have been involved in the decision to initiate seclusion and/or restraint. NSW Health requires ratification and reviews to be carried out by staff with seniority and skills in risk management, clinical safety and trauma informed care.
- The senior clinician may vary depending on time of day, context, local resources and available skill mix. Examples include a staff specialist, Visiting Medical Officer, nurse unit manager or paramedic in an ambulance. Reviews are to be carried out in-person or, where required, via phone or videoconference.
- NSW Health staff must make every effort to ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies, including bedding and clothing appropriate to the circumstances, food and drink and adequate hygiene and toilet arrangements.
- NSW Health must consider staffing and skill mix required to undertake increased observations and perform reviews. Senior medical staff must be considered alongside nursing and allied health provision to provide appropriate multidisciplinary skill mix.

3.3 Observations and engagement during seclusion and restraint

- NSW Health requires high levels of clinical care, monitoring and reporting when seclusion and restraint are used. Any deterioration in a person's physical condition, mental state or cognitive state must be managed promptly.
- For the safety of the person, NSW Health clinical staff must continuously observe, and where possible, engage with a person in seclusion or four-limb mechanical restraint for the duration of the practice.
- For other forms of restraint, NSW Health clinical staff must continuously observe and, where possible, engage with the person for the first hour. After the first hour, NSW Health staff must clinically observe a person in restraint at least every 15 minutes.
- For people at higher risk during the intervention, more frequent and additional monitoring may be indicated, for example where acute sedation has been used
- Clinical monitoring must include vital signs (respiratory rate, blood pressure, temperature and pulse rate). The frequency of monitoring vital signs must be determined by the Clinical Team, parameters set and reviewed when required.

- It may not be possible to monitor all of the vital signs if, by doing so, safety of the staff or person being secluded is compromised. However, in those circumstances, continuous visual observation is required to ensure safety. If vital signs cannot be taken, staff must ensure the reasons are documented in the Health Care Record.
- Observations must be conducted in person and must not be undertaken using closed circuit television (CCTV).

3.4 Governance of seclusion and restraint

- NSW Health staff must adhere to the legal framework authorising the use of seclusion and restraint.
- NSW Health organisations must ensure that there are clinical governance processes for review of all instances of seclusion and restraint within the healthcare setting to improve safety and quality.
- NSW Health staff must notify a senior manager (or on-call manager) if seclusion is used, as soon as practicable.
- The NSW Health Incident Management Policy (*PD2019_034*) requires NSW Health staff to notify all identified incidents, near misses and complaints in the incident management system (IIMS) or IMS+. Staff must include information about seclusion and restraint in these reports, where applicable.
- Where an adverse event occurs related to seclusion and restraint, NSW Health organisations must implement open disclosure, as required under the NSW Health Opend Disclosure Policy (PD2014_028).
- Where mechanical restraint devices are used, NSW Health organisations' governance committees must review and approve their use by the specific facility or unit. Specific policies, procedures and infection control advice must guide their use. These organisations must provide staff with specific training in the use of mechanical restraint devices.

3.5 Monitoring the use of seclusion and restraint

NSW Health staff must document all episodes of seclusion and restraint and debriefing sessions in the Health Care Record in proportionate detail to enable a review of practice.

Records should include:

• IIMS incident number (where seclusion or restraint is part of a reportable incident) • antecedents • adherence to prevention strategies • alternative least restrictive interventions trialled or considered • reason for seclusion or restraint • staff who initiated the use of seclusion or restraint • Aboriginal identification • authorisation • location of seclusion or restraint episode • medication offered or administered • reviews by senior staff	• frequency of observations • any physical injury • notification of family or carer • clinical examinations undertaken and outcomes • food and fluid intake • start and finish time of seclusion and/or restraint • active practices to reduce duration • debriefing, including service user and family/carer feedback • identification of future prevention and intervention strategies • multidisciplinary review • review of care plan.

NSW Health organisations must collect data and report on episodes of seclusion and restraint in accordance with this policy, legislative requirements and the National Safety and Quality Health Service Standards (2nd edition).

NSW Health organisations must make information and data about the use of seclusion and restraint available to staff, people accessing services and their carers and family to support quality improvement and aid preventive approaches.

3.6 Notification

Where legally permitted and after considering privacy requirements, NSW Health staff must make every effort to notify the following persons (as applicable to the person and legal status) about the use of seclusion and restraint and the reasons for using it as soon as practicable:

- a carer
- a guardian
- a parent if the person is under the age of 16 years
- other, as appropriate and identified by local protocols (e.g. senior executive).

This may not be feasible in specific situations, for example, care by NSW Ambulance.

3.7 Debriefing

NSW Health organisations must have protocols for debriefing after the use of seclusion or restraint, including safe and appropriate involvement of people who have been secluded or restrained, their carers and family (as applicable) and staff.

This may not be appropriate or feasible in all cases (e.g., care provided by NSW Ambulance).

Debriefing processes are intended to provide an opportunity to identify systemic practices and individual factors that provoke or trigger incidents. Debriefing should aim to maximise learning, minimise any potential traumatising effects and identify strategies to prevent future incidences.

3.8 Prohibited practice

NSW Health staff must not:

- use seclusion and restraint as a form of discipline, punishment or threat
- use seclusion or restraint as a means to reduce behaviours not associated with immediate risk of harm
- use seclusion for people who are actively self-harming or suicidal
- seclude a person who is also being mechanically restrained
- use metal handcuffs or hard manacles as a form of mechanical restraint (although a person may be in metal handcuffs when they have been transported by police or other custodial staff and remain under police or other custodial supervision while in the health facility)
- use vest restraints for older people.

4 ADDITIONAL REQUIREMENTS FOR SPECIFIC SETTINGS

4.1 Declared emergency departments and mental health units

As defined under the Mental Health Act 2007.

All mental health inpatient services must have 24-hour, everyday on-site supervision from accountable management representatives. This supervision must include in-person rounding on every shift.

In mental health units, each seclusion and restraint (currently physical and mechanical) episode must also be recorded in a dedicated Register to allow for reporting. This requirement also applies to seclusion and restraint of mental health consumers in declared emergency departments.

The Register must include:

- a separate entry for each episode of seclusion or restraint
- IIMS incident number (where seclusion or restraint is part of a reportable incident)
- details of the person being secluded or restrained, including identification of Aboriginal people
- date of seclusion and restraint episode
- type of seclusion and restraint episode
- time started
- time ended.

The register is to be kept in a secure location, noting adherence to privacy legislation and policy.

NSW Health organisations must submit seclusion and restraint data from all mental health units and declared emergency departments to the NSW Ministry of Health.

NSW Health organisations must provide Official Visitors access to all records relating to seclusion and restraint, including monthly summary information and seclusion and restraint Registers.

There are no additional requirements for non-declared emergency departments. The general requirements outlined in this policy apply.

4.2 NSW Ambulance

A paramedic must be with the person being restrained at all times until handover is complete.
Staff must record all physical/mechanical restraints in the person's Health Care Record and, for any person who meets the criteria for being mentally ill or mentally disturbed and being detained, staff must also complete a Mental Health Act 2007 Section 20 form (State Form SMR 025.205 NH606721) each time restraint is used.

4.3 Residential Aged Care

Includes State Government Residential Aged Care Facilities and Multipurpose Services

An approved health practitioner (i.e. a medical practitioner, nurse practitioner or registered nurse) who has day-to-day knowledge of the resident (for physical restraint), or a medical or nurse practitioner who has prescribed a medication (for chemical restraint) must:

- assess the resident as posing a risk of harm to themselves or any other person, and requires the restraint (physical or mechanical)
- document the assessment, unless the use of restraint is needed in an emergency then document the assessment as soon as possible after using the restraint
- document the alternatives that were considered and used, unless emergency restraint was necessary
- use the least restrictive form of restraint possible
- have informed consent of the person or their representative, unless restraint is needed in an emergency. If restraint is used without consent, inform the person's representative as soon as possible after the health practitioner starts to use the restraint

NSW Health staff must not use the following in residential aged care:

- seclusion
- posey crisscross vest
- leg or ankle restraint
- manacles/shackles (hard)
- soft wrist/hand restraints.

All residential aged care facilities funded by the Australian government must collect and provide quality indicator data to the Department of Health. This includes NSW State Government Residential Aged Care Facilities (SGRACFs). These services must measure, monitor and report on mandatory quality indicators including use of physical restraint. Official Community Visitors must have access to the seclusion and restraint Register and monthly summary of seclusion and restraint data from all visitable services.

4.4 Transportation and transfer of care

NSW Health staff must adhere to legal and policy requirements if using restraint during transportation. If a person is transferred while in restraint, the receiving medical practitioner, paramedic or senior registered nurse must use all available information to assess the need to continue or cease restraint. NSW Health staff should review the use of restraint as soon as possible, unless the person remains under the custody of an accompanying officer from NSW Police Force, Youth Justice NSW, Corrective Services NSW or Border Protection Services.

5. APPENDIX LIST

1. Implementation Checklist
2. NSW Health and Commonwealth policies, guidelines and reports

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:	**Date of Assessment:**		
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Develop local implementation plan in collaboration with staff, individuals who access health care services and carers/families.	❑	❑	❑
	Notes:		
2. Develop local policies, procedures and education programs to support implementation of the policy and incorporation of review feedback; includes any plans for specific areas (e.g. Emergency Department, Intensive Care Unit), staffing and physical environment.	❑	❑	❑
	Notes:		
3. Detail ways in which the principles and values of the policy will be implemented. Recognise the impact of seclusion and restraint as a physical and psychological safety issue for people accessing services and staff and take action to support a culture of quality improvement to reduce and where possible eliminate the practice	❑	❑	❑
	Notes:		
4. Promote the policy to all staff (paid and unpaid, contractors, etc.).	❑	❑	❑
	Notes:		
5. Establish monitoring and reporting processes, including implementation of risk assessments and prevention strategies.	❑	❑	❑
	Notes:		
6. Conduct annual (minimum) audits of compliance with policy.	❑	❑	❑
	Notes:		
7. Ensure that clinical governance processes include reviews of seclusion and restraint performance in all healthcare settings	❑	❑	❑
	Notes:		

Attachment 2: NSW Health and Commonwealth policies, guidelines and reports

NSW Health Policy documents

Policy Directives

- PD2012_042 - Aboriginal and Torres Strait Islander Origin - Recording Information of Patients and Clients
- PD2013_049 - Recognition and Management of Patients who are Clinically Deteriorating
- PD2014_028 - Open Disclosure Policy
- PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace-A Zero Tolerance Approach
- PD2017_001 - Responding to Needs of People with Disability during Hospitalisation
- PD2019_049 - Compulsory Reporting for Residential Aged Care Services
- PD2017_025 - Engagement and Observation in Mental Health Inpatient Units
- PD2017_043 - Violence Prevention and Management Training Framework for NSW Health Organisations
- PD2018_002 - Service Specifications for Transport Providers, Patient Transport Service
- PD2018_027 - Identifying and Responding to Abuse of Older People
- PD2019_034 - Incident Management Policy

Guidelines

- GL2012_005 - Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused upon Older People
- GL2014_010 - NSW Acute to Aged Related Care Services Practice Guidelines
- GL2015_001 - Safe Use of Sensory Equipment and Sensory Rooms in NSW Mental Health Services
- GL2015_007 - Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments
- GL2016_016 - NSW SMHSOP Acute Inpatient Unit Model of Care Guideline
- GL2017_003 - Specialist Mental Health services for Older People (SMHSOP) Community Model of Care Guideline
- GL2017_022 - NSW Older People's Mental Health Services SERVICE PLAN 2017-2027
- GL2019_008 - Communicating Positively: A Guide to Appropriate Aboriginal Terminology

Other NSW Government documents that support good practice

- A Guide to Build Co-design Capability August 2019
- Advance care planning in New South Wales
- Building collaborative cultures of care within NSW mental health services
- Carers (Recognition) Act 2010 No 20
- Charter for Mental Health Care in NSW
- Disability Inclusion Act 2014 No 41
- Lived Experience Framework for NSW
- Making an Advance Care Directive

- Mental Health for Emergency Departments: A Reference Guide (NSW Health, 2015) (commonly referred to as 'the Red Book')
- NSW Health - NSW Police Force Memorandum of Understanding 2018: Incorporating provisions of the Mental Health Act 2007 (NSW) No 8 and the Mental Health (Forensic Provisions) Act 1990 (NSW)
- Protecting People and Property-NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies - in particular:

  Chapter 14 Role of Security Staff in NSW Health

  Chapter 29 Code Black Arrangements
- Safe Assessment Room Guidelines[1]
- Safety Notice 003/16 Use of Prone Restraint and Parenteral Medication in Healthcare Settings

Commonwealth guidelines/documents that support good practice

- Aged Care Quality and Safety Commission (2018). Guidance and Resources for Providers to support the Aged Care Quality Standards
- Australian Commission on Safety and Quality in Health Care: Open Disclosure
- Australian Commission on Safety and Quality in Health Care's Recognising Signs of Deterioration in a Person's Mental State
- Australian Commission on Safety and Quality in Health Care's Delirium Clinical Care Standard
- Australasian Health Facility Guidelines seclusion room
- Australian Human Rights Commission-Human Rights Explained fact sheets
- Charter of Aged Care Rights
- Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care
- Guidance and Resources for providers to Support Aged Care Quality Standards
- Mental Health Statement of Rights and Responsibilities 2012
- National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018
- National Mental Health Commission Seclusion and Restraint Project
- National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services
- National Safety and Quality Health Service (NSQHS) Standards User Guide for Aboriginal and Torres Strait Islander Health
- National Safety and Quality Health Service (NSQHS) Standards Guide for Multi-Purpose Services and Small Hospitals
- National Safety and Quality Health Service (NSQHS) Standards User Guide for Health Services Providing Care for People with Mental Health Issues
- Royal Commission into Aged Care Quality and Safety: Restrictive Practices in Residential Aged Care in Australia
- Safe in Care, Safe at Work ACHMN 2019
- Safe Work Australia Review of the model WHS laws: Final report 2018
- Safe Work Australia Work related psychological health and safety: A systematic approach to meeting your duties

1 Not yet published

AGGRESSION, SECLUSION & RESTRAINT IN MENTAL HEALTH FACILITIES – GUIDELINE FOCUSED UPON OLDER PEOPLE (GL2012_005)

PURPOSE

This document provides guidance about caring for older people whose behaviour can potentially cause harm.

KEY PRINCIPLES

The key principles outlined in the Australian National Seclusion and Restraint Project (2009) *National Suite of Documentation* guide this document. These principles are summarised below and detailed in PD2012_035 Appendix 3.

Principle 1: Protection of fundamental human rights
Principle 2: Protection against inhumane or degrading treatment
Principle 3: Right to highest attainable standards of care
Principle 4: Right to medical examination
Principle 5: Documentation and notification
Principle 6: Right to appropriate review mechanisms
Principle 7: Compliance with legislation and regulations

USE OF THE GUIDELINE

This guideline may be used in mental health facilities in NSW focussed upon older consumers. It can be applied to the care of older people in all mental health units.

It is designed to be read in conjunction with PD2012_035 Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW.

For the complete Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2012/GL2012_005.html

NSW HEALTH MENTAL HEALTH SUPPORTING PLAN TO NSW - (HEALTHPLAN) (GL2012_006)

PURPOSE

The plan is the NSW Health Mental Health Services Supporting Plan to the NSW Health Services Functional Area Disaster Plan (NSW HEALTHPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

This plan identifies the emergency management arrangements necessary for the coordination of mental health services at State level when HEALTHPLAN is activated in response to a range of Emergency situations.

The arrangements in this plan will also provide guidance for the preparation of the Local Health Districts.

KEY PRINCIPLES

The plan outlines the agreed roles and functions for the mental health services component of NSW Health being one of the five major contributing health service components that constitutes a whole of health response incorporating an all hazards approach.

The plan identifies recommended actions under four emergency management phases: Prevention, Preparation, Response and Recovery. Actions under the Prevention and Preparation phases are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases are recommended to be carried out once the Mental Health Services Supporting Plan has been activated by the State Health Services Functional Area Coordinator (HSFAC).

USE OF THE GUIDELINE

Responsibilities of key parties are detailed in Part Two of the Mental Health Services Supporting Plan. The plan should be communicated to those with roles and responsibilities under this plan and the HEALTHPLAN.

To download the Guideline go to http://www.health.nsw.gov.au/policies/gl/2012/GL2012_006.html

CLINICAL CARE OF PEOPLE WHO MAY BE SUICIDAL (PD2022_043)

(PD2022_043 replaces PD2016_007)

POLICY STATEMENT

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies that aim to prevent suicide, including facilitating access to appropriate care.

The requirements of this Policy Directive apply specifically to the specialist mental health workforce providing clinical care across community, inpatient and emergency settings and in collaboration with other health professionals and the individual's support network.

SUMMARY OF POLICY REQUIREMENTS

NSW Mental Health Services are to implement processes consistent with the requirements of this Policy Directive to ensure the provision of timely evidence-based clinical care of people at risk of suicide in NSW Health services.

All NSW Health staff have a role in identifying and responding to people who may be suicidal.

Local Health District and Specialty Health Network Chief Executives and Health Service Executives need to assign responsibility, personnel and resources to implement and provide line managers with support to mandate this Policy in their areas.

Ensure that local protocols are in place in each facility to support implementation and ensure that all mental health service staff are aware of the requirements.

NSW mental health services and clinicians are to meet minimum standards for the clinical care of people who may be suicidal which includes the key components of:

- Identification: the early identification of suicide risk, including subsequent triage and interim observational management followed by timely and appropriate referral for further assessment.
- Assessment: the comprehensive mental health assessment of people presenting with, or identified as possibly having, suicidal thoughts or behaviour. Assessment includes but is not limited to appropriate supervisory consultation and documentation of mental state, assessment and risk formulation, safety planning, treatment, suicide care planning, review, transition and handover, and any other actions and precautions taken as an outcome of those assessments.
- Formulation: synthesising and documenting information collected during the assessment to develop an understanding of the person and their circumstances to inform care planning such as appropriate interventions and treatment.
- Brief intervention: activities that can be enacted immediately to help to ensure a person is safe and better able to manage suicide risk.
- Treatment: refers to the care, therapies and resources that support a person to address their suicidality directly and is documented in a comprehensive care plan, in consultation with the person and their support system.
- Transition and discharge: Follow-up at transition and post-discharge is to be incorporated into the care plan, including timing, frequency and modality as these stages represent times of potential increase in suicide risk.

Processes and protocols for the clinical care of people who may be suicidal are to align with requirements for incident management, open disclosure and mental health clinical documentation where applicable.

Local Health District and Specialty Health Network policies, procedures and standards need to be developed in consultation with the Mental Health Branch, NSW Ministry of Health to ensure they are consistent with all relevant state-wide policies, procedures and guidelines referenced in this document.

Health services are to ensure that all staff undertake appropriate education and training.

1. BACKGROUND

Suicide prevention is everyone's business, and all NSW Health staff have a role to play. It is important that all health staff can identify people at risk of suicide, take action that may prevent suicide deaths and implement management strategies, including referral to relevant services for further assessment and expert supports.

This Policy has been specifically developed for the specialist mental health workforce providing care across community, inpatient and emergency settings, in collaboration with other health professionals and the individual's support network.

Mental health clinicians may work in emergency departments, mental health telephone triage services, community mental health services, mental health inpatient facilities and general health facilities. When care is provided by community teams this will extend to other settings such as the home, school, aged care facilities and other community settings.

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies that aim to prevent suicide, including facilitating access to appropriate care.

Non-clinical mental health staff and supports also have a vital role to play in comprehensive and effective suicide prevention in the health system.

In 2020 NSW Health instituted the Zero Suicides in Care Initiative, informed by the Zero Suicide Healthcare Framework which identified that evidence-based practices can be applied across the elements of suicide care, supported by leadership, training and ongoing improvement. The Zero Suicide Healthcare Framework includes an aspirational goal of eliminating suicide deaths, implemented within a safety culture that supports consumers, family, carers and staff to heal following critical incidents.

Consistent with Zero Suicides in Care, NSW mental health services[1]:

- Lead system-wide culture change committed to reducing suicides:

  Supporting the development of organisations that demonstrate leadership, providing tangible supports to staff, promoting a culture of restorative justice and learning, and ensuring people with lived experience co-design the development and evaluation of the program.

- Train a competent, confident, and caring workforce:

  Commitment to the ongoing development of all mental health staff utilising local and state-wide resources and ensuring that all staff, both clinical and non-clinical, are able to engage with people who may be suicidal.

- Care for all people presenting to mental health services:

  Responding to the needs of people at risk of suicide in a manner that is caring, compassionate, trauma-informed, culturally responsive, respectful, and non- judgmental.

- Improve policies and procedures through continuous quality improvement:

  Organisations collect data and evaluate clinical outcomes and the effect of training and clinical model change through continuous quality improvement in a safety oriented and supportive culture.

1.1 Principles of care

Building positive therapeutic engagement with a person who is experiencing suicidal ideation is essential for compassionate clinical care for people who may be suicidal at all stages of suicide care. Research shows a strong link between the quality of the therapeutic relationship and therapeutic outcomes[2].

An empathetic and compassionate approach by the clinician will build important trust and rapport. A good therapeutic relationship includes trust, care and respect, agreement on the goals of care, and collaboration on the care plan and tasks to be undertaken.

Compassionate care of people who may be suicidal is also culturally responsive, inclusive, non-judgmental, person-centered, recovery-oriented, trauma-informed (including recognising the potential of mental health service environments and interventions to cause or compound trauma), and evidence-based.

1.2 About this document

This Policy Directive establishes minimum standards that NSW mental health services and mental health clinicians are required to meet; in the identification of people who may be suicidal, and the assessment and treatment of people with suicidal thoughts and behaviour within NSW Health care settings.

This Policy reinforces the emphasis on comprehensive assessment and broadens the focus on provision of brief interventions to all people presenting to health services who may be suicidal and, where appropriate, providing advice about or referral to appropriate clinical and non-clinical services within or outside of NSW Health.

This Policy Directive is intended to:

- Support the provision of timely, evidence-based clinical care of people at risk of suicide to ensure people remain safe and are supported in their recovery
- Outline the roles and responsibilities of mental health services and clinicians to inform local policies and procedures
- Support a consistent and coordinated evidence-informed approach to the application of clinical guidelines and training.

1.3 Key definitions

Carer	An individual who provides care and support to a family memberor friend who lives with a disability, mental illness, alcohol or drug dependency, chronic condition, terminal illness or who is frail due to age.
Culturally responsive	Culturally responsive services and staff are self-aware, respectful of all cultures, and actively respond to the cultural needs and strengths of all people, paying particular attention to social and cultural factors in managing therapeutic encounters and providing culturally safe care environments.
Cultural safety	Cultural safety requires healthcare professionals and their healthcare organisations examine the potential impact of their own culture on service delivery. Healthcare professionals and organisations are required to acknowledge and address their biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care. Cultural safety encompasses a critical consciousness with ongoing self-reflection, self-awareness and accountability for providing culturally responsive care, as defined by consumers and their communities, and as measured through progress towards achieving health equity. Cultural safety has universal application but is most important in the Australian context for

	Aboriginal and Torres Strait Islander people.
Evidence-based care	Healthcare practice that involves integrating the best available research evidence with clinical knowledge and expertise, whileconsidering consumers unique needs and preferences.
Family	'Family' has different meanings for different people, and customs for parenting, marriage and kinship vary across cultures and societies. Family usually means two or more people with shared ancestry or enduring legal or cultural ties to each other and may encompass any significant person includingpartners, parents, children, grandparents, siblings, extended family and others significant to the person.
Mental Health Clinician	A person who provides evidence-based, clinical care for mental health, including medical practitioners, nurses and allied health clinicians.
Mental health service	Any specialised mental health service within NSW Health or funded by NSW Health, including clinical and non-clinical care services and settings.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception, or memory.
Mental State Examination	An examination used to gain an understanding of a persons psychological functioning at a particular point in time including but not limited to consideration of appearance and behaviour, speech, mood, affect, thought, perception, cognition, insight and judgement.
Non-clinical care services and settings	Mental health services that predominantly or exclusively provide non-clinical care and support, such as Safe Havens.
Peer worker	A staff member who has personal, lived experience of mental illness or suicide, and recovery, or of supporting family or friends with mental illness or suicidality. This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.
Person-centered care	Care that is respectful of, and responsive to, the preferences,needs and values of the individual patient.
Priority populations	Population subgroups identified as having a risk of suicide or self-harm that is higher than that of other populations, the impacton the community is different or they have specific requirements for culturally appropriate suicide prevention or postvention services.
Psychosocial history	An evaluation of the patient that includes a history of psychiatric illness, developmental history, educational history, marital and family life, and employment history.
Recovery	From the perspective of the individual, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.
Recovery-oriented care	The application of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.
Restorative justice	A process to involve, to the extent possible, those who have a stake in a serious adverse incident and collectively identify and address harms, needs and obligations in order to heal and put things as right as possible.
Restorative, just and learning culture	A culture within a mental health setting of restorative justice and forward-thinking accountability that is non-blaming, supports healing for consumers, families and staff, and ensures learnings are translated into actions to improve systems of care.
Risk stratification	A systematic process to classify patients who are at risk of suicide, and inform interventions offered. This is not the current best practice approach; mental health services and clinicians are to offer treatment

	for the individual based on comprehensive individual assessment.
Safety planningintervention	A collaborative process with the person, clinician and family and carers that leads to the development of a tailored, prioritised list of strategies and sources of support a person can use when they experience a suicidal crisis.
Self-harm	Any behaviour that involves the deliberate causing of pain or injury to oneself.
Suicide	An act of intentionally terminating one's life.
Suicide attempt	Self-initiated, potentially injurious behaviour with the intent to die, but does not result in a fatal outcome.
Suicide prevention	An approach that aims to decrease the number of people who die by suicide or attempt suicide, focusing on reducing risk factors in individuals for suicide and enhancing available resources that prevent suicide and suicidal behaviour.
Suicide risk factors	Biological, psychological and social factors that are associated with an increased risk of suicide, including modifiable and non-modifiable risk factors.
Suspected suicide	The term used until the Coroner has made the determination the death was suicide.
Trauma-informed care	An approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage.

1.4 Implementation

Local Health District and Specialty Health Network Chief Executives and Health Service Executives need to:

- Assign responsibility, personnel and resources to implement this Policy
- Provide line managers with support to mandate this Policy in their areas
- Ensure local protocols are in place in each facility to support implementation
- Ensure that all mental health service staff are aware of the requirements of this Policy
- Ensure mental health clinicians undertake training in assessment and management of suicidality
- Work together with the Mental Health Branch, NSW Ministry of Health to ensure Local Health District and Specialty Health Network policies, procedures and standards are consistent with all relevant state-wide policies, procedures and guidelines referenced in this document
- Comply with this Policy including role modelling behaviours consistent with a restorative just culture.

Implementation of this policy is to be supported by:

- Integration of peer workers across clinical settings, as well as establishing care pathways and collaborative approaches between clinical and non-clinical services
- Consultation and partnerships with Aboriginal mental health workers and community
- Co-design approaches, where appropriate.

1.5 Legal and legislative framework

The NSW Health Legal Compendium contains the full list of NSW Health legislation, policy directives and guidelines and are to be referred to for a complete list of relevant Policy Directives and Guidelines and the most up to date version of all documents.

1.5.1 NSW Legislation

- *Children and Young Persons (Care and Protection) Act 1998* (NSW)
- *Disability Inclusion Act 2014* (NSW)
- *Guardianship Act 1987* (NSW)
- *Health Administration Act 1982* (NSW)
- *Health Administration Regulation 2020* (NSW)
- *Health Care Complaints Act 1993* (NSW)
- *Health Records and Information Privacy Act 2002* (NSW)
- *Health Records and Information Privacy Regulation 2022* (NSW)
- *Health Services Act 1997* (NSW)
- *Mental Health Act 2007* (NSW)
- *Privacy and Personal Information Protection Act 1998* (NSW)

1.5.2 Key policy directives and guidelines

- NSW Health Policy Directive *Mental Health Triage Policy* (PD2012_053)
- NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)
- NSW Health Policy Directive *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025)
- NSW Health Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters* (PD2017_044).
- NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045)
- NSW Health Policy Directive *Seclusion and Restraint in NSW Health Settings* (PD2020_004)
- NSW Health Policy Directive *Incident Management* (PD2020_047)
- NSW Health Policy Directive *Mental Health Clinical Documentation* (PD2021_039)

Refer to the NSW Health Legal Compendium, Mental Health for additional relevant Policy Directives and Guidelines.

2. WORKING WITH DIVERSE PEOPLE AND SPECIFIC NEEDS

Clinical care of people who may be suicidal needs to be respectful of, and responsive to, the preferences, needs and values of the individual person. This includes consideration of the whole person, including factors such as their culture, language, age, gender identity, sexual orientation, physical and mental health and abilities, occupation, socioeconomic status, and geographic location, and modifying approaches where appropriate.

All NSW Health mental health services are to ensure:

- Locally developed protocols are in place that respect diversity and guide the delivery of care that is person-centered, respectful, trauma-informed, culturally responsive and appropriate to the local population and context
- All mental health service staff complete appropriate training for working with culturally, socially and linguistically diverse people and priority populations
- All mental health services are delivered in culturally safe service environments with access to Indigenous and/or culturally responsive non-Indigenous staff

- All consumers, families and carers who do not speak English as a first language, or who are deaf have access to professional healthcare interpreters in accordance with the NSW Health Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters* (PD2017_044).

All mental health clinicians have the responsibility to ensure a person's social and cultural context and identity is considered and respected when developing care plans, providing interventions, engaging with families, carers and support networks, and when connecting a person with healthcare supports including peer workers and Aboriginal health workers.

Different characteristics of the individual's need are to be considered together, as many people may belong to more than one diverse or cultural group and this intersectionality can lead to different needs and experiences within healthcare[3].

3. IDENTIFICATION

All NSW Health staff have a role to play in the early identification of suicide risk, which can occur:

- In any part of the health system, including where health services are provided in the home or community
- As part of structured screening in health services which may include use of screening tools to increase early identification of suicidal risk beyond self-disclosure or clinical judgement (noting that screening tools alone must not be used to assess risk or determine treatment) [3, 4].
- At any stage of an individual's interaction with health and mental health services.

All mental health services are to:

- Ensure locally developed protocols are in place that support:
    - Appropriate and timely triage of persons experiencing suicidality and interim observational management pending referral to mental health services
    - Staff to ask people directly about their suicidal ideation, as many people do not talk about suicidal thoughts and plans unless asked directly[5]
    - Establishment of referral pathways to assist in early identification and access to care for people with suicidal behaviour or ideation.
- Provide guidance to staff regarding expected processes for identifying emergent suicidal ideation during care.

The NSW Health Policy Directive *Mental Health Triage Policy* (PD2012_053) defines and outlines the clinical processes to identify the presenting factors that suggest risk, the appropriate response required, and how to manage call situations, including callers who express self-harm ideation.

4. ASSESSMENT

All mental health clinicians undertaking assessment are to:

- Provide clinical management and care in accordance with the *Mental Health Act 2007* (NSW)
- Undertake a comprehensive mental health assessment with people presenting with, or identified as possibly having, suicidal thoughts or behaviour, and seek supervision and support in this responsibility where appropriate
- Ensure clinical records document ongoing mental health state, assessment and risk formulation, safety planning, treatment, suicide care planning, review, transition and handover, and actions and precautions taken as an outcome of those assessments
- Include consultation with supervisors and the person's key carer network where management plans change to support ongoing communication across the care and social support systems

- Complete a NSW Police Force Firearms Registry Disclosure of Information by Health Professionals Form if the person is known to have access to a firearm, and there is an assessed level of risk of harm to self or others.

A comprehensive mental health assessment:

- Is an opportunity to build therapeutic engagement and show compassion and understanding
- Is based on a comprehensive clinical interview conducted by the mental health clinician/s in collaboration with the person at risk of suicide and their family and carers. Corroborative history is to be obtained whenever possible
- Includes assessing suicidal thoughts and behaviour, medical and psychiatric history, psychosocial history, life stressors, drug and alcohol history including current use and withdrawal status, presence of risk factors for suicide including current access to lethal means, a person's strengths and protective factors, and available supports and ability to recover in the community
- Includes review of current care levels, engagement and observation or status in the community
- Includes a Mental State Examination (MSE)
- Is to be sensitive to the distress of the person and the fact that assessment involves significant disclosure. This must be carried out in a manner that is culturally safe, recovery-oriented and trauma-informed
- Focuses on treatment planning and risk minimisation, not prediction or risk stratification
- Provides an understanding of the person at a point in time. This understanding will evolve and be reviewed over time.

A further comprehensive mental health assessment may be required to reassess a person's suicide risk and planned care, particularly in response to any changes in personal circumstances or care needs.

5. FORMULATION

Formulation is the process of synthesising information collected during an assessment to develop an understanding of a person and their circumstances and informs care planning.

When a person is identified as having suicidal ideation, mental health clinicians must undertake suicide prevention formulation. Suicide prevention formulation is relevant to a person's suicide risk. It aims to capture how a person's history and context interact to produce and mitigate suicide risk.

A person-centered suicide prevention formulation provides the best way to ensure that the most effective care can be tailored to a person's needs and the process includes:

- Considering the suicide risk factors a person presents, as identified in the comprehensive assessment
- Identifying which risk factors are modifiable and can be addressed
- Determining the nature of an individual's internal coping resources and how they can be strengthened
- Detailing the external resources available to help a person navigate distress such as family, social network, professional supports or wider community
- Considering the changeability of the current situation including factors internal to the person, potential changes in important relationships and external factors that could rapidly escalate risk
- Consulting and collaborating with colleagues, including advice sought from senior colleagues, particularly where the decision is made not to admit someone to a mental health inpatient unit where ongoing suicidality is identified.

The suicide prevention formulation provides the basis for the safety plan and, where appropriate, a comprehensive care plan. Suicide risk formulations are reviewed regularly and updated with any significant changes in presentation, context or availability of support.

Suicide prevention formulation is documented in the electronic medical record system (eMR).
Most people requiring ongoing mental health care will require a comprehensive mental health formulation in addition to a suicide risk formulation.

6. BRIEF INTERVENTION

Brief interventions refer to activities that can be enacted immediately to help to ensure a person is safe and better able to manage suicide risk. Brief interventions can be used early in the therapeutic engagement process – as early as first contact. This enables timely support to be provided and immediate needs to be addressed, while also promoting ongoing engagement with care.

Brief intervention is to be outlined in a safety plan that incorporates the following activities routinely used when a person is identified with suicidal risk:

- Address access to lethal means
- Provide education and information to the person, and their family and carers
- Identify contingency plans in the event of acute deterioration using an agreed escalation process
- Where appropriate, identify non-clinical services within and outside of NSW Health where the person may be able to access support in future crisis or receive short term support to address interpersonal or social factors contributing to the suicidal crisis.

A safety planning intervention is a collaborative process with the person and clinician and family and carers wherever possible. The intervention leads to the development of a tailored, prioritised list of strategies and sources of support a person can use when they experience a suicidal crisis. The safety planning intervention is to include identification of warning signs, internal coping strategies, identification of social contact that may distract from suicidal thoughts, access to social supports to help resolve the crisis, professional supports and counselling on access to lethal means. Clear actions and roles and responsibilities for addressing access to lethal means are also be agreed upon in this process.

The safety plan is to be put in place as early as possible and reviewed regularly as circumstances change, including after a crisis or suicide attempt.
In addition to the person having a copy of the safety plan, a copy must be documented in the electronic medical record (eMR) system in accordance with the requirements for clinical documents.

7. TREATMENT

All people who are identified as requiring ongoing clinical care in NSW specialist mental health services are to address the risk of suicide, require a comprehensive care or treatment plan. The plan is to be developed in collaboration with the person, their family, carers and key supports.
Treatment refers to the care, therapies and resources that support a person to address their suicidality directly and is documented in a comprehensive care plan that:

- Addresses modifiable risk factors
- Mitigates the impact of long-standing risk factors
- Consolidates and builds on a person's strengths and available resources.

Modifiable risk factors include mental illness (mood disorders, psychosis, anxiety disorders,bipolar disorder, eating disorders), impact of past trauma, substance misuse, pain, physical illness, isolation, unemployment and factors related to social and cultural networks.

Suicidal thoughts can be treated directly using evidence-based treatment models known to specifically reduce suicidality.

Ongoing management of a person's mental health and/or suicidal risk requires mental health clinicians regardless of their setting to:

- Prioritise the safety and wellbeing of the person at risk of suicide and NSW Health staff
- Consider decisions about care and treatment in accordance with the *Mental Health Act 2007* (NSW), including that:
    - People receive care and treatment in the least restrictive environment possibleenabling the care and treatment to be effectively given
    - Every effort that is reasonably practicable is made to obtain the person's consent and to involve them in treatment and recovery planning, considering their capabilities, preferences, views and expressed wishes
    - The views of a parent, designated carer, guardian or principal care provider are sought and considered by clinicians when making decisions about the person
- Ensure care in a public health facility includes a safe physical environment
- Routinely consider a person's cultural context and identity, and how this may influence suicidality and pathways to recovery
- Regularly reassess the person noting that suicidal risk can fluctuate with both deterioration and improvement in overall mental state
- Review the treatment plan regularly along the care pathway, including transition points or when the context or other factors change.

8. TRANSITION OF CARE AND DISCHARGE

Transitions of care and discharge represent times of potential increase in suicide risk[6].

Follow-up at transition and post-discharge is to be incorporated into the care plan, including timing, frequency and modality. Follow-up arrangements must consider factors such as the person's age, cultural identity, geographic location, diagnosed mental illness, access to communication technology, domestic situation and support networks[3].

All mental health clinicians regardless of their setting are to:

- Ensure the requirements outlined in the NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045) are followed for the care of people with suicide risk
- Review and update assessments and care plans at points of significant transitions in care
- Conduct warm handover to other service providers that combines written referrals with a person-to-person discussion using a consistent format such as ISBAR (Introduction, Situation, Background, Assessment, Recommendation)
- Follow up within 24-48 hours of transition of care where possible or as agreed in the care plan based on clinical need and the person's individual circumstances, and document accordingly
- Make direct contact with mental health consumers discharged from an acute psychiatric admission to the community within the timeframe indicated in the transfer of care plan and ideally within 72 hours, or within a maximum of 7 days.
- At each transition point, ensure accurate and up to date contact details for the person, their next of kin or carer, and their general practitioner are recorded in the person's electronic medical record (eMR).

8.1 Discharge

Discharge planning is a collaborative process involving the person and their family or carers. Discharge planning commences on entry to the service.
Safe discharge from an acute inpatient care unit requires mental health clinicians to deliver assertive and coordinated follow-up through direct contact as soon as possible following discharge. This contact needs to assess the success of initial transition back into the community and therefore must include both direct contact with the person and, where possible, discussion with the person's principal carer.
Ongoing care options include:

- Community mental health services
- The person's general practitioner
- Inpatient and community private sector care
- Non-clinical services such as The Way Back Support Service
- Drug and Alcohol Services.

Discharge from the mental health service must be accompanied by:

- Written details of discharge plans including referrals to other treatment teams, such as general practitioners or non-clinical assertive follow-up supports provided to the person
- Information about how the person or their family/carers can escalate concerns about deterioration including access to the 24/7 Mental Health Line 1800 011 511.

8.2 Responding to people with ongoing suicidality

Mental health services are required to develop clear strategies to support the person's recovery, to respond to changes in risk over time and to ensure that services have strategies to contain emotional distress. This will necessitate review of the historical and dynamic nature of risk and the capacity of the person and their support network to utilise personal coping strategies. Reviews are to involve all relevant parties, integrating clinical and non-clinical care and supports (including case conferencing) and include regular reviews of the management plan.

Some overarching principles include:

- Establish a team approach to risk formulation and response
- Acknowledge the underlying distress that drives suicidal ideation and assess the risk at each presentation
- Where available, refer to brief intervention models such as Project Air for more comprehensive care planning
- Actively respond to all co-existing conditions
- Set clear expectations of the assessment and support process, including a clear management plan and guidelines on expected behaviour of the person
- Facilitate the person's engagement with and linkage to programs that promote emotional self-mastery and problem-solving skills.

9. MANAGEMENT FOLLOWING A SUSPECTED DEATH BY SUICIDE

The NSW Health Policy Directive *Incident Management* (PD2020_047) outlines how services identify all people affected by suspected death by suicide including; consumers, carers and staff, the needs of those people, and who is responsible for addressing their needs.

A serious adverse event review (SAER) is required for suspected death by suicide of a person:

- Within an acute psychiatric unit or acute psychiatric ward

- Who has received care or treatment for a mental illness from the relevant health services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation
- Who is a NSW Health staff member.

All NSW Mental Health Services are to ensure:

- Effective local incident management systems are consistent with the NSW Health Policy Directive *Incident Management* (PD2020_047)
- Effective local open disclosure processes are consistent with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028), including the provision of ongoing support for families, carers and staff which is responsive to their needs and expectations, for as long as is required
- There are active measures to support their workforce and any staff member affected by a suicide death or suicide attempt is offered support from their team manager, clinical supervisor and the Employment Assistance Program (EAP).

All mental health clinicians regardless of their setting need to:

- Demonstrate compassion, openness, respect and empathy to the family and carers of a person who has died
- Be aware of and observe a standardised approach in communicating with families and other support people after an incident in care that is consistent with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)
- Advise any clinician (including private psychiatrists and general practitioners) or non-clinical psychosocial support service who has been managing care of the deceased in the community of the death as soon as possible.

10. CLINICAL SUPERVISON AND SUPPORT

All NSW Mental Health Services are to:

- Ensure clear local protocols are in place to support less experienced clinicians to seek advice from more senior clinicians regarding the clinical assessment or care of people who may be suicidal
- Ensure that mental health clinicians have access to appropriate clinical supervision, consultation or advice from a senior clinician at all times
- Recognise the ongoing impacts on clinicians and aim to mitigate times of high distress including anniversaries.

11. CLINICAL DOCUMENTATION

All NSW public mental health services are required to use available electronic medical record (eMR) systems for the documentation of clinical practice and care.

All NSW Mental Health Services need to ensure mental health clinicians complete training in mental health clinical documentation, and related eMR systems and processes.

All mental health clinicians regardless of their setting have a professional and legal responsibility to maintain clear, accurate and timely records and to document clinical practice and care as mandated in the NSW Health Policy Directive *Mental Health Clinical Documentation* (PD2021_039).

12. ENVIRONMENTAL HAZARDS

Mental health inpatient facilities are to remove or reduce environmental hazards for patients with suicidal behaviour and ideation.

All NSW Mental Health Services are to:

- Ensure respectful and trauma-informed development and implementation of standardised practices intended to improve patient safety, eliminate hazards and reduce the likelihood of adverse incidents occurring, including:
    - Ensuring each shift changeover incorporates assessment of environmental risks
    - Undertaking monthly environmental safety audits that identify and ameliorate the risks presented by low-lying ligature points and non-collapsible curtain rails
    - Undertaking annual environmental safety audits that identify any obstructions to the observation of high-risk patients in mental health inpatient facilities
    - Ensuring strategies to monitor and prevent potentially dangerous items being brought into the inpatient unit by patients, family, carers or friends
    - Using processes to escalate and address safety issues, and for this to include the use of tools and checklists that are specifically developed in the mental health inpatient facility
    - Designating a staff member responsible for undertaking the environmental audit which is to be dated, signed and retained as a formal record.

The *Access to Means of Suicide and Deliberate Self-Harm Facility Checklist* (appendix 16.1) has been developed to specifically address safety issues in mental health inpatient facilities.

Mental health inpatient units are also to ensure minimum standards of observation and engagement to manage the risk or concern of harm to a consumer or others, consistent with the NSW Health Policy Directive *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025).

13. EDUCATION AND TRAINING

Maintaining effective and current clinical skills and practice in assessing and managing suicidal behaviour and ideation are core requirements for all mental health clinicians.

All NSW Mental Health Services are to ensure that:

- All mental health clinicians, regardless of setting, undertake training in identification and assessment of the person at risk of suicide, suicide risk formulation, safety planning, treatment and management
- All mental health service staff undertake appropriate training in culturally responsive practice and trauma-informed care.

All mental health clinicians, regardless of their setting, need appropriate education and training to:

- Understand current clinical and legal responsibilities in the delivery of mental healthcare
- Integrate the key principles of good clinical care in the delivery of clinical management and care of people with suicidal behaviour and ideation, including:
    - Empathetic and compassionate approaches
    - Building positive therapeutic engagement
    - Providing care that is culturally responsive, inclusive, non-judgmental, person-centered, recovery-oriented, trauma-informed and evidence-based.

- Deliver evidence-based clinical practice in the assessment and management of people with suicidal behaviour and ideation
- Recognise the differing presentations of possible suicidal behaviour in different age groups and diagnostic categories to respond effectively and efficiently in the provision of ongoing care
- Maintain competency in undertaking detailed evaluations of suicidal behaviour and ideation.

14. REFERENCES

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[4] Matheson, SL; Shepherd, AM; Carr, VJ. Commissioned by the Mental Health Drug andAlcohol Office (MHDAO) NSW Ministry of Health and brokered by the Sax Institute, "Management of suicidal behaviour - a review for models of care: an Evidence Check rapid review," Sax Institute, Sydney, 2014.

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[6] H. Bickley, H. IM, K. Windfuhr, J. Shaw, L. Appleby and K. N, "Suicide within two weeksof discharge from psychiatric inpatient care: A case-control study," *Psychiatric Services,*vol. 64, no. 7, p. 653–659, 2013.

APPENDIX – ACCESS TO MEANS OF SUICIDE AND DELIBERATE SELF HARM CHECKLIST

This checklist may be used or adapted to assist with review of the physical structure of the mental health inpatient unit to identify:

- Any obstructions to the observation of high-risk patients
- Structures that could be used in suicide by hanging.

Inpatient units must remove (or make inaccessible) all likely ligature points
Safety risks are to be determined with reference to the workplace health and safety matrix as outlined in NSW Health Policy Directive *Enterprise-Wide Risk Management* (PD2022_023).

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Hanging points				
Non-collapsible curtain rails				
Non-collapsible bed frames				
Non-collapsible shower frames				
Internal piping				
Shower or bath fittings and curtains				
Exhaust fan				
Wardrobes and cupboards, including clothes rod				
Light fittings, ceiling fans and ceiling panels				
Bedroom and bathroom doors, hinges,door handles and knobs				
Windows, blinds and curtains				
Fire/duress alarms and signage				
Blind spots				
Corners				
Alcoves				

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Under stairways				
Power-board rooms				
Other				
Access to facility and exit points				
Door security including use by non-regular staff				
Gate security including use by non-regular staff				
Garden fences and walls, including movable garden furniture/objects				
Air conditioning vents				
Other				
Hazards at exit points				
Consider potential access to busy roads, railway lines, rivers, oceans,cliffs and other hazards				
Poisonous substances kept in locked cupboard or storeroom				
Medication				
Reagents				
Cleaning fluids				
Any other hazardous material				
Windows – structure and design				
Are windows made of full glass, meshed glass or small panes				
Safety policy and procedures				

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Search of patient on admission				
Leave plans include search on return relevant to risk assessment				
Further search of patient (where permissible) when there are groundsfor suspicion				
Monitoring of items conveyed from friends and family to patients and information provided on the safety of items bought in to the unit				
Access to areas of particular risk: bathrooms, kitchens, toilets				
Removal of linen from patient's bedroom where there are concerns around self-harm				
Careful observation of: - cutlery, including plastic cutlery - tools - power cords, phone chargers - plastic bags - any other potentially dangerous objects				
Incident reporting, investigating and reviewing				

Actions required to reduce risk:

Implementation procedure:

Completed by:	Name:	
	Signature:	
Next review date and time:		

SEXUAL SAFETY – RESPONSIBILITIES AND MINIMUM REQUIREMENTS FOR MENTAL HEALTH SERVICES (PD2013_038)

PURPOSE

This Policy Directive outlines the minimum requirements to be met in relation to establishing and maintaining the sexual safety of mental health consumers and responding appropriately to incidents that breach or compromise this safety.

It should be read in conjunction with the NSW Health *Sexual Safety of Mental Health Consumers Guidelines* GL2013_012. The Guidelines, which support this Policy Directive, provide comprehensive information and advice regarding how mental health services can improve the sexual safety of consumers. The Guidelines should be used to ensure the broad, overarching responsibilities of mental health services outlined within this Policy are met.

MANDATORY REQUIREMENTS

Attachment 1 nominates those requirements that are mandatory for mental health services to meet in relation to the sexual safety of mental health consumers.

These requirements provide clear direction to mental health services regarding a baseline for the establishment and maintenance of the sexual safety of the consumers who use their service. All services are required to build on this baseline utilising the *Sexual Safety of Mental Health Consumers Guidelines* GL2013_012.

IMPLEMENTATION

Implementation of this policy and its requirements will be an iterative process over two years, with six-monthly milestones and reporting should occur as per the requirements outlined at 5.2 in the *Responsibilities and Minimum Requirements for Mental Health Services*.

The Local Health District (LHD) has responsibility for ensuring that:

BY JUNE 2014

- All line managers clearly understand they are accountable for effective implementation of the processes required to meet the outlined responsibilities of this Policy Directive.
- Structures are established to appropriately implement this Policy Directive.
- Lead staff member and champions nominated to drive implementation of the Guidelines and Policy Directive at LHD level.
- Consultation is undertaken with staff, consumers and carers to identify training/education needs and this information is provided to the Mental Health and Drug & Alcohol Office (MHDAO).

BY JUNE 2015

- This Policy Directive is successfully implemented within the LHD, as *p*er the requirements outlined in this Policy Directive at 6 - *Implementation*.
- Policies and procedures are developed to ensure the requirements of this Policy Directive are met.
- Regular file audits are undertaken to monitor compliance with this Policy Directive.

The Mental Health and Drug and Alcohol Office (MHDAO) has responsibility for ensuring that:

BY JUNE 2014

- Hard copies of the *Sexual Safety of Mental Health Consumers Guidelines* GL2013_038 are printed and readily available.
- The availability of the above Guidelines, any associated resources and training is promoted to Local Health Districts.
- A training needs assessment is completed with LHDs to support the implementation of this Policy.

BY JUNE 2015

- A training framework is developed and implemented, in consultation with LHDs, to support mental health staff to implement this Policy Directive.
- Implementation of this Policy Directive is monitored, in accordance with the reporting requirements for LHDs.

1. DEFINITIONS

Acute inpatient mental health setting	Service setting in which care is provided to individuals with acute mental health conditions. Acute inpatient mental health services operate 24 hours a day, are short-term, and care is provided by a multidisciplinary team, often within general hospitals. The primary goals of acute inpatient services are to provide a comprehensive evaluation; rapidly stabilise acute symptoms; address the individual's health and safety needs; and develop a comprehensive discharge/transfer of care plan that allows the individual to quickly return to the community or other appropriate levels of care.
Community mental health setting	Service setting in which care and support is provided that assists individuals with a mental health condition to develop skills in self-care and independent living in their own environment. Community mental health services may operate from hospital-based ambulatory care environments, such as outpatient clinics, or be attached to community health centres, and outside of crisis-care, are generally day programs.
Consensual sexual activity	Sexual activity that occurs after mutual sexual consent has been provided by those involved. Also see 'sexual consent'.
Consumer	Someone with a mental illness or disorder that uses a mental health service.
Gender sensitive practices	The different needs of men and women are considered in all aspects of service planning and service delivery.
Informed decision	A decision made by a consumer who understands the nature, extent, or probable consequences of the decision, and can make a rational evaluation of the risks and benefits of alternatives. The decision cannot be considered informed unless the consumer is mentally competent and the decision made voluntarily.
Mental health service	Any establishment or any unit of an establishment that has the primary function of providing mental health care.
Mental health workers/staff	Any person working in a permanent, temporary, casual, termed appointment or honorary capacity within a NSW Health mental health organisation. This includes volunteers, consumer advocates, contractors, visiting practitioners, students, consultants and researchers performing work within NSW Health facilities.
Non-acute and residential mental health settings	Service setting in which care is provided for individuals with a mental health condition that is moderate to severe in complexity. Non-acute inpatient and residential mental health services can be secure, for people with a serious mental illness whose behaviours may put themselves or others at risk or for those who have unremitting and severe symptoms which inhibit their capacity to live in the community. Alternatively,

	services can provide intensive psychosocial rehabilitation and supports in group accommodation prior to residents living independently.
Perpetrator/offender	Someone who has breached the sexual safety of a consumer.
Sexual activity	Activity of a sexual nature with oneself (masturbation) or another (sexual touching, sexual intercourse, oral sex).
Sexual assault	Sexual assault occurs when: a) a person is forced, coerced or tricked into sexual acts against their will or without their consent, or b) a child or young person under 16 years of age is exposed to sexual activities, or c) a young person over 16 and under 18 years of age is exposed to sexual activities by a person with whom they have a relationship of 'special care' e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc.
Sexually disinhibited behaviour	Poorly controlled behaviour of a sexual nature, where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations; at the wrong time; or with the wrong person.
Sexual harassment	Unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances. Can involve physical, visual, verbal or non-verbal conduct.
Sexual health	A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons. (World Health Organisation)
Sexual safety	The recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people.
Sexual safety 'champions'	Individuals who work in mental health who have an interest in or responsibility for sexual safety, or sexual assault prevention and response, as it relates to mental health consumers, and are willing to act as advocates for the implementation of the NSW Ministry of Health *Sexual Safety of Mental Health Consumers Guidelines* and this policy directive.
Sexual safety incident	The term used to refer to an incident that breaches or compromises the sexual safety of a consumer, and which is recognised as either sexual assault or harassment, consensual sexual activity in an inappropriate setting or sexually disinhibited behaviour.
Trauma informed care	Mental health treatment that is directed by: • a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual; and • an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. (Jennings, 2004)[2]

2. INTRODUCTION

Sexual assault and violence are crimes that have long term consequences for their victims. While these types of crimes potentially affect all members of the community, research confirms that people with a mental illness or impairment are at a considerably higher risk. Sexual or other abuse or violence can also be a significant contributing factor in the development or compounding of mental health issues.

192(14/11/13)

[2] Jennings, A. (2004). *The damaging consequences of violence and trauma: facts, discussion points, and recommendations for the behavioural health system.* Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

This makes sexual safety critical for people who use a mental health service – whether the consumer is receiving treatment in a hospital setting, a rehabilitation or residential setting, or within the community.

Sexual safety

Sexual safety refers to the respect and maintenance of an individual's physical (including sexual) and psychological boundaries.

Sexual safety incidents

The types of behaviour that can breach and/or compromise the sexual safety of a mental health consumer have been split into the following three incident types:

- Sexual assault and harassment.
- Consensual sexual activity in an inappropriate context or setting.
- Sexually disinhibited behaviour.

Within the context of this Policy Directive, each of these behaviours is referred to as a 'sexual safety incident'.

3. POLICY CONTEXT

This Policy Directive responds to feedback provided to the Mental Health and Drug and Alcohol Office (MHDAO) and the Clinical Advisory Council (CAC) indicating the need for clear and mandated direction for mental health services regarding their responsibilities in relation to the sexual safety of mental health consumers in all care settings.

To date, mental health services have been guided by the NSW Health Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services, which were first released in 1999 and revised and re-released in 2005. However, these guidelines were only applicable to inpatient settings and insufficient information was provided regarding how staff should respond to particular sexual safety issues (e.g. prior sexual assault trauma; consensual sex; disinhibited behaviour etc). Accordingly, these guidelines have now been superseded by the *Sexual Safety of Mental Health Consumers Guidelines* GL2013_012, which should be read in conjunction with this Policy Directive.

The objectives of this Policy Directive have linkages to the State Plan – A New Direction for NSW, specifically F3(a-c): Improved outcomes in Mental Health, as well as the State Health Plan, Towards 2010 – A New Direction for NSW, specifically Strategic Direction 2: Create better experiences for people using health services.

Other Australian and NSW government strategies, legislation and NSW Ministry of Health Policy Directives that should be considered when implementing this Policy Directive are noted within the *Sexual Safety of Mental Health Consumers Guidelines.*

4. AIM AND OBJECTIVES

4.1 Aim

The aim of this Policy Directive is to provide direction to NSW mental health services regarding the establishment and maintenance of the sexual safety of mental health consumers who use their service. It should be read in conjunction with the NSW Health *Sexual Safety of Mental Health Consumers Guidelines* GL2013_012. The Guidelines, which support this Policy Directive, provide practical information, advice and strategies to help mental health services maintain the sexual safety of mental health consumers.

The Guidelines should be used to ensure the broad, overarching responsibilities of mental health services outlined within this Policy are met.

4.2 Objectives

The objectives of this Policy Directive are to:

a. Establish expected standards for the sexual safety of mental health consumers in all care settings;
b. Clearly outline the responsibilities of mental health services in relation to establishing and maintaining the sexual safety of mental health consumers;
c. Develop a consistent, co-ordinated, approach to the promotion of sexual safety and the prevention of and response to sexual safety incidents; and
d. Improve the sexual safety of consumers of mental health services.

4.3 Principles

The following principles have been developed to provide a clear foundation for the establishment and maintenance of the sexual safety of consumers in all mental health service settings.

1. All mental health consumers are entitled to be sexually safe.
2. All mental health services are responsible for taking appropriate action to prevent and appropriately respond to sexual safety incidents.
3. All mental health services are responsible for supporting mental health consumers to adopt practices and behaviours that contribute to their sexual safety, both within the mental health service environment and within the community.
4. All mental health services are responsible for developing individual sexual safety standards appropriate for their particular setting, in collaboration with all members of the service – staff, consumers, carers, clinicians, advocates etc.
5. The physical environment of the mental health service takes account of the need to support the sexual safety of mental health consumers in its layout and use, particularly in regard to gender sensitivity.
6. Mental health consumers, and their families, carers and advocates, are given access to clear information regarding the consumer's rights, advocacy services, and appropriate mechanisms for complaints and redress regarding sexual safety issues.
7. Mental health service staff and clinicians foster a compassionate and open culture that encourages reporting of incidents relating to the sexual safety of mental health consumers.
8. Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the complainant's privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.
9. Mental health service staff are provided with training and education to enable them to:
    a. Effectively promote strategies to support sexual safety and prevent sexual assault and harassment; and
    b. Respond appropriately and sensitively to sexual safety issues involving mental health consumers, both within the service environment and within the community; and
    c. Integrate trauma-informed care principles into all aspects of treatment.
10. Mental health consumers are provided with opportunities to undertake education to enable them to:
    a. Effectively recognise and respond to behaviours, both their own and other people's, that may compromise or breach their own or another person's sexual safety;
    b. Develop self-protective behaviours; and
    c. Establish and maintain good sexual health.

5. RESPONSIBILITIES AND MINIMUM REQUIREMENTS

5.1 All services

5.1.1 Responsibilities

Mental health services in all settings have a responsibility to:

5.1.1.1 Implement and monitor observance of the NSW Health Sexual Safety of Mental Health Consumers - Guidelines to establish and maintain the sexual safety of the consumers who use their service.

5.1.1.2 Define and promote the appropriate standard of behaviour expected of consumers and staff involved with the service.

5.1.1.3 Promote the rights and responsibilities of members of the service in relation to sexual safety.

5.1.1.4 Ensure information about sexual safety, and available support services in particular, is provided to consumers and their families and carers and is readily accessible by all members of the service.

5.1.1.5 Ensure the requirements of the NSW Health Code of Conduct and other relevant policies, standards and legislation is promoted to and readily accessible by all members of the service and particularly by service staff.

5.1.1.6 Foster a culture that supports and understands the importance of sexual safety through leadership, promotion and training.

5.1.1.7 Work collaboratively with local relevant sexual assault and other services to ensure the most appropriate support is available to consumers who disclose a sexual assault.

5.1.1.8 Take account of the sexual vulnerability of a consumer and any history of prior assault, trauma or disinhibited behaviour in the planning and provision of mental health interventions.

5.1.1.9 Recognise gender differences within their care provision.

5.1.1.10 Respect the consumer's right to privacy and confidentiality, within the limits of legislation, when they have experienced a sexual assault.

5.1.1.11 Support staff to whom a disclosure of sexual assault or harassment is made, or when a staff member witnesses an assault.

5.1.1.12 Appropriately report and record any sexual safety incident, taking account of the incident type, whether the alleged perpetrator is a consumer or staff member, and the age of the consumer who has disclosed the incident.

5.1.2 Minimum Requirements

Mental health services in all settings must:

5.1.2.1 Ensure all staff have access to the NSW Health *Sexual Safety of Mental Health Consumers Guidelines*.

5.1.2.2 Develop sexual safety standards that define appropriate behaviour for the service setting in consultation with all members of the service, including consumers and their families and carers – see Appendix A in the *Sexual Safety of Mental Health Consumers Guidelines* for example standards.

5.1.2.3 Provide clear information and advice to consumers that takes account their cultural background, gender, age, sexual orientation, and personal experiences regarding:
- their rights and responsibilities in relation to sexual safety
- the sexual safety standards that exist in the service setting
- the process for addressing a sexual safety incident
- the support services available should they experience sexual assault or harassment
- how to manage sexual health issues, such as contraception, sexually transmitted diseases (STDs) and pregnancy.

5.1.2.4 Organise for relevant frontline staff and managers, and consumer workers and representatives involved with the service, to undertake training to enable them to effectively prevent and respond to sexual safety incidents, and increase the confidence of staff to discuss sexual health and safety issues with consumers. Such training must include:
- How to assess a consumer's vulnerability and take a sexual assault history
- Consider gender sensitive and trauma informed care principles
- Be undertaken as part of an orientation process where practicable, with refresher training considered annually or biannually.

5.1.2.5 Build or strengthen partnerships with local key stakeholders such as the NSW Health Sexual Assault Service (SAS) and other sexual assault support agencies, the NSW Police Force, General Practitioners (GPs) etc.

5.1.2.6 Conduct an audit to assess the current level of gender sensitivity within the service so that priorities for action can be determined to increase safety and gender sensitivity, and repeat this audit every two years.

5.1.2.7 Assess the vulnerability of each consumer on their admission to the service, which should include any history of sexual assault or incidences of sexual disinhibition, and ensure care plans take account of this. (Note: this assessment can be part of any existing violence screening e.g. domestic violence, elder abuse etc).

5.1.2.8 Respond to a disclosure of sexual assault in accordance with the key actions at Appendix I of this policy directive until assessment of the consumer's clinical mental state determines otherwise (as detailed within the *Sexual Safety of Mental Health Consumers Guidelines*).

5.1.2.9 Ensure any information regarding a sexual safety incident is not disclosed without the consent of the consumer involved, except for the purpose for which the information was collected or the incident is identified as a sexual assault and:
- The alleged perpetrator is a staff member.
- The consumer who has been assaulted is under 16 years of age.
- The consumer who has been assaulted is over 16 but under 17 years of age and in a care relationship with the alleged perpetrator in which case the incident must be reported to the NSW Police Force (see 5.1.2.11).

5.1.2.10 Provide staff with an opportunity to de-brief as required when a consumer discloses an incident of sexual assault or harassment to them, or they witness a sexual safety incident.

5.1.2.11 Report a sexual safety incident identified as a sexual assault as per the process outlined within the *Sexual Safety of Mental Health Consumers Guidelines*, and summarised at Appendix II of this policy directive.

5.2 Acute Inpatient Mental Health Setting

5.2.1 Responsibilities

Within this setting mental health services have an additional responsibility to:

5.2.1.1 Support consumers to be free from pressure to engage in sexual activity with another person, including the consumer's partner or spouse, while in the service environment.

5.2.1.2 Offer sexuality and sexual health education to consumers that is sensitive to each individual's culture, age and sexual orientation and is relevant to non-acute and residential settings.

5.2.1.3 Consider how changes to the physical environment of the service may improve sexual safety for consumers.

5.2.1.4 Respond to all disclosures of sexual assault or harassment according to the key actions as outlined in the *Sexual Safety of Mental Health Consumers Guidelines* and summarised at Appendix I, until assessment of the consumer's clinical mental state determines otherwise.

5.2.2 Minimum Requirements

Within this setting, mental health services must also:

5.2.2.1 Ensure the sexual safety standards for the service highlight that sexual activity, regardless of its consensual nature, is not supported in an acute inpatient setting due to the extreme vulnerability of the consumer/s involved, as well as the vulnerability of the consumers that may witness any such activity, and reiterate this to consumers and their families, carers and partners.

5.2.2.2 Consult with consumers and carers involved with the service around the requirement for sexual safety and sexual health education for consumers and ensure that consumers are able to contribute to determining the topics such education should involve.

5.2.2.3 Work towards improving the physical environment of existing services, where practicable, and ensure new services are planned, to take account of sexual safety in accordance with the *Sexual Safety of Mental Health Consumers Guidelines,* which are supported by and aligned with the current Australasian Health Facility Guidelines for Adult Acute Mental Health Inpatient Units.

5.2.2.4 Organise for the senior clinician (where not involved in the allegation) to carry out an assessment of the clinical mental state of the consumer who has disclosed an assault or harassment within 24 hours.

5.3 Non-acute and residential mental health settings

5.3.1 Responsibilities

Within this setting mental health services have an additional responsibility to:

5.3.1.1 Consider how to appropriately and safely address the sexuality needs of consumers.

5.3.1.2 Ensure access to sexuality and sexual health education for consumers that is sensitive to an individual's culture, age and sexual orientation on topics relevant to non-acute and residential settings.

5.3.1.3 Consider how changes to the physical environment of the service may improve sexual safety for consumers.

5.3.1.4 Respond to all disclosures of sexual assault or harassment according to the key actions as outlined in the *Sexual Safety of Mental Health Consumers Guidelines* and summarised at Appendix I of this policy directive, until assessment of the consumer's clinical mental state determines otherwise.

5.3.2 Minimum Requirements

Within this setting, mental health services must also:

5.3.2.1 Ensure the sexual safety standards for the service recognise that sexual activity is a normal and healthy part of life and can be supported in a non-acute and residential setting provided that consent, capacity and safety issues are taken into account.

5.3.2.2 Have an understanding of the capacity of the consumers under their care to consent to sexual activity and if this capacity is in doubt, conduct an assessment of the consumer's clinical mental health status, communication skills and current level of knowledge and understanding regarding sexual and personal relationships. This assessment must be recorded in the consumer's collaborative care plan and reviewed on a regular basis.

5.3.2.3 Work with those consumers who lack the capacity to consent to sexual activity to explore solutions should they wish to engage in such activity.

5.3.2.4 Ensure consumers have access to condoms and sexual health information and advice.

5.3.2.5 Monitor the general wellbeing of a consumer or consumers involved in a sexual relationship and attempt to obtain an understanding of how this relationship may be impacting upon their wellbeing.

5.3.2.6 Consult with consumers and carers involved with the service around the requirement for sexual safety and sexual health education for consumers and ensure that consumers are able to contribute to determining the topics such education should involve.

5.3.2.7 Work towards improving the physical environment of existing services, where practicable, and ensure new services are planned, to take account of sexual safety in accordance with the *Sexual Safety of Mental Health Consumers Guidelines,* which are supported by and aligned with the current Australasian Health Facility Guidelines for Adult Acute Mental Health Inpatient Units.

5.3.2.8 Organise for the senior clinician (where not involved in the allegation) to carry out an assessment of the clinical mental state of the consumer who has disclosed an assault or harassment within 48 hours.

5.4 Community mental health setting

5.4.1 Responsibilities

Within this setting mental health services have an additional responsibility to:

5.4.1.1 Help consumers to access education that is sensitive to their culture, age and sexual orientation on topics relevant to the community setting if required.

5.4.1.2 Protect consumers from further contact with the alleged perpetrator if this is a staff member of the service and provide access to appropriate support if the alleged perpetrator is the consumer's family member, carer or friend or another consumer involved with the service.

5.4.2 Minimum Requirements

Within this setting, mental health services must also:

5.4.2.1 Consult with consumers around education needs and identify and advise consumers about existing educational materials or courses that may satisfy such a need.

5.4.2.2 Protect consumers from further contact with the alleged perpetrator if this is a staff member of the service and provide access to appropriate support if the alleged perpetrator is the consumer's family member, carer or friend or another consumer involved with the service.

6. IMPLEMENTATION

6.1 Process and timing

Implementation of this policy directive must be undertaken according to the implementation plan outlined at Appendix III. In recognition of the significant changes to current practice that must be made at a LHD level, and the investment required at a Ministry level to develop an appropriate and consistent training framework, implementation will need to be staged over a two year period. Implementation must be completed by June of 2014.

6.2 Monitoring and verification

Implementation by individual services should be monitored by each Local Health District via the Individual Service Implementation Monitoring Form at Appendix IV. Progress with implementation must be reported annually to the NSW Ministry of Health Mental Health and Drug and Alcohol Office until implementation is completed, in accordance with the following timeline.

First progress report due:	December 2013
Second progress report due:	June 2014
Third progress report due:	December 2014
Final progress report due:	June 2015

The template form at Appendix V will support this process. This form must be signed by the Local Health District Mental Health Director and submitted to the NSW Ministry of Health Mental Health and Drug and Alcohol Office.

7. ATTACHMENTS

APPENDIX I - Key actions when responding to a sexual assault
APPENDIX II - Reporting process for an incident of sexual assault
APPENDIX III - Broad implementation plan
APPENDIX IV - Mental Health Service Implementation Monitoring Form
APPENDIX V - Local Health District Implementation Verification Form

APPENDIX I - Key actions when responding to a sexual assault

Step	Action	Information
1	**Acknowledge and affirm the disclosure**	Be non-judgemental, compassionate and understanding when a consumer discloses their experience of sexual assault or harassment and respond promptly, in accordance with the *Sexual Safety of Mental Health Consumers Guidelines*, whether the assault occurred prior to or after the consumer's admission.
2	**Explore the disclosure**	Provide the consumer with a safe, quiet, private space and gently encourage them to provide information about the assault. Ensure an assessment of the consumer's clinical mental state is undertaken within 24 hours in an acute inpatient setting and within 48 hours in all other settings before proceeding with next steps.
3	**Establish and maintain safety**	Assess whether the consumer is in current danger and the need for special accommodations to make the consumer feel safe, being mindful that it is the alleged perpetrator and not the consumer who has been assaulted that should be moved from the facility if required, unless the consumer who has disclosed the assault specifically requests otherwise or there are other extenuating circumstances.
4	**Secure any evidence**	Keep any clothing worn by the consumer at the time of the assault, ensure only the consumer handles these clothes, and secure the location of the assault if possible along with any CCTV footage of the area in which the incident occurred.
5	**Offer support and options**	Provide the consumer with advice and information regarding their options (Appendix D of the *Sexual Safety of Mental Health Consumers Guidelines*) so they can decide how they want to proceed. The consumer's wishes regarding how to proceed must be respected unless legislatively prohibited or they lack the capacity to make an informed decision (see Step 6).
6	**Organise medical care**	Encourage the consumer to seek immediate medical care to identify and treat any physical injuries and to discuss issues such as the risk of infection or pregnancy. Offer counselling as required and ensure consent is obtained for any forensic exam.
7	**Assess capacity to make informed decisions**	This assessment will need to include an evaluation of the consumer's capacity to understand their options, process and communicate information and effectively exercise their rights. If they are assessed as not having the capacity to make an informed decision regarding their options, any such decision should be delayed if possible until the consumer's capacity is restored. Alternatively, urgent application can be made for a Guardian to make some decisions.

APPENDIX II - Reporting process for an incident of sexual assault

Internally

- **To the Team Leader/Nursing Unit Manager, who must inform the Senior Manager.**
- **Through the Reportable Incident Brief (RIB) system** – RIB must be submitted within 24 hours when:
  - the alleged perpetrator is a staff member; or
  - the consumer who has been assaulted is under 16 years of age; or
  - the consumer who has been assaulted is over 16 but under 17 years of age and is in a care relationships with the alleged perpetrator.
- **Through the Root Cause Analysis (RCA) investigation process.**

Externally

- **To the NSW Police Force when:**
  - the consumer requests this and an assessment of the consumer's clinical mental state does not preclude this as a relevant step;
  - the alleged perpetrator is a staff member; or
  - the consumer is under 16 years of age; or
  - the consumer is over 16 but under 18 years of age and in a care relationship with the alleged perpetrator; or
  - the consumer does not have the capacity to make an informed decision, and the senior clinician has a duty of care to formally report the assault.
- **To the Child Protection Helpline (13 36 27) when:**
  - the consumer is a child under 16 years of age. The Helpline must also be contacted if the consumer is a child at risk of significant harm (which includes when they have had consensual sexual intercourse); or
  - the consumer is over 16 but under 17 years of age and in a care relationship with the alleged perpetrator.

APPENDIX III - Broad implementation plan

Local Health District (LHD)	Individual service
To be completed by June 2014	
▪ Nominate a lead staff member to be responsible for driving implementation of the Guidelines and Policy Directive at LHD level ▪ Identify at least 2 'champions' who will work with the lead staff member to promote and support staff to implement the Guidelines and Policy Directive	▪ Nominate a staff member to be responsible for implementing and monitoring adherence to the Guidelines and Policy Directive at a local level
▪ Promote the availability of the Guidelines and Policy Directive and encourage services to order adequate hard copies	▪ Order adequate hard copies of Guidelines to support ready access by staff, consumers and carers
▪ Provide clear advice to services and key staff regarding the changes required in order to meet the *Sexual Safety of Mental Health Consumers Guidelines* and Policy Directive	▪ Introduce the Guidelines and Policy Directive to staff, consumers and carers involved with the service and communicate about implementation process ▪ Develop and implement a consultation strategy involving consumers, carers and staff to define and promote the sexual safety standards for the service ▪ Develop and implement a strategy to establish or build on local partnerships with key stakeholders, such as the local Sexual Assault Service and other sexual assault agencies, GPs, NSW Police Force, relevant Community Managed Organisations etc
▪ Consult with services regarding training requirements and feed outcomes up to MHDAO ▪ Provide feedback to MHDAO on any draft training framework or materials developed	▪ Consult with staff, consumers and carers regarding training/education needs and feed information up to identified lead staff and champions ▪ Develop plan that identifies individual staff members to participate in training and consumers interested in education
▪ Communicate with services to determine progress with implementation and request completion of the Individual Service Implementation Monitoring Form ▪ Complete and submit the Implementation Verification Form to MHDAO, according to specified timeline	▪ Complete Individual Service Implementation Monitoring Form

Local Health District (LHD)	Individual service
To be completed by June 2015	
▪ Develop local policies and procedures to support services to meet the requirements of the *Sexual Safety of Mental Health Consumers Guidelines* and Policy Directive ▪ Develop processes and documentation to support services to review and assess their: o level of gender sensitivity o physical environment o violence screening and admission processes o reporting processes	▪ Review the following areas of service practice and assess against the Guidelines: o level of gender sensitivity o physical environment o violence screening and admission processes o reporting processes ▪ Based on the outcomes of the above assessment, develop and implement plans to improve these areas to support compliance with the Guidelines and Policy Directive
▪ Promote the availability of the training once it is released by MHDAO and advise of the need for staff to participate	▪ Implement training/education plan for staff and consumers ▪ Ensure future training plans factor in the need for refresher training
▪ Communicate with services to determine progress with implementation and request completion of the Individual Service Implementation Monitoring Form ▪ Complete and submit the Implementation Verification Form to MHDAO, according to specified timeline	▪ Complete Individual Service Implementation Monitoring Form

APPENDIX IV - Mental Health Service Implementation Monitoring Form

Policy Directive: SEXUAL SAFETY – RESPONSIBILITIES & MINIMUM REQUIREMENTS FOR MENTAL HEALTH SERVICES

Mental Health Service Name		**Date**	/ /
Authorised by Service Manager	**Name**		
	Signature		
First progress report ❑ **Second progress report** ❑ **Third progress report** ❑ **Final progress report** ❑			

Has your service…….	NOT COMMENCED	UNDERWAY	COMPLETED
Nominated a staff member to be responsible for implementing and monitoring adherence to the Guidelines and Policy Directive at a service level?	❑	❑	❑
Ordered adequate hard copies of Guidelines to support ready access by staff, consumers and carers?	❑	❑	❑
Introduced the Guidelines and Policy Directive to staff, consumers and carers involved with the service and communicated about the implementation process?	❑	❑	❑
Developed and implemented a consultation strategy involving consumers, carers and staff to define and promote the sexual safety standards for the service?	❑	❑	❑
Developed and implemented a strategy to establish or build on local partnerships with key stakeholders, such as the local Sexual Assault Service and other sexual assault agencies, GPs, NSW Police Force, relevant Community Managed Organisations etc?	❑	❑	❑
Reviewed the following areas and assessed against the Guidelines? • The level of gender sensitivity within the service • The practical environment or layout of the service • The service's violence screening and admission processes • The service's reporting processes	❑	❑	❑
Developed and implemented plans to improve these areas, based on the outcomes of the above assessment, to support compliance with the Guidelines and Policy Directive?	❑	❑	❑
Consulted with staff, consumers and carers re training/education needs and provided this feedback to identified LHD champions?	❑	❑	❑
Developed a training and education plan that identifies which staff must participate in training and which consumers are interested in education?	❑	❑	❑
Implemented your training and education plan for staff and consumers upon the release of the new training based on the Guidelines?	❑	❑	❑

SUBMIT COMPLETED FORM TO THE MENTAL HEALTH DIRECTOR AT LOCAL HEALTH DISTRICT

APPENDIX V - Local Health District Implementation Verification Form

Policy Directive: **SEXUAL SAFETY – RESPONSIBILITIES & MINIMUM REQUIREMENTS FOR MENTAL HEALTH SERVICES**

LOCAL HEALTH DISTRICT		**Date**	/ /
Verified by Mental Health Director	**Name**		
	Signature		

First progress report ❑ **Second progress report** ❑ **Third progress report** ❑ **Final progress report** ❑

IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Lead staff member and champions nominated to drive implementation of the Guidelines and Policy Directive at LHD level	❑	❑	❑
	Notes:		
2. Availability of the Guidelines and Policy Directive promoted and services encouraged to order adequate hard copies of Guidelines	❑	❑	❑
	Notes:		
3. Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy Directive	❑	❑	❑
	Notes:		
4. Review undertaken by services regarding the changes required to service delivery and practices to meet the Guidelines and Policy Directive	❑	❑	❑
	Notes:		
5. Plans developed and implemented by services to support compliance with the Guidelines and Policy Directive	❑	❑	❑
	Notes:		
6. Services consulted regarding training requirements and outcomes communicated to MHDAO	❑	❑	❑
	Notes:		
7. Available training and requirement to attend promoted to services	❑	❑	❑
	Notes:		

SUBMIT COMPLETED FORM TO MHDAO BY EMAIL AT MHDAO@doh.health.nsw.gov.au

SEXUAL SAFETY OF MENTAL HEALTH CONSUMERS GUIDELINES
(GL2013_012)

GL2013_012 rescinds GL2005_049.

PURPOSE

The Sexual Safety of Mental Health Consumers Guidelines provide practical information, advice and strategies to help mental health services maintain the sexual safety of mental health consumers and respond appropriately to incidents that breach or compromise this safety. Sexual safety refers to the recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people.

These Guidelines should be read in conjunction with Policy Directive PD2013_038, which mandates the minimum requirements that must be met in this regard.

KEY PRINCIPLES

The key principles in these Guidelines, and the associated Policy Directive, are listed below.

1. All mental health consumers are entitled to be sexually safe.
2. Mental health services take appropriate action to prevent and appropriately respond to sexual safety incidents.
3. Mental health services support mental health consumers to adopt practices and behaviours that contribute to their sexual safety, both within the mental health service environment and within the community.
4. Mental health services develop individual sexual safety standards appropriate for their particular setting, in collaboration with all members of the service including staff, consumers, carers, clinicians, advocates etc.
5. The physical environment of the mental health service takes account of the need to support the sexual safety of mental health consumers in its layout and use, particularly in regard to gender sensitivity.
6. Mental health consumers, and their families, carers and advocates, are given access to clear information regarding the consumer's rights, advocacy services, and appropriate mechanisms for complaints and redress regarding sexual safety issues.
7. Mental health service staff and clinicians foster a compassionate and open culture that encourages reporting of incidents relating to the sexual safety of mental health consumers.
8. Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the complainant's privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.
9. Mental health service staff are provided with training and education to enable them to:
    a. Effectively promote strategies to support sexual safety and prevent sexual assault and harassment.
    b. Respond appropriately and sensitively to sexual safety issues involving mental health consumers, both within the service environment and within the community.
    c. Integrate trauma-informed care principles into all aspects of treatment.

10. Mental health consumers are supported to access education to enable them to:
    a. Effectively recognise and respond to behaviours, both their own and other people's, that may compromise or breach their own or another person's sexual safety.
    b. Develop self-protective behaviours.
    c. Establish and maintain good sexual health.

USE OF THE GUIDELINE

These Guidelines apply to NSW Health services providing specialist mental health care in all settings including acute inpatient, non-acute inpatient, rehabilitation and community.and staff working for such services.

Where a service has a mix of acute and non-acute consumers in the one unit or facility, it is the responsibility of the service to ensure they implement these Guidelines and the associated Policy Directive in a way that addresses this mix.

The scope of the Guidelines does not extend to providing practical and detailed guidance about how services can best manage issues relating to sexual activity involving consumers. Services are encouraged to develop their own local policies and protocols in relation to this area, being mindful of the policy approach advocated within these Guidelines regarding the right of consumers to express their sexuality safely and respectfully in the appropriate settings.

The Policy Directive outlines a number of Responsibilities and Minimum Requirements for:
- all Mental Health Services, (pg 11)

with additional Responsibilities and Minimum Requirements specific to:
- acute inpatient mental health settings (pg 13)
- non-acute and residential mental health settings (pg 14)
- community mental health settings (pg 15).

Implementation will be staged over a two year period, and must be completed by June of 2014. Implementation by individual services should be monitored by each Local Health District via the Individual Service Implementation Monitoring Form at Appendix IV of the associated Policy Directive.

To download the Guidelines please go to
http://www.health.nsw.gov.au/policies/gl/2013/GL2013_012.html

THE NSW ABORIGINAL MENTAL HEALTH AND WELLBEING STRATEGY 2020-2025 (IB2021_002)

IB2021_002 rescinds PD2007_059

PURPOSE

This Information Bulletin is to advise that the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 has been released. The Strategy is available from the NSW Health website - Mental Health – Resources.

KEY INFORMATION

The Strategy supports and assists NSW Health services in delivering respectful and appropriate mental health services in partnership with Aboriginal services, people and communities.

The Strategy is the foundation for change that will support a future way of working under the national Agreement for Closing the Gap in Aboriginal Health outcomes. The Strategy is supported by three goals:
Goal 1: Holistic, person and family-centred care and healing
Goal 2: Culturally safe, trauma-informed, quality care
Goal 3: Connected care

Each goal is underpinned by several strategic directions. These provide clear guidance for NSW Health services on what actions are required to achieve each goal.

Co-design of local implementation plans
All Districts and Networks are to co-design local implementation plans with Aboriginal stakeholders (including consumers, carers, those with lived experience and families). Implementation Plans are to be co-signed by the Director/Manager of Aboriginal Health and the Director of Mental Health, approved by Chief Executives and submitted to the Mental Health Branch by 30 September 2021 at MOHMentalHealthBranch@health.nsw.gov.au.

The co-design processes are to be based on the five principles identified in the Agency for Clinical Innovation's *A Guide to Build Co-design Capability*.

Local implementation plans are to provide specific, operational guidance to enable the implementation of the Strategy within the local context.

In developing implementation plans, Districts and Networks will need to consider:

- how key deliverables and actions may be embedded in individual or local performance planning
- how the plans complement existing commitments or activities on Aboriginal engagement and co-design
- how public and community accountability can be best achieved and supported, including through local consultation and reporting
- how a co-design and genuine partnership approach can lead to improved planning, delivery, evaluation and coordination of services.

Monitoring and reporting framework
The Ministry will develop and implement a monitoring and reporting framework with a co-design approach to help Districts and Networks measure progress.

The monitoring and reporting framework will help Districts and Networks to provide data on a regular basis. This will help inform future decisions and drive better outcomes.

Where possible, the Ministry will develop performance indicators with Districts and Networks to assess performance against the strategic actions in addition to measures already identified in Service Agreements.

Further information
For further information, contact the Mental Health Branch at MOH-MentalHealthBranch@health.nsw.gov.au.

NSW OLDER PEOPLE'S MENTAL HEALTH SERVICES SERVICE PLAN 2017-2027
(GL2017_022)

GL2017_022 rescinds GL2006_013

This plan is intended to guide NSW older people's mental health (OPMH) services over the next ten years. Pressure on these specialist services will grow as the population ages and the number of older people with complex mental health problems increases. The Plan outlines the purpose, scope, target group and key elements of OPMH services, the context in which they operate and current developments in the service environment. It identifies evidence-based service models and key strategic priorities for the development, delivery and improvement of OPMH services.

This document can be accessed at the following link:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_022

314(13/12/17)

SPECIALIST MENTAL HEALTH SERVICES FOR OLDER PEOPLE (SMHSOP) COMMUNITY SERVICES MODEL OF CARE GUIDELINE (GL2017_003)

PURPOSE

The purpose of this Guideline is to outline a good practice model of care for NSW Specialist Mental Health Services for Older People (SMHSOP) community services.

This model of care explains how community mental health services for older people should be delivered. The aims involve providing the right care to people at the right time, by the right team in the right place, with care directed by the consumer and carer with expert clinician assistance alongside. It is intended to guide policy makers, service planners, service managers and clinicians in improving and re-orienting SMHSOP community services in a manner that is evidence-based, recovery-oriented and responds to key themes identified from consumer, carer, clinician and stakeholder consultations.

Both the SMHSOP community and Behavioural Assessment and Intervention Services (BASIS) teams across NSW are in the primary scope of the model of care.

The Guideline focuses on the model of care and relevant recommendations for SMHSOP community teams. Additional detailed information is available in the SMHSOP Community Model of Care Project Report.

KEY PRINCIPLES

This Guideline is guided by the principles of recovery, consumer-directed care and partnering with the consumer, carer(s), GP, and other key services and supports.

The SMHSOP community model of care has been informed by work being done at the state and national level in the mental health and / or aged care space. It aligns with key national and state standards and policy frameworks.

USE OF THE GUIDELINE

This Guideline should be used by SMHSOP community services to assist them to make improvements in service delivery which are based upon the best available evidence. It is to be developed in collaboration with consumers, carers, clinicians, managers, health care partners and other key stakeholders. It will also provide guidance to existing community services and new services, to inform planning and promote the best use of available resources.

This document can be accessed at the following link:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_003

314(18/10/17)

DISCHARGE PLANNING AND TRANSFER OF CARE FOR CONSUMERS OF NSW HEALTH MENTAL HEALTH SERVICES (PD2019_045)

PD2019_045 rescinds PD2016_056

PURPOSE

This Policy provides direction to NSW Health mental health services. It applies to NSW Health mental health staff involved in **the assessment, care, discharge planning or transfer of care of a mental health consumer**.

The Policy Directive

- Establishes minimum standards to support effective and safe discharge planning and transfer of care for consumers of NSW Health mental health services.
- Sets out a consistent, coordinated approach to ensure continuity of care and support for the consumer and for their family/carers at the point of transfer of their care.
- Clarifies the role and responsibility of mental health services in discharge planning and transfer of care including their linkages with other health care providers and support services, to meet the needs of mental health consumers and their family/carers.

Key Performance Indicators

This Policy Directive aims to address three key performance indicators to improvemental health outcomes:

- reduce re-admissions within 28 days to any acute mental health unit
- increase community follow-up within 7 days post discharge from an acute mental health unit
- reduce the number of involuntary patients who abscond (Types 1 and 2) frominpatient mental health units.

This Policy Directive supersedes PD2016_056 *Transfer of care from mental healthinpatient services*.

MANDATORY REQUIREMENTS

Local Health Districts (LHDs)/Specialty Health Networks (SHNs) have responsibility to ensure that:

- mental health staff are aware of the requirements of this Policy Directive
- mental health staff are trained and supported to implement the requirements ofthis Policy Directive
- local relevant policies and procedures align to the key principles and procedures in this Policy Directive
- mental health staff are familiar with local procedures, communication and documentation standards for discharge planning and transfer of care within their setting
- discharge planning and transfer of care processes and documentation are routinely monitored and subject to clinical review processes, and the results are provided to clinical staff
- processes are in place to monitor the post-discharge community care indicator (7-day follow up), rates of re-admission to an acute mental health service within 28 days, and the number of involuntary patients who abscond from inpatient mental health units.

IMPLEMENTATION

Roles and Responsibilities

The Ministry

- provides mandatory requirements for mental health discharge planning andtransfer of care
- reviews and takes appropriate follow up action on the implementation reportssubmitted by Local Health Districts and Specialty Health Networks.

Chief Executives

Ensure that:

- the principles and requirements of this Policy Directive are applied, achieved andsustained
- all relevant staff understand and comply with the requirements of this Policy Directive
- all relevant staff receive education and training to enable them to carry out their roles and responsibilities in relation to the Policy Directive
- the LHD or SHN submits a report on the Policy Directive's implementation for the initial six and 12 month periods. The reports are to be submitted to the Mental Health Branch, Ministry of Health, on the templates provided (see Procedures document Appendix C and D).

Mental Health Staff

- Read, understand and comply with the requirements of this Policy Directive.

Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services Procedures

1 BACKGROUND

1.1 About this document

Transitions between services and care providers are times of significant risk for mental health consumers and their families/carers. Collaborative and comprehensive discharge planning and transfer of care improves safety for the consumer, their family/carer and the wider community.

1.2 Scope of policy

This Policy Directive applies to **NSW Health mental health staff involved in the assessment, care, discharge planning and/or transfer of care of a mental health consumer**. It sets out the principles and essential requirements for effective and safe discharge planning and transfer of care for consumers of all ages (younger people, adults and older persons) **to services including but not limited to**:

- public mental health inpatient units
- community mental health services
- medical wards
- Local Health Districts (LHDs) and Specialty Health Networks (SHNs)
- private psychiatric hospitals
- general practitioners
- private psychiatrists, psychologists and other health professionals
- community managed organisations (CMOs)
- drug and alcohol inpatient units
- community drug and alcohol services
- government agencies and service providers (for example, Community Living Supports, Housing and Accommodation Support Initiatives, National Disability Insurance Agency/National Disability Insurance Schemes, Police and Correctional facilities)
- aboriginal community controlled health services (ACCHS)
- residential aged care facilities

1.3 Key definitions

Carer/s	Refers to a family member, friend or guardian who is identified as a designated carer and/or a principal care provider under the Mental Health Act 2007.
Consumer	Refers to a person with lived experience of a mental health condition who is accessing or has previously accessed a mental health service. For children and younger people, their caregivers may sometimes be described as consumers (Mental Health Coordinating Council, 2018). In this document the term 'patient' is used when associated with legal status.
Discharge planning	This term is usually associated with assessments, referrals and recovery plans put in place to support continuity of care for a consumer returning to the community after a hospital admission. It links hospital treatment with community based health care and support services. In this document the term 'discharge planning' also refers and extends to the planning, coordination and continuity of care process involved when a mental health consumer moves between any of the settings identified under section 1.2 *Scope of the policy*.
Multidisciplinary team	Refers to the treating team including psychiatrist, doctors, nursing, allied health professionals and other support staff including peer workers.
Telehealth	Telehealth is the secure transmission of images, voice and data between two or more units via telecommunication channels, to provide clinical advice, consultation, monitoring, education and training and administrative services (Agency for Clinical Innovation, Guidelines for the use of Telehealth for Clinical and Non Clinical Settings in NSW, 2015, p4).
Transfer of care	Refers to the transfer of professional responsibility and accountability for the care of a mental health consumer to another person or professional group.

1.4 Legal and legislative framework

The NSW Mental Health Act 2007 (the Act) has informed this Policy Directive. If there are any inconsistencies between this Policy and the Act, the provisions of the Act take precedence.

This Policy Directive has also been informed by:

- *National Mental Health Service Standards* (2010)
- *National practice standards for the mental health workforce* (2013)
- *National Safety and Quality Health Service Standards* (second edition-2017)
- recommendations from *New South Wales Auditor-General's Report (Performance Audit), Mental Health Post Discharge Care* (2015)

Recommendations from coronial inquests and findings from Root Cause Analysis investigations have also informed this Policy Directive.

The NSW Health policy for *PD2011_015 Care Coordination: Planning from Admission to Discharge in NSW Public Hospitals* provides key requirements for all inpatients discharged to the community.

Other relevant legislation, related policies and guidelines are listed at Appendix E.

2. KEY PRINCIPLES

Effective discharge planning and transfer of care relies upon active, collaborative planning involving consumers and their families/carers, the treating team and the receiving team. This will support seamless and coordinated delivery of care.

Timely, clear **verbal communication** and **documentation** are essential elements of safe and effective discharge planning and transfer of care for mental health consumers.
The following key principles underpin this policy:

2.1 **Care planning including discharge planning and transfer of care practices are based on trauma-informed and recovery oriented principles and practices.** These practices prioritise the safety and wellbeing of the consumer, and their family/carer including children.

2.2 **Consumers and carers are partners in care planning including discharge planning and transfer of care.** They must be listened to and involved, as appropriate, throughout care planning from admission through to discharge and transfer of care to another service provider**.**

2.3 **Planning for transfer of care commences as soon as practicable after the consumer's admission to the service.**

2.4 **There is both autonomy and treatment collaboration in the context of safe and comprehensive care.** Staff are to make every effort to support and maintain the consumer's rights, choice and self-determination**.**

2.5 **This process is an active one. There is comprehensive assessment and timely reviews** of a consumer's mental state, their physical health, strengths, vulnerabilities, and consideration of any parenting and family responsibilities, and available supports to enhance effective planning for discharge and/or transfer of care. As with any clinical review, it should be age appropriate and consider cognitive function e.g. psychogeriatric assessment), developmental stage, and co-existing disabilities.

2.6 **There is continuity of care following transfer**. Effective coordination and continuity of care following transfer of care relies on clear and timely **verbal communication and documentation** between the treating team, the consumer, their family/carer and the receiving service.

2.7 **Consumers are not discharged without issues of homelessness being addressed**. Consumers are to be discharged into appropriate accommodation and/or referred to local homelessness services.

2.8 **To maximise opportunities to support the consumer, all modalities of service delivery should be employed. Consider the use of telehealth** (where clinically appropriate) as an effective and efficient modality to support discharge planning and transfer of care.

2.9 Discharge planning and transfer of care **must take into account a consumer's language, culture, and diversity** (i.e. Aboriginal and Torres Strait Islander background), **gender and/or sexual orientation**.

2.10 The Clinical Excellence Commission (CEC) recommends the use of ISBAR(Introduction; Situation; Background; Assessment; and Recommendation) as a key communication guide to achieve a standardised handover procedure that is thorough and person-centered. http://www.cec.health.nsw.gov.au/qualityimprovement/team-effectiveness/insafehands/clinical-handover

3 DISCHARGE PLANNING AND TRANSFER OF CARE

The following guidelines will assist LHDs and SHNs to develop local written procedures which address and manage key aspects of mental health discharge planning and transfer of care. These local procedures must set out requirements and practices applicable for **all** service settings

3.1 Discharge Planning: Working with consumers, families and carers

Mental health services must:

- **Identify a key contact/coordinator from the multidisciplinary treating team**, who is responsible for ensuring that each step of the discharge planning process is completed.
- **Estimate the date of discharge (EDD) in collaboration with the consumer and their family/carer**, based on mental state and other assessments. Regular review of this date must consider current events and clinical advice. The EDD supports timely transfer of care planning and is helpful for the consumer and carer.
- **Carry out regular mental state examinations and assessments of the consumer's personal strengths and vulnerabilities, social supports, safety and practical needs**. These assessments should consider factors such as:
    - harm to self or harm to others (including children in contact with the consumer)
    - risk from others
    - parenting and family responsibilities
    - housing, homelessness or risk of homelessness
    - medication history (including non-adherence with psychiatric medication)
    - history of trauma
    - history of substance use or misuse
    - co-existing physical health and other disabilities
    - history of domestic violence as a victim or perpetrator
    - vulnerability to elder abuse
    - access to firearms or weapons
    - existing and planned support services and their location.
- **Develop and document management strategies for identified risks** in the consumer's *Mental Health Care Plan* in their medical record and consider the need for documenting any appropriate 'Alerts' and 'Problems'.
- Services should **facilitate the use of risk assessment processes and management strategies** that respond to violence, abuse and neglect and prioritise the safety and wellbeing of consumers, regardless of whether the consumer is identified as the victim or the perpetrator.
- **Consider the need for a Community Treatment Order** (Part 3 *Involuntary treatment in the community* of the Act), where appropriate.
- **Consider child protection and wellbeing issues** and respond accordingly (refer to the *Child Wellbeing and Child Protection policies and procedures for NSW Health*).
- **For consumers with long inpatient stays** who are being discharged under the *Pathways to Community Living* initiative, refer to local *Pathways to Community Living* procedures and processes.
- **Support the consumer to update or develop their Wellness Plan**, which will include contingency plans for changes in circumstances including:
    - deteriorating mental or physical health and
    - emergency contacts.
- Ensure all relevant information for safe discharge are discussed with the consumer and family as well as **provided in writing.**

3.2 Discharge Planning: Working with other services

Mental health services must:

- **Engage the receiving service,** for example the community mental health team, other health provider or support service, in discharge planning.
- **Establish mechanisms to enhance the transition experience and reduce the risk of the consumer being lost to care**, for example:
    - Facilitate the consumer's engagement with the receiving community mental health team, other health provider and support service. This could be an introduction by phone, videoconference/telehealth or face-to-face prior to discharge.
    - Use mental health peer workers, if the consumer requests this, to support the consumer transitioning from inpatient to community based services.
    - Offer input from Aboriginal Health Workers or culturally diverse workers in discharge planning.
    - Offer the consumer and their family/carer access to translating and interpreting services where appropriate.
- **For consumers who live in social or community housing**, make early contact with Family and Community Services (FACS) or the relevant community housing provider to ensure that rental obligations are considered and occupancy is maintained.
- Services involved in current and ongoing treatment must **establish a follow-up procedure** for consumers who do not keep or are reluctant to engage with the planned follow-up arrangements as part of discharge planning.

3.3 Transfer of care

Mental health services must establish a standard procedure for transferring a consumer's care that includes **both verbal and written handover**. See section 3.5 Documentation for guidance on the provision of documentation and mechanisms for the treating (referring) team to confirm that the written information has been received by the receiving service provider.

3.3.1 Planning for transfer of care

- Transfer of care discussions are to include the consumer's goals and practical considerations such as:
    - estimated time and date of discharge (EDD)
    - transportation needs
    - access to suitable services
    - supports post-discharge
    - other responsibilities such as parenting and family issues
    - safety planning where the consumer is a victim of domestic and/or family violence or other abuse. Safety planning should be undertaken by, or with a psychosocially trained health worker in consultation with the consumer
    - appropriate referrals for ongoing care and supports.
- Ensure that the local *Transfer of Care Checklist* in the electronic medical record or its equivalent is completed for all consumers.
- Discuss the *Your Experience of Service* (*YES*) with the consumer and give them supporting documentation (e.g. brochure) and a paper copy or the online link with the service code identifier, to complete.
- Discuss the *Carers Experience Survey (CES)* with the carer and give them supporting documentation and a paper copy or the online link with service code identifier, to complete.

3.3.2 Transferring care

From a community mental health service:

- When a **community mental health service is transferring a consumer's care to an external service provider**, including a general practitioner, private psychiatrist or psychologist, they must include the *Discharge/Transfer Summary* from any recent inpatient admission. This summary document offers important information about recent treatment and care of a psychiatric or medical condition, including changes in medication.
- When transitioning **from a community mental health service**, the multidisciplinary team should review all prior discharges/transfers. This review should **confirm in writing** that discharge/transfer is indicated and that the care plan is comprehensive.

From an inpatient service:

- When **an inpatient service is transferring a consumer's care to the community**, ensure that the treating **Psychiatrist or their delegate authorises in writing** the arrangements for a consumer's discharge/transfer of care to the community under the discharge plan section of the *Discharge/Transfer Summary* document. **If the consumer is an involuntary patient**, **the authorising Psychiatrist must be an Authorised Medical Officer (AMO) under the Act.**

To a medical or other ward:

- When transferring **to a medical or other ward**, discuss the transfer with the consumer and carer/s. Ensure that risk assessments and tailored management strategies are conducted.
- Ensure all relevant information for safe transfer of care are included in the **verbal clinical handover** to the ward's treating team as well as **provided in writing.**

When discharging to the community from other Health settings where the Mental Health Service has been involved in the person's assessment or care, the responsible mental health staff member should collaborate with the treating team in relation to discharge planning/transfer of care.

This includes clarity about each staff group's responsibilities in providing both clear verbal and written advice to the consumer and their family/carer on post discharge care as well as referral to community-based services if appropriate.

3.3.3 At the time of discharge/transfer:

With consumers and families/carers:

- The *Discharge/Transfer Summary* document or (if unavailable at discharge) the *Information Handout* is a crucial document for consumers and their families providing information on care and safety of consumers.
- **It is imperative that the *Discharge/Transfer Summary* or *Information Handout* is given to the consumer and their family/carer at the time of discharge and a copy kept in their medical record**.
- The nominated mental health key contact/coordinator must take time to go through the *Discharge/Transfer Summary* with the consumer and their family/carer, and ensure they understand it and answer any questions.
- Section 3.5 Documentation provides detailed guidance on information to be included in the *Discharge/Transfer Summary.*
- The consumer must also receive a copy of their *Wellness Plan*.

With receiving service provider/s:

- The *Discharge/Transfer Summary* document must be forwarded to the receiving service provider and other support services within 12 hours of discharge/transfer, or earlier as clinically indicated.
- The discharging (referring) service must phone the receiving service provider and other support services to advise that the consumer has been discharged, where the consumer's follow up appointment is within 24 hours of discharge.

3.4 Follow-up in the community

- Timing of follow up contact should be based on clinical need/priority and discussed at the time of discharge with the consumer/family as part of the discharge planning process.
- **The receiving community mental health service** must contact the consumer within seven (7) days of discharge from an acute inpatient mental health unit including a Psychiatric Emergency Care Centre. This contact must include clear plans for next actions/follow-up. Identification of clinical deterioration should be escalated and managed as appropriate.
- Where the team is unable to contact the consumer, (or the consumer is a young person), they must contact the consumer's family/carer to gain their perspective on how well the consumer is settling in the community and to identify any concerns that need to be addressed, or to identify additional referrals that could assist this process.

3.5 Documentation

Discharge documentation, including the *Discharge/Transfer Summary*, gives essential information to support continuity of care for the consumer in the initial transition period. It should be given to the consumer at the time of discharge, and to their family/carer, where appropriate.

- Discharge documentation must be **clearly written and summarise care provided with sufficient information for the intended audience.** It must be **understood according to the consumer's culture and language**. Information should include, but not be limited to:
    - correctly entered diagnosis
    - current medications and any side effects
    - agreed care plan
    - identified risks and contingency plans relapse prevention strategies as discussed, and steps to take if relapse is likely,
    - telephone contacts for access/re-entry to the mental health service
    - contact numbers and appointment details of health professionals or support services to which the consumer has been referred for ongoing care
    - treatment and other therapeutic interventions
    - physical health care follow up
    - description of any parenting or family responsibilities
    - include mental health outcome measures as appropriate
    - family and carer information/contact details
- Information that is auto populated in the discharge summary in the electronic medical record (e.g. phone numbers, GP details, medications, diagnosis), should be routinely checked for accuracy.

  If the *Discharge/Transfer Summary* is not available at the time of discharge, an Information Handout is to be given to the consumer and their family/carer (refer to Appendix B). A dated copy of this information handout is to be kept in the consumer's medical record together with details of who completed it and to whom it was given.

- NSW Health mental health clinicians are to follow the requirements under *Mental Health Clinical Documentation* which specifies the mandatory implementation of standardised mental health clinical documentation within NSW public mental health services.

4 THE ROLE OF LEAVE TO SUPPORT DISCHARGE PLANNING AND RECOVERY

Many of the requirements for assessment, communication, documentation and transfer of care as set out in this document also support the planning and management of approved leave.

Graduated leave provides the consumer and the treating team with the opportunity to assess readiness for discharge to the community. Leave periods may present increased risk for the consumer and for others, however leave should be designed to provide opportunities for a strengths-based approach geared towards a consumer's identified goals for discharge.

Approved leave plays an important part in preparation for discharge from mental health inpatient units. The purpose of leave is in the context of treatment goals and strategies. Periods of leave help the consumer maintain links with their life outside hospital and supports their recovery. Consumers detained under the Act are granted leave under Section 47 of the Act.

4.1 Leave Procedures

LHDs and, SHNs must develop local written inpatient leave procedures to ensure consistent and safe leave planning, management and review practices for both voluntary and involuntary mental health inpatients.

4.1.1 The leave plan: Development and communication essentials

If the family/carer is unwilling or unable to participate in the leave plan, it must be reviewed and the outcome documented. Where the outcome of assessment prior to leave raises concern, leave arrangements may be altered or cancelled by the assessing clinician.

Local leave procedures must ensure that leave plans:

- are developed in discussion with the consumer (when a young person, with their carer/parent)
- are discussed, understood and agreed upon with family, friends or care providers who are expected to support and/or supervise the consumer during leave
- prioritise the safety and wellbeing of the consumer, carers, and family members including children
- consider and set out the requirements for voluntary and involuntary patients under the Act
- referrals to the community mental health service to provide clinical care during leave, must be agreed with that service

Details of these discussions/referrals must be recorded in the consumer's leave plan/medical record.

4.1.2 Approval of the written leave plan

- is subject to the multidisciplinary team's consideration of the consumer's improved assessment including risk of harm to self and others and risk of absconding
- is the outcome of the multidisciplinary team's discussion and is recorded in the consumer's medical record
- has the written approval of the treating psychiatrist, or their delegate, who must be an authorised medical officer (AMO) under the Act if the consumer is an involuntary patient

4.1.3 Provision of written leave information

The consumer and the family/carer, or other care provider, **must be given written advice for the leave period**. This document should detail relevant matters such as:

- purpose of leave
- departure and return times
- medication and supervision requirements
- guidance on measures to manage risks during leave
- contact details for the inpatient unit
- arrangements for crisis support
- any restrictions on the consumer's activities and agreed responsibilities.

4.1.4 Post leave follow up requirements include:

- discussion with the consumer, family / carer / community mental health service about the success of leave
- mechanisms for post leave reports to inform clinical reviews
- local safety and security practices to ensure that the consumer has not brought materials to the unit following leave that could pose a threat to themselves or others.

4.1.5 Failure to return from leave or absent from the unit

Steps to follow if a consumer;

  - does not return from leave as arranged
  - is missing
  - has absconded from the unit (i.e. involuntary patients under the Act).

- If there are concerns about a voluntary patient's vulnerability or risk of harm to themselves or others, consider initiating detention processes under Section 19 of the Act **or** provide guidance about notifying the police to request a welfare check.
- If an involuntary inpatient has not returned from approved leave (or has absconded from the unit), procedures must take into account requirements under the Act including notifying the police (also refer to section 3.4.7 of the *NSW Health-NSW Police Memorandum of Understanding 2018*).
- Services must complete incident reporting requirements in line with NSW Health PD2014_004 *Incident Management Policy* and local procedures.

Mental health inpatient units must implement processes to review incidents where an involuntary patient absconds from the unit or during approved leave, to identify areas for improvement and to promote the delivery of responsive and effective care.

5 PRIVACY AND INFORMATION SHARING

To ensure a safe and effective transfer of care, information about the consumer gathered during the episode of care may need to be disclosed to a range of people. This may include health providers, Community Managed Organisations (CMOs), families/carers, the Appointed Guardian and government agencies.

The collection, use or disclosure of a consumer's personal or personal health information must comply with the following legislation:

- The *Privacy and Personal Information Protection Act 1998* (NSW)
- The *Health Records and Information Privacy Act 2002 (NSW)*

In essence, the disclosure of the consumer's information must be:

- directly related to the purpose for which the information was collected
- relevant to the treatment, care or support provided by the third party
- for statutory provisions for mandatory notification purposes (see Appendix A)

Consumers must be consulted about who will be provided with their personal health information and the reasons why. This consultation should take into account the consumer's age, maturity, safety needs, capacity and obligations under the Act and NSW *Privacy Manual for Health Information*. It may be particularly important to seek input from culturally diverse workers.

The consumer may refuse their consent, however, the senior treating clinician must make every effort to explain to the consumer the value of providing certain information to identified people to ensure the best possible care and support is provided. This is especially important if the person is residing with a family member or other carer.

The outcome of these discussions must be clearly documented in the consumer's medical record. Ensure the consumer is given a copy of the Privacy Leaflet for Patients.

6 MONITORING AND REPORTING

LHDs and SHNs must develop local monitoring, reporting and compliance processes for discharge planning and transfer of care which support quality, continuity of care and system-wide improvement.

The following key performance indicators are included in Service Performance Agreements between LHDs/SHNs and the Secretary, NSW Health, to support an integrated system which delivers connected care:-

- the rates of the post discharge 7- day follow up in community for consumers discharged from acute mental health inpatient units
- the rates of re-admission to acute mental health units within 28 days
- the number of involuntary inpatients who abscond from an inpatient unit or who abscond while on approved leave (Incident types 1 and 2).

LHDs/SHNs should also implement other monitoring processes **which include, but are not limited to** clinical audits and other quality assurance mechanisms to assess:

- level of participation of the consumer, their family/carer, receiving health care professionals and other support services, in discharge planning and transfer of care
- the timeliness and quality of information in the discharge documentation
- evidence that discharge/transfer of care documentation has been received by the receiving health service provider and other support services
- the submission of six and twelve month policy directive implementation reports to the Mental Health Branch of the NSW Ministry of Health (Appendix C and D).

7 APPENDICES

Appendix A: Privacy and Information Sharing

There is a range of people with whom information may need to be shared to ensure a consumer's safe and effective transfer of care. They include:

- **Health Providers**

Under the ***Health Records and Information Privacy Act 2002 (NSW)*** – relevant information may be provided to other health professionals providing care, so long as the disclosure is directly related to the primary purpose for which the information was collected and the patient has a reasonable expectation that their information will be used in such a manner.

- **Community Managed Organisations (CMOs)**

Information exchange supports a continuum of care. When sharing information with CMO service providers the information must be either for a directly related purpose (depending on the service provision) or occur where the consumer consents to receiving the support service. Either way, the consumer must have a reasonable expectation that their information will be used for this purpose, or have consented to the service provision. If there is serious concern about imminent risk to the safety of the consumer or others, relevant risk assessment information may be released to the CMO if it is reasonably necessary for the CMO to provide the relevant service.

- **Family and Carer**

Carers identified under the Mental Health Act 2007 must be included in transfer of care planning. However, with consent of the consumer, it may be good practice to involve other members of the family or carer network. A person who is over the age of 14 and under 18 years may not exclude a parent from being given information about them (Section 72(3) of the Act).

Where a consumer is being discharged into the care of their family and/or carers, and with the consumer's consent, they should have sufficient information to properly support the consumer's ongoing health care needs. This may include providing a written copy of transfer of care documents that provide easy access to critical information such as advice about the medication regimen and the management of suicide risk. The consumer must also have a reasonable expectation that their information will meet this requirement. This expectation is best met by communicating with the consumer about relevant discharge planning and ensuring consumers receive a copy of the Privacy Leaflet for Patients

In some circumstances, provision of generic information about general matters relating to mental health care and treatment options may be appropriate.

If the consumer has not consented, it is important that any disclosure to family or care providers is directly related to the primary purpose for which the information was collected.

- **Role of Appointed Guardian**

If a consumer has a guardian, the guardian will be the consumer's designated carer and therefore all the provisions of the Act relating to designated carers will apply.

If the consumer under guardianship lacks capacity, then under the *Health Records and Information Privacy Act*, the guardian essentially stands in the shoes of the consumer and all information can be provided to the guardian.

- **Mandatory notification and exchange of information between prescribed bodies**

Appropriate information must be provided to prescribed agencies for statutory provisions for mandatory notification (as occurs in relation to suspected child abuse, and certain notifiable diseases), such as mandatory notification obligations imposed on registered practitioners.

The law also allows for personal health information to be disclosed to prescribed agencies/bodies in certain circumstances, for example:

- to law enforcement agencies, such as the Police, in order to provide information relating to a serious crime, including assault, domestic violence, child abuse
- to comply with a subpoena or search warrant if your personal information is required as evidence in court
- To prevent or lessen a domestic violence threat in accordance with Part 13A *of the Crimes (Domestic and Personal Violence) Act 2007* and associated Information Sharing Protocols.
- to exchange information about the safety, welfare or wellbeing of children and young people in accordance with the *Children and Young Persons (Care and Protection) Act 1998*.

Please refer to the *Privacy Manual for Health Information* for guidance on these requests (see Appendix E).

APPENDIX B: Sample Information Handout for consumers returning to the community

If the *Discharge/Transfer Summary* and other documentation is not available at the time of discharge to the community, the consumer and their family/carer **must be given an Information Handout in plain language.**

A dated copy of the handout is to be kept in the consumer's clinical record and should identify who completed it and to whom it was given (i.e. the consumer/carers name).

The content of this handout will vary according to the consumer's clinical needs, the setting and other local factors, but should include:

- the consumer's name and current contact details
- date of discharge from service/facility
- carer's name and contact details
- current medication/s, regimen, advice about possible side effects and safety measures
- current medical concerns/treatment/follow-up
- follow up health care arrangements or details of support services, such as:
    - community mental health service: name, address, telephone contact details, name of contact person and appointment details
    - GP phone number and appointment details
- early warning signs of relapse, identification of risks and strategies to reduce eachrisk identified
- contingency plans and relapse prevention strategies
- emergency telephone contacts for access/re-entry to the mental health service
- information or standard handouts about educational or community support services
- information on family and carer support services.

Appendix C: LHD/SHN 6-month implementation reporting form

Mental Health Discharge Planning and Transfer of Care 6-month Implementation Verification Form

LOCAL HEALTH DISTRICT/ SPECIALTY HEALTH		**Date**	/ /
Verified by Mental Health Director	**Name**		
	Signature		
First 6 month progress report ❑			

IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Nomination of a staff member responsible for implementing the policy within the organisation	❑	❑	❑
2. Access to the Policy Statement and Procedures is promoted throughout the organisation	❑	❑	❑
	Notes:		
3. Review undertaken by services regarding the changes required to service delivery and practices to meet the Policy Statement and Procedures	❑	❑	❑
	Notes:		
4. Local protocols developed and disseminated to support services to understand and meet the requirements of the Policy Statement and Procedures	❑	❑	❑
	Notes:		
5. Implementation plans, including education strategy developed by the service to support compliance with Policy Statement and Procedures	❑	❑	❑
	Notes:		

SUBMIT COMPLETED FORM TO MENTAL HEALTH BRANCH BY EMAIL TO:
MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)

Appendix D: LHD/SHN 12-month implementation reporting form

Mental Health Discharge Planning and Transfer of Care LHD/SHN 12-month Implementation Verification Form

LOCAL HEALTH DISTRICT/ SPECIALTY HEALTH		**Date**	/ /
Verified by Mental Health Director	**Name**		
	Signature		
Second 12 month progress report ❑			

IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
Review process has been established to:	❑	❑	❑
a) Measure the percentage of discharged consumers and their family/carer who were included in the discharge planning and transfer of care process	❑ Notes:	❑	❑
b) Measure the percentage of discharged consumers and their family/carer who received the relevant discharge information at discharge.	❑ Notes:	❑	❑
c) Measure the percentage of discharged consumers whose discharge planning and transfer was discussed with the receiving service provider/s prior to transfer of care	❑ Notes:	❑	❑
d) Documentation that referral / discharge information has been received by the receiving health and/support service providers	❑ Notes:	❑	❑

SUBMIT COMPLETED FORM TO MENTAL HEALTH BRANCH BY EMAIL TO:
MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)

Appendix E: Legislative framework, policy and guidelines

Legislation

1. *Mental Health Act 2007*
https://www.legislation.nsw.gov.au/#/view/act/2007/8
2. *Guardianship Act 1987*
https://www.legislation.nsw.gov.au/#/view/act/1987/257
3. Health Records and Information Privacy Act 2002
https://www.legislation.nsw.gov.au/#/view/act/2002/71
4. *Privacy and Personal Information Protection Act 1998*
https://www.legislation.nsw.gov.au/#/view/act/1998/133
5. Children and Young Persons (Care and Protection) Act 1998
https://www.legislation.nsw.gov.au/#/view/act/1998/157
6. *Crimes (Domestic and Personal Violence) Act 2007*
https://www.legislation.nsw.gov.au/#/view/act/2007/80/full

Related polices, guidelines, manuals, and other related documents

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DRUG AND ALCOHOL PSYCHOSOCIAL INTERVENTIONS PROFESSIONAL PRACTICE GUIDELINES (GL2008_009)

These guidelines aim to provide a benchmark for the delivery of quality psychosocial interventions to drug and alcohol treatment services. They recognise the value of such interventions within the D&A field, and support professional implementation of them. They emphasise the need for better understanding about the purpose and benefits of the interventions.

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2008/GL2008_009.html

MENTAL HEALTH CLINICAL DOCUMENTATION GUIDELINES (GL2014_002)

GL2014_002 rescinds GL2008_016.

PURPOSE

This Guideline supports the Policy Directive Mental Health Clinical Documentation (PD2010_018) by outlining the suite of Mental Health Clinical Documentation to be used by NSW Mental Health Services. The primary aim of this Guideline is to provide broad guidance for the use of the modules to document the episode of care from triage through to transfer/discharge. It is not intended as a script or text for conducting a clinical assessment, deciding upon interventions to be undertaken or the application of care.

KEY PRINCIPLES

Mental Health Clinical Documentation is separated into Core (required in all circumstances and clinical settings) and Additional modules (to be undertaken when clinically indicated) to be applied across the episode of care. The modules interrelate such that completion of the Core modules informs what Additional modules to document further assessments are required and such that the clinical record as documented through the clinical documentation forms a coherent narrative about the episode of care.

The suite of Clinical Documentation Modules are to be viewed as a tool for recording assessments and care provided and are not a script for undertaking these procedures. The modules are a place to document clinical information and are not a substitute for clinical skills, training, supervision or judgement.

USE OF THE GUIDELINE

This Guideline should inform the use of the suite by clinicians in mental health and other settings and provides advice on the intent and process of the development of the documents. The Guideline provides advice on when to complete individual Clinical Documents and where the results of a thorough clinical assessment should be recorded to allow consistency across episodes of care and between clinical records.

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2014/GL2014_002.html

PHYSICAL HEALTH CARE WITHIN MENTAL HEALTH SERVICES (PD2017_033)

PD2017_033 rescinds PD2009_027

PURPOSE

This policy supersedes PD2009_027 *Physical Health Care within Mental Health Services,* which was first released in 2009.

It should be read in conjunction with the *NSW Health Physical Health Care of Mental Health Consumers* – Guideline (GL2017_019).

The policy provides direction to NSW mental health services in improving the provision of physical health care to mental health consumers by:

1. Establishing expected standards for the physical health care.
2. Clarifying the role of mental health services, and appropriate linkages with other health care providers, to meet physical health care needs.
3. Developing a consistent, co-ordinated, approach to the physical health care of mental health consumers.

MANDATORY REQUIREMENTS

Mental health services in all settings have responsibility to ensure that:

- Staff are trained and supported to implement the *NSW Health Physical Health Care within Mental Health Services.*
- Provision and access to physical health care for mental health consumers; or facilitating or advocating for the provision of such care; is recognised as the responsibility of the mental health service.
- Organic causes must be excluded or appropriately treated at first presentation of mental illness or in the event of major changes in mental health presentation.
- Adverse physical health outcomes from mental health treatment are minimised and options discussed with the consumer.

Services are required to develop their own local policies and protocols for mental health settings such as inpatient units, community mental health services and psychiatric emergency care centres.

IMPLEMENTATION

Chief Executives are required to ensure:

- The principles and requirements of this policy and guidelines are applied, achieved and sustained.
- All appropriate staff are made aware of their roles and responsibilities in relation to this policy.
- All appropriate staff receive education and training to enable them to carry out their roles and responsibilities in relation to the policy.

Managers must:

- Ensure that all mental health staff read and understand this document.
- Monitor compliance with this policy.

Clinicians are required to:

- Read, understand and comply with the requirements of this policy.

NSW Ministry of Health will:

- Review this policy directive at 5 years following the date of publication. 314(26/09/17)

BACKGROUND

All consumers of mental health services have the right to expect health care that is responsive and in line with the care provided to the general population.

According to available research, both national and international, the physical health of people with a mental illness is poor, and poor physical health is associated with impaired mental health. People with severe mental illness have high rates of mortality and reduced life expectancy as well as decreased access to healthcare.

Mental health services are uniquely placed to support improvement in the physical health of mental health consumers through the adoption of a holistic approach to the care and treatment provided.

Appropriate support provided by well-trained mental health staff can assist consumers to identify and seek treatment for physical illnesses or disease.

Working collaboratively with primary health providers, such as General Practitioners (GPs), Primary Health Networks and non-government organisations play a critical role in the initiation of preventative measures for consumers.

KEY PRINCIPLES

1. Mental health consumers are entitled to quality, evidence based education, care, and treatment for all aspects of health, including physical health.

2. Physical health for mental health consumers is considered by mental health services in planning, education, access, health promotion, screening and preventative activities.

3. Physical health care for mental health consumers must:
   a) recognise consumers as critical partners in the care team
   b) appropriately involve consumers, their families and carers
   c) discuss with the consumer and be delivered in a respectful, non-judgemental and culturally sensitive way
   d) support the consumer to make informed choices.

4. Mental health services work collaboratively with other key health providers in providing quality physical health care for mental health consumers. GPs, Primary Health Networks and non-government organisations have a pivotal role in the provision of care.

5. Physical health care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

PHYSICAL ASSESSMENT CORE COMPONENTS

Core components of a physical assessment of a consumer admitted to inpatient or community mental health care include a relevant history and physical examination.

The core components of a relevant history at first assessment are:

- current prescribed, over the counter or alternative medications
- drug and alcohol use assessment, including smoking

- the presence of any new physical problems or symptoms that are concerning the consumer, their carer or family
- known presence of
    - diabetes
    - high blood pressure
    - high cholesterol
    - asthma or other respiratory illness
    - 'other' illness
- relevant family history

If the assessment is being conducted as part of a review it should also include information about;

- diet
- physical activity
- the consumer's wish to discuss any relevant health issues
- the consumer's participation in relevant preventative health care

History may be obtained as part of a broader mental health assessment, or using a form completed by the consumer, with the assistance of carer or family if appropriate.

The core components of a physical examination are:

- observations - BP; pulse and respiratory rate; temperature
- weight and waist circumference
- height (if not already recorded from previous contact)
- examination of respiratory, cardiovascular and gastrointestinal systems
- initial examination of the neurological system including at least notation regarding presence or absence of marked abnormality of key features such as:
    - equality of pupil size, or eye movement
    - facial symmetry
    - limb and hand power
    - gait
    - limb tone
    - orientation and alertness
    - involuntary movement or akathesia (the Abnormal Involuntary Movement Scale may be used to assist this if clinically appropriate)

RELEVANT HEALTH INTERVENTIONS

Health interventions particularly relevant to the long term health status of mental health consumers are listed below. 'List A' includes those that are particularly relevant to cardiovascular health and 'List B' are other potentially indirect interventions.

List A – Cardiovascular Health

- Smoking cessation (if relevant)
- Weight control interventions, including dietary and life-style advice, if BMI > 25 or abdominal obesity
- Regular exercise
- BP monitoring

List B – Potentially Indicated Interventions

- Contraceptive advice (if of reproductive age) and sexual safety/sexual health advice
- Visual acuity and clinical hearing evaluation, with referral to secondary care if any abnormalities
- Dental review if not conducted in previous 12 months or a need is identified prior to this
- Education on breast (women) or testicular self- examination and symptoms of prostatism (men over 55 years)
- Provision of information regarding HPV vaccination (females <27yo)
- Influenza vaccination when indicated
- Examination for skin malignancies
- Education on risks related to alcohol and illicit drug abuse

MONITORING AND REPORTING

Monitoring the implementation of this policy will occur in part through analysis of the physical health related questions developed for the NSW mental health version of the National Your Experience Survey. Other potential mechanisms to assess service quality and monitor progress against desired outcomes will continue to be explored and Local Health Districts will be consulted regarding any additional proposed mechanisms to support the reporting and monitoring process.

APPENDIX

Attachment 1: Equipment checklist

ITEM	
• A private, warm, well lit area with an examination couch or bed suitable for conducting of physical examinations, together with sheets or towels	
• Stethoscope	
• Sphygmomanometer	
• Thermometer	
• Tendon hammer	
• Non-stretchable measuring tape	
• Tuning fork (256 Hz)	
• Weighing scales	
• Urinalysis sticks	
• Auriscope and ophthalmoscope	
• Examination torch	
• Snellen chart	
• Height measure	
• Disposable gloves	
• Examination lubricant	
• Neurological testing pins	
• Peakflow monitor	
• Glucometer	
• Alcometer/breathalyser	
• Oximeter	
• X-ray box or electronic substitute	
• Pathology venipuncture and associated collection equipment	
• Pathology specimen containers	

Attachment 2: Implementation checklist

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
4. Assign responsibility, personnel and resources to implement the principles and procedures in mental health service settings.	❑	❑	❑
	Notes:		
5. Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy.	❑	❑	❑
	Notes:		
6. Develop and implement a strategy to establish or build on local partnerships with GPs, Primary Health Networks, Community Managed Organisations and other health providers	❑	❑	❑
	Notes:		
7. Undertake a review of current staff skills, identify gaps in knowledge and factor these into future training plans.	❑	❑	❑
	Notes:		
8. Identify, develop and implement strategies to address at risk populations.	❑	❑	❑
	Notes:		

PHYSICAL HEALTH CARE FOR PEOPLE LIVING WITH MENTAL HEALTH ISSUES (GL2021_006)

GL2021_006 rescinded GL2017_019

GUIDELINE SUMMARY

NSW Health is committed to improving the physical health outcomes and reducing early mortality of people with a lived experience of mental health issues. Local Health Districts (Districts) and Specialty Health Networks (Networks) have a responsibility to provide equitable access to high quality, holistic, person-centred physical health care.

This Guideline builds upon the Fifth National Mental Health and Suicide Prevention Plan and the Equally Well Consensus Statement. It reinforces the expectations of NSW Health and the measures required to deliver a whole of health approach to reduce the physical health inequalities experienced by people with lived experience of mental health issues.

KEY PRINCIPLES

Improving and sustaining the physical health care of people with lived experience is the responsibility of all NSW Health mental health and non-mental health services.

All Services are to review their current policies, procedures and practices against the expectations stated in this Guideline. Local policies and protocols are to be developed to address any identified gaps.

The core expectations of this Guideline are;

- All services in contact with people with lived experience of mental health issues are to offer and support interventions to prevent physical illness and promote and sustain health.
- Mental health services are to complete routine physical health screening as an essential component of care.
- Mental health services are to deliver equitable and timely access to physical health assessment, intervention and review.
- Mental health services are to provide access to equitable, evidence-based interventions that target cardiometabolic and behavioural risk factors.
- Clinicians are to complete routine comprehensive assessment as part of an integrated physical and mental health care plan.
- Clinicians are to support, coordinate and document any additional assessments and/or investigations required.
- Clinicians are to offer routine medication assessment and optimisation to minimise risk and negative medication effects.
- Mental health services are to develop partnerships and pathways with key stakeholders to address identified physical health needs as part of an integrated care plan.
- Clinicians are to use a coordinated team approach to deliver high-quality holistic care.
- District and Networks are to deliver safe and effective physical health assessments, interventions and treatment. These are to support sustained health outcomes and health care experiences that matter to the people who receive them.

To view the Physical Health Care for People Living with Mental Health Issues: Guideline go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_006

SAFE START STRATEGIC POLICY (PD2010_016)

(A component of the NSW Health/Families NSW Supporting Families Early Package)

PURPOSE

This policy provides direction for the provision of coordinated and planned responses by health workers involved in the identification of families at risk of adverse outcomes during the perinatal period. It outlines the core structure and components required by NSW Health services to implement the SAFE START model of universal psychosocial assessment, depression screening and follow-up care and support during the perinatal period.

MANDATORY REQUIREMENTS

All Area Health Services are to develop multidisciplinary and multi-agency systems of family-focused health care for pregnant women and families with infants up to two years age. Implementation of the SAFE START model in each Area Health Service must be focused on early identification of psychosocial risk and depressive symptoms and timely access to appropriate interventions for pregnant women and families with infants up to two years of age. Area Health Services will implement strategies outlined in the policy to enhance the knowledge and skills of health and related workers to deliver psychosocial assessment and depression screening; and in the provision of early mental health interventions for mothers, infants and their families.

IMPLEMENTATION

Chief Executives are to ensure a written local SAFE START action plan, as described in this policy and its associated documents, is in place. Local SAFE START action plans should be developed by local executive lead governance groups comprising representation from maternity, child and family health, mental health, drug & alcohol, Aboriginal and multicultural health services. Local executive lead governance groups will guide development and implementation of multidisciplinary and multi-agency systems of family-focused health care for pregnant women and families with infants up to two years age. Ongoing performance monitoring of the SAFE START model and related reporting will be the responsibility of the local executive lead governance groups and will demonstrate that pregnant women and families with infants up to two years age identified as vulnerable are engaged with appropriate specialist assessment and access to family-focused, integrated health care.

This policy must be read in conjunction with the following documents that comprise the NSW Health/ *Families NSW* Supporting Families Early Package.

- GL2010_004 - SAFE START Guidelines: Improving mental health outcomes for parents and infants available at: http://www.health.nsw.gov.au/policies/gl/2010/GL2010_004.html
- PD2010_017 - Maternal and Child Health Primary Health Care Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_017.html

The SAFE START Strategic Policy can be downloaded from http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html

SAFE START GUIDELINES: IMPROVING MENTAL HEALTH OUTCOMES FOR PARENTS & INFANTS (GL2010_004)

(A component of the NSW Health/Families NSW Supporting Families Early Package)

PURPOSE

The SAFE START Guidelines outline the rationale for psychosocial assessment, risk prevention and early intervention during pregnancy and the postnatal period. The Guidelines propose a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment and depression screening in the antenatal and postnatal (perinatal) period. The Guidelines add value to the companion documents that comprise the *NSW Supporting Families Early Package*: *Maternal and Child Health Primary Health Care Policy* and *SAFE START Strategic Policy.* The importance of the broader specialist roles of mental health and drug & alcohol services in addressing the needs of parents at risk of developing, or with, mental health and drug & alcohol problems, are outlined in the Guidelines.

KEY PRINCIPLES

The key principles of the SAFE START model are that NSW Area Health Service staff should:

1. Promote continuity of family care throughout pregnancy, postnatal and early childhood periods;
2. Recognise the significance of risk and protective factors in health. The complex interaction between risk and resilience is acknowledged as well as the strengths and diversity of local communities in the determinants of health;
3. Acknowledge the role of parents and family systems in providing sound foundations for the healthy development of children. The vital role of support systems, especially fathers or partners, is identified and opportunities to include them and participate in care;
4. Ensure interventions are undertaken as early as possible and are flexible enough to respond to variations in individual and family circumstances;
5. Participate in a comprehensive network of local government and non-government resources and services including hospital and community health services, general practitioners, primary health and specialist health services such as mental health and drug & alcohol services and community agencies;
6. Facilitate ongoing partnerships for service delivery based on communication, collaboration and cooperation between the mother, her family and various professionals across the spectrum of care.

USE OF THE GUIDELINE

The SAFE START Guidelines provide support material for local executive lead governance groups and front-line health professionals from maternity, child and family health, mental health, drug & alcohol, Aboriginal and multicultural health services to promote an integrated approach to the care of women, their infants and families in the perinatal period.

This guideline must be read in conjunction with the following documents that comprise the NSW Health/*Families NSW* Supporting Families Early Package.

- PD2010_016 - SAFE START Strategic Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html
- PD2010_017 - Maternal and Child Health Primary Health Care Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_017.html

The SAFE START Guidelines can be downloaded from http://www.health.nsw.gov.au/policies/gl/2010/GL2010_004.html

SCHOOL-LINK INITIATIVE MEMORANDUM OF UNDERSTANDING (PD2010_020)

PURPOSE

This policy:
1) Introduces the NSW School-Link Initiative Memorandum of Understanding between NSW Department of Health and the NSW Department of Education and Training.
2) Outlines what is required by NSW health services to implement the NSW School-Link Initiative Memorandum of Understanding.

MANDATORY REQUIREMENTS

The Memorandum of Understanding provides a framework for a collaborative approach by NSW Department of Health and NSW Department of Education and Training in improving the mental health of children and young people in NSW.

The framework will facilitate the interaction between NSW Department of Health and the NSW Department of Education and Training on:
- the roles and responsibilities of the two Departments in meeting the mental health needs of children and young people in NSW government schools.
- issues relevant to the management of children and young people with mental health problems and the provision of shared care and collaborative support to students with mental health problems.
- the provision of ongoing joint training in the assessment and management of identified mental health problems for school and TAFE counsellors and mental health staff.
- the process for identification and development of new School-Link Initiatives.
- promoting information sharing about each Department's programs, services and other resources, to facilitate better outcomes for children and young people coping with mental health problems.
- specifying joint funding arrangements.
- the development and delivery of mental health prevention, promotion and early intervention programs for children and young people.

IMPLEMENTATION

Area Health Services

All Area Health Services are required to establish local School-Link Steering Committees to assist in the implementation of the Memorandum of Understanding.

All **Area Directors of Mental Health** (or their nominees) together with Regional Directors from the Department of Education and Training (DET) (or their nominees) are responsible for establishing and maintaining local arrangements for the implementation of agreed activities as contained in the memorandum of understanding (additional schedules are currently being developed).

Local direction

Local direction in School-Link matters will be provided by Area Health School-Link Steering Committees which will include Area Health School-Link Coordinators, District Guidance Officers, NSW Department of Education and Training regional personnel, other representatives from Area Mental Health Services and non government school representatives. The School-Link Steering Committees will report regularly to the NSW School-Link Management Committee.

NSW Department of Health

NSW Department of Health has established a NSW School-Link Management Committee comprising senior officers from NSW Health MH-Kids and the NSW Department of Education and Training Student Welfare Directorate. This committee will lead the implementation of the Memorandum of Understanding, setting the strategic directions, developing and overseeing the schedules and activities and the management of the NSW School-Link Initiative. Liaison with other individuals, groups or agencies will occur from time to time as required.

NSW School-Link Initiative Memorandum of Understanding between NSW Health and the Department of Education and Training (DET). *Available from the School-Link webpage:* http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_020.pdf

ELECTROCONVULSIVE THERAPY: ECT MINIMUM STANDARD OF PRACTICE IN NSW (PD2011_003)

PD2011_003 rescinds PD2010_068.

PURPOSE

This Policy Statement defines minimum requirements that must be met in the delivery of electroconvulsive therapy (ECT) in New South Wales.

These requirements apply to all facets of care, including the indications for treatment, potential risks and strategies to minimise them, issues of consent, facilities, anaesthesia, application of the procedure, and the required quality improvement framework.

MANDATORY REQUIREMENTS

The minimum requirements that must be met by health care providers and the health care system are detailed in Minimum Requirements in the delivery of ECT in NSW.

This policy statement is to be read in conjunction with the Guidelines: ECT Minimum Standards of Practice in NSW.

IMPLEMENTATION

Roles and responsibilities of the NSW Department of Health:
- Provide advice and assistance for the implementation of this policy.
- Monitor and evaluates the health system implementation of standards for ECT.

Roles and responsibilities of Chief Executives:
- Assign responsibility, personnel and resources to implement the standards for ECT.
- Report on the implementation and evaluation of ECT standards of Practice to the NSW Department of Health.

Roles and responsibilities of the health service executives responsible for clinical operations and governance:
- Ensure successful implementation of the ECT standards.
- Monitor and evaluate the implementation of ECT standards across their services and feedback evaluation results to staff.
- Ensure the ECT standards are incorporated into orientation programs for relevant clinical staff.
- Educate relevant clinical staff in the use of the ECT standards.

Roles and responsibilities of hospital, facility, clinical stream, unit managers and heads of departments:
- Locally implement the ECT standards.
- Evaluate compliance with the: ECT standards.
- Annually monitor and evaluate local ECT practices and processes in line with the ECT standards.

Roles and responsibilities of all clinicians:
- Ensure their work practices are consistent with the standard for ECT.

ACCESSING INPATIENT MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS (IB2023_001)

IB2023_001 rescinded PD2011_016

PURPOSE

This Information Bulletin advises NSW Health of the release of the framework Accessing Inpatient Mental Health Care for Children and Adolescents and the guide Guide to Understanding Inpatient Mental Health Admissions for Children and Adolescents that replaces the NSW Health Policy Directive Children and Adolescents with Mental Health Problems Requiring Inpatient Care (PD2011_016).

KEY INFORMATION

The decision to admit a child or adolescent into inpatient care is challenging due to the limited research evidence, and the diversity of children and adolescents and their ill-health. Internationally, it has been recognised that inpatient care can be a traumatic experience for children and adolescents (and their families, carers, or close social supports).

In response to new evidence and approaches, as well as a shift in consumer's expectations of appropriate mental health support to children and adolescents, Perinatal Child and Youth, Mental Health Branch, NSW Ministry of Health have developed two new documents to support clinical decision-making and empower decision makers.

Accessing Inpatient Mental Health Care for Children and Adolescents is a framework for clinicians and health care providers who are involved in decision-making surrounding whether, and under which model of care, to admit children and adolescents into inpatient mental health care.

Guide to Understanding Inpatient Mental Health Admissions for Children and Adolescents is a resource document for people who are currently involved in or may become involved in caring for a child or adolescent experiencing mental-ill health. This could include families and carers, social workers, Peer Workers, education professionals, adult mental health, and nonmental health clinicians such as paediatricians and emergency department consultants, general practitioners, communities and justice professionals and children and adolescents themselves.

The framework and the guide builds on the key principles outlined in the NSW Health Policy Directive Children and Adolescents with Mental Health Problems Requiring Inpatient Care (PD2011_016) and provides for determining the most appropriate treatment facility for those children and adolescents with mental health problems who require inpatient treatment. This includes admission into specialist child and adolescent mental health service (CAMHS) units, paediatric hospitals and paediatric wards in general hospitals, and Psychiatric Emergency Care Centres (PECCs).

CHIEF PSYCHIATRIST PANEL REVIEW OF COMPLEX MENTAL HEALTH TREATMENT PLANS (PD2011_055)

PURPOSE

The purpose of this Policy Directive is:

1. To provide an independent high level clinical review of treatment plans that lie outside of usual clinical practice where there is an urgent need.
2. To establish an expert panel chaired by the Chief Psychiatrist that will convene for the purpose of reviewing the treatment plan.
3. To set out a formal procedure to address concerns that have been raised about the clinical management of patients which have been considered to be highly complex and may lie outside usual clinical practice.

MANDATORY REQUIREMENTS

That the attached protocols are established and complied with in all Local Health District Mental Health Services.

IMPLEMENTATION

Chief Executives, Local Health Districts are to ensure that this Policy Directive is implemented in accordance with the attached 'Protocols for the Chief Psychiatrist Panel Review of Complex Mental Health Treatment Plans'.

Any local protocols currently in place must be consistent with the principles contained in the attached Protocols.

The Policy Directive is to be trialled for 2 years and re-assessed in December 2013.

INTRODUCTION

This document outlines the process for a Panel, to be led by the Chief Psychiatrist, to review complex mental health treatment plans that are not typical or standard. This includes plans which require additional clinical oversight when there is an urgent need for treatment that is clinically indicated and to prevent injury or prolonged suffering of the consumer.

MEMBERSHIP

The panel will consist of the Chief Psychiatrist plus at least one Senior Mental Health Clinician who is not associated with the referring Local Health District (LHD). The Chief Psychiatrist will decide on the membership of the panel based upon requirements and availability, but will be a minimum of two people with sufficient and appropriate expertise.

The Chief Psychiatrist will keep a list of potential panel members.

Membership of the panel will be determined in the context of the circumstances of each case. This is due to the fact that each case is likely to present different diagnoses, proposed treatment options and varying complex medical histories. It should also be noted that the composition of each panel may vary according to the Local Health District involved, to ensure independence.

The Chief Psychiatrist will facilitate the review process. In the event that the Chief Psychiatrist is unavailable, the panel is to be chaired by a LHD Mental Health Director or Clinical Director who is a neutral party to the referral.

REFERRAL PROCESS

Only the following positions have the responsibility for referring treatment plans directly to the Chief Psychiatrist:

- LHD Mental Health Service Clinical Directors
- LHD Directors of Mental Health
- LHD Health Service Chief Executives
- Director, Mental Health and Drug & Alcohol Programs
- NSW Health Deputy Director-General
- Director-General.

The Panel will then consider the treatment plan as soon as is practicable, bearing in mind that these treatment plans may need urgent review given the gravity of the situation. The patient's medical condition may be such that any delay in treatment is likely to result in injury, prolonged suffering or be potentially life threatening.

The review may be either written and/or by verbal submission considering the timeframes.

Circumstances for making a referral:

Mental Health Clinicians are able to seek approval from their Clinical Director and Chief Executive to invoke a review of proposed treatment in the following circumstances:

- all other treatments have already been tried with unsatisfactory results, and the situation is so problematic that the treating team considers this treatment is urgently required
- the treating team has sought at least one second opinion and has undertaken peer review which has included the LHD Clinical Director and other appropriate Senior Clinicians.

The treatment plan should be referred for the consideration of the panel once it is endorsed by the District Executive.

Appropriate referrals would include treatment plans where:

- Two or more conventional treatments are used together in a way not previously combined and/or
- A standard treatment is used outside the regular setting and/or
- A particular person presents with an unusual and highly complex set of presentations.

Because it is difficult to define every possible scenario, the LHD Clinical Director will need to use clinical judgment in deciding which treatment plans to refer for a panel decision. However, all treatment plans that involve the continuation of anaesthesia for treatment or control of psychiatric/ behavioural problems beyond what is usually required for the administration of ECT must be referred.

It is important to note that the trial of new medication or experimental treatment remains an ethical consideration and is outside the scope of this policy. The panel will only give consideration to treatment plans for individuals which include currently available treatment options available in clinical settings.

ROLE OF THE PANEL

1. To consider the proposed treatment plan based on the clinical findings and plan of care to be provided and to give an opinion as to:
   a. Whether this treatment is reasonable for this patient and that,
   b. All aspects of safety and patient, family and staff welfare have been considered.
2. To offer any further advice to the treating team that the panel feels is necessary.
3. To advise relevant bodies e.g. Mental Health Review Tribunal (MHRT) or Official Visitors of the decision made on the treatment plan. The advice given to the MHRT is to be provided prior to, or during any relevant hearing which considers this emergency treatment.
4. The panel should reach a consensus on the treatment plan. In the event that a consensus is not able to be reached, the authorised medical officer from the referring LHD is required to consider the advice given by the Chief Psychiatrist.

RESPONSIBILITIES

Chief Psychiatrist's responsibilities:

To provide a record of decisions and rationale on each case to the Director of Mental Health and Drug & Alcohol Programs (MHDAO) once the panel has reached a resolution. A copy of the decision is to be provided to the Director-General.

To provide advice to the MHRT, Official Visitors and other relevant bodies on the decision made by the panel.

A de-identified report of the work of the panel will be provided to the NSW Mental Health Clinical Advisory Council (CAC) at least yearly or more often if need arises.

Panel member's responsibilities:

To assist in determining a resolution on the treatment plan as a member of the panel.

Local Health District staff responsibilities:

That the LHD Clinical Director or their delegate make a timely referral to this panel in the instance where their clinical judgement determines that such a referral is required.

The LHD should provide a report on the treatment and clinical outcome to the Chief Psychiatrist within one month.

RIGHT OF APPEAL

The rights of appeal for mental health consumers and their carers are outlined in the Statement of Rights (Schedule 3 *Mental Health Act 2007*) as such:

> *"You (or a carer or friend or relative) may at any time ask the medical superintendent or another authorised medical officer to discharge you. If the medical superintendent or authorised medical officer refuses or does not respond to your request within 3 working days you (or a carer or friend or relative) may lodge an appeal with the Mental Health Review Tribunal. You will be given a notice setting out your appeal rights."*

Consumers and their carers should be made aware of their right of appeal and information on how to undertake an appeal should be provided.

TIMELINES

The panel will be convened as soon as practicable, and no longer than 48 hours, in order to make an urgent decision on an arising treatment plan.

The Chief Psychiatrist will provide the panel's record of decisions and rationale on each case to the Director, Mental Health and Drug & Alcohol Programs (MHDAO) within a two week period. This will be copied to the Director-General, NSW Health.

The Policy Directive is to be trialled for 2 years and re-assessed in December 2013.

MONITORING CLOZAPINE INDUCED MYOCARDITIS (GL2022_011)

GL2022_011 replaced PD2012_005)

GUIDELINE SUMMARY

This Guideline provides guidance for NSW Health staff in the monitoring, detection and management of clozapine-induced myocarditis. It includes a threshold and guidance for cessation where clinically indicated.

KEY PRINCIPLES

Clozapine is an effective antipsychotic medication for the management of treatment-resistant schizophrenia. It is associated with various cardiac disorders including myocarditis, cardiomyopathy and death.

Myocarditis is most commonly observed early in treatment. Consumers receiving clozapine must be monitored carefully throughout treatment to minimise the risk of adverse cardiac events.

There is to be a collaborative care approach to monitoring and management of clozapineinduced myocarditis. Treatment must be person-centred and consumers and family/carers are to be actively involved in the provision of care. Consumers must be informed of the benefits of treatment with clozapine as well as the associated risks.

Sound clinical judgement and knowledge are essential in the implementation of this Guideline to ensure safe monitoring and use of clozapine in consumers.

Local Health Districts and Specialty Health Networks must have local procedures in place to establish roles and responsibilities in relation to clozapine monitoring, including pathways for medical escalation, onward referral and transfer of care.

Given the potential success of clozapine, every opportunity for continuation of clozapine is to be taken provided it can occur safely.

To view the Monitoring Clozapine induced myocarditis Guideline, go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_011

FORENSIC MENTAL HEALTH SERVICES (PD2012_050)

PURPOSE

Forensic mental health services provide assessment, care, treatment, and other services to people with mental illness who are, or have been, in contact with the criminal justice system. The provision of health care services for forensic and correctional patients, and for civil patients who are a high risk of harm to others, requires the coordination of specialist and general mental health services.

The purpose of this policy is to ensure that there are appropriate standards for forensic mental health services and general mental health services that provide care and treatment to forensic patients.

Forensic mental health services are underpinned by the same principles that underpin general mental health services with the addition of specific principles, legislation and processes that are applicable to forensic and correctional patients, including the *Mental Health (Forensic Provisions) Act 1990*. The general principles include those such as the Charter for Mental Health Services in NSW. Forensic mental health services in NSW aim to adhere to the National Statement of Principles for Forensic Mental Health.[3]

As with the broader NSW mental health system, an effective and efficient forensic mental health system involves a strong collaborative approach between service providers.

MANDATORY REQUIREMENTS

This policy applies to all Public Health Organisations which provide services to correctional patients, or forensic patients detained in mental health facilities or other places, or conditionally released in the community, and to high risk civil patients that come into, or who are referred to, the forensic mental health system.

IMPLEMENTATION

Local Health District Chief Executives, Health Service Executives, Managers:

- Assign responsibility, personnel and resources to implement this policy.
- Provide line managers with support to mandate this policy in their areas.
- Ensure that local protocols are in place in each facility to support implementation.
- Work together with the Justice and Forensic Mental Health Network (JFMHN) to ensure that Local Health District (LHD) policies, procedures and standards are consistent with statewide policies, procedures and standards set out for the forensic system.
- Report compliance with this policy to the NSW Ministry of Health as required.

Chief Executive and Managers, Justice and Forensic Mental Health Network

- Ensure that the *Guidelines for Forensic and Correctional Patient Ground Access, Leave, Handover, Transfer, and Release* are reviewed and updated at intervals of no greater than three years.
- Work together with LHDs, and provide leadership and expertise in relation to the development of system wide policies, procedures and standards for forensic mental health services.

NSW Health Service staff and visiting practitioners providing relevant services:

- Comply with this policy.

To access the attachment to this Policy Directive please go to
http://www.health.nsw.gov.au/policies/pd/2012/PD2012_050.html

[3] Australian Health Ministers' Advisory Council, Mental Health Standing Committee (2006) *National Statement of Principles for Forensic Mental Health*.

MENTAL HEALTH TRIAGE POLICY (PD2012_053)

PURPOSE

An efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.

This policy has been developed by the NSW Ministry of Health in collaboration with Local Health Districts (LHD)/Health Networks. It defines mental health triage, the mental health triage process and the Standards for NSW Health mental health telephone triage services. It also briefly outlines the main roles and responsibilities of the key stakeholders in supporting the delivery of public mental health triage services.

The 1800 011 511 *NSW Mental Health Line* is a single number, state-wide mental health telephone service operating 24 hours a day, 7 days a week and is staffed by mental health professionals. The *Mental Health Line* provides universal and equitable access to mental health triage and referral to the most appropriate point of care.

The *NSW Mental Health Line* is one component of the State Mental Health Telephone Access Line (SMHTAL) Program. The other component of the SMHTAL Program is to improve the operation of public mental health telephone triage services so that they meet the Standards for NSW Health mental health triage services (the Standards) (see section 12.3).

MANDATORY REQUIREMENTS

This policy applies to all public mental health telephone triage services operated by Local Health Districts/Health Networks or their equivalent and by private providers contracted to deliver mental health telephone triage services on behalf of Local Health Districts/Health Networks.

This policy is underpinned by the National Standards for Mental Health Services 2010, in particular Standard 10.2 'Access: The mental health service is accessible to the individual and meets the needs of the community in a timely manner'; and Standard 10.3 'Entry: The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment', as well as the Standards.

Local Health District/Health Network policies, procedures, protocols, guidelines or other documents relating to mental health triage must be consistent with this policy.

IMPLEMENTATION

The NSW Ministry of Health is responsible for the state-wide development and implementation of the SMHTAL Program, including:

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program.
- Funding Local Health Districts/Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.

- Funding the development and delivery of standardised mental health telephone triage training to mental health clinicians who undertake the mental health telephone triage function.
- Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
- Monitoring and quality improving the operation of the SMHTAL Improvement Project.

Local Health Districts/Health Networks and Mental Health Services are responsible for the clinical governance and local corporate governance of the triage policy and associated mental health telephone triage service/s. This includes:

- Implementing the State Mental Health Triage Policy.
- Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline 'Call Handling Guidelines for Mental Health Telephone Triage Services' GL2012_008).
- Monitoring the operation of its mental health telephone triage service/s to achieve the Standards and meeting Ministry of Health reporting requirements.
- Ensuring staff undertaking the triage function receive relevant training and ongoing support.
- Ensuring adequate resource allocation for human resource costs, minor capital works activity and other costs associated with the delivery of triage services.
- Implementing routine evaluation and clinical practice improvement processes, including complaint/incident management.
- Communicating with stakeholders within the Local Health District/Health Network about the operation of its mental health telephone triage services.

Clinical staff are responsible for reading, understanding and complying with the requirements of this policy. (Refer Section 2 'Roles and Responsibilities' for additional information).

1. BACKGROUND

1.1 About this document

In *NSW: a new direction for mental health (June 2006)*, a commitment was made to establish a 24 hour state-wide mental health telephone advice, triage and referral service, staffed by mental health clinicians and linked into the National Health Call Centre Network (agreed to by the Council of Australian Governments). The NSW Ministry of Health developed the State Mental Health Telephone Access Line (SMHTAL) Program to fulfil this commitment.

The aim of the SMHTAL Program is to facilitate access to appropriate mental health services by the people of New South Wales.

The SMHTAL Program is being implemented via an Improvement Project. The Improvement Project will facilitate access to appropriate mental health services through the establishment of a 1800 state-wide mental health telephone number operating 24 hours a day, 7 days a week (the *NSW Mental Health Line*); and by improving the operation of Local Health District (LHD)/Health Network mental health telephone triage services so that they meet state-wide performance Standards.

NSW Health recognises that an efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.

1.2 Key definitions (for the purpose of this policy)

Triage – Mental Health triage is a clinical process conducted by a mental health clinician and documented using the NSW Health Mental Health Clinical Documentation triage module. Triage prioritises service type, need and urgency based on assessed risk, need, disability and dysfunction.

Assessment – A comprehensive mental health assessment conducted by a mental health clinician and documented using NSW Health Mental Health Clinical Documentation standardised assessment module.

Alerts/Clinical Risk Assessment – Alerts/clinical risk assessment is the process used to identify and evaluate potential and imminent risk of harm to self and others.

Action Plan/Risk Management – The formulation of the Action Plan should take into consideration the clinical risk assessment and any other relevant information gathered during the triage process.

Local Health Districts/Health Networks - The organisations within the New South Wales public health system that provide public sector health services.

Mental Health Service – refers to New South Wales public sector mental health services.

1.3 Aim of this document

To define mental health triage, the mental health triage process, the Standards, and Local Health District/Health Network responsibilities with regard to the delivery of mental health triage services.

1.4 Key principles

- Effective and equitable access to mental health services for the people of New South Wales.
- As an entry point to mental health support and treatment, mental health triage services must take responsibility for the management of a caller until transfer to the appropriate agency or person for follow up. This includes:
  - Delivery of timely and consistent services for all people seeking assistance for a mental illness.
  - Facilitation of access to advice and information on other services where a public mental health service intervention is not required.
- Local Health District/Health Network mental health telephone triage services are staffed by appropriately trained and experienced mental health clinicians.
- The triage process will determine urgency of response based on an assessment of risk, distress, dysfunction and disability.
- Triage can be completed face-to-face or by telephone.
- Where a mental health triage indicates that a specialist mental health assessment is likely to be required, the Local Health District/Health Network is responsible for ensuring that a mental health assessment is provided within the urgency of response time frame.
- Where possible local information including relevant consumer care plans should be accessible to triage services.
- Professional interpreter services are engaged in accordance with Ministry of Health policy requirements.
- Triage services will adhere to the principles identified in the National Standards for Mental Health Services 2010: Standard 10.2 Access 'The mental health service is accessible to the individual and meets the needs of the community in a timely manner'; Standard 10.3 Entry 'The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment'.

2. ROLES AND RESPONSIBILITIES

This section briefly outlines the main roles and responsibilities of the key stakeholders in supporting the delivery of effective and efficient triage services.

2.1 NSW Ministry of Health

The NSW Ministry of Health is responsible for the state-wide development and implementation of the SMHTAL Program, including:

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program, including development of marketing collateral.
- Funding Local Health Districts/Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards, and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.
- Funding the development and delivery of standardised mental health telephone triage training to mental health telephone triage clinicians.
- Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
- Monitoring and quality improving the operation of the SMHTAL Improvement Project.

2.2 Local Health Districts/Health Networks

Local Health Districts/Health Networks and Mental Health Services are responsible for the clinical governance and local corporate governance of the triage policy and associated mental health telephone triage service/s. This includes:

- Implementing the State Mental Health Triage Policy.
- Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline 'Call Handling Guidelines for Mental Health Telephone Triage Services' GL2012_008).
- Monitoring the operation of its mental health telephone triage service/s to achieve the Standards and meeting Ministry of Health reporting requirements.
- Ensuring staff undertaking the triage function receive relevant training and ongoing support.
- Ensuring adequate resource allocation for human resource costs, capital works activity and other costs associated with the delivery of triage services.
- Implementing routine evaluation and clinical practice improvement processes, including complaint/incident management.
- Communicating with stakeholders within the Local Health District/Health Network about the operation of its mental health telephone triage services

2.3 Mental Health Telephone Triage Service Clinicians

The primary role of a mental health clinician undertaking the telephone triage function is to offer assistance to all callers at the first point of contact.

Mental health clinicians undertaking the telephone triage function will be experienced mental health clinicians with current registration or professional affiliation in the disciplines of nursing, social work, psychology, occupational therapy. While there is no explicit definition of "experienced mental health clinicians", for the purposes of the SMHTAL Program "experienced" means having at least three years' experience working in acute mental health settings conducting initial mental health assessments.

The NSW Health Mental Health Clinical Documentation triage module (triage module) must be completed whenever it is indicated that the caller may need further mental health service intervention, including but not limited to: referral to community mental health services or other health provider, admission to a hospital, ongoing phone contact or gathering information for future referral.

The triage module must also be completed when referring to another service such as:

- Health service (not mental health)
- General Practitioner
- Another Local Health District/Health Network
- Non-Government Organisation
- Specialist mental health services
- Information for possible future referral i.e. client may be escalating.

Mental Health clinicians undertaking the telephone triage function must manage callers in line with Local Health District/Health Network protocols, and must ensure that triage referrals are forwarded to the most appropriate service within the Urgency of Response scale timeframe.

Mental Health clinicians will complete, but not be limited to, the State mental health telephone triage training program or equivalent training programs, in addition to completing local orientation and induction programs.

Mental Health clinicians will have access to appropriate supervision and will have ready access to senior staff for consultation, training and support.

2.4 Mental Health Clinician/Team Receiving Triage

Local Health District/Health Network and Mental Health Service clinical staff are expected to respond to triage referrals within the Urgency of Response scale timeframe.

When there is a resource issue impacting on the ability of the receiving team to respond within the Urgency of Response scale timeframe, this should be clearly communicated to the patient/consumer and duly documented on the patient's file. Refer to section 9.1, *"Responding to urgency of response"*.

Clinicians receiving the triage referral are expected to complete a comprehensive assessment within the urgency of response timeframe.

When a Mental Health Service provides a consumer with the 1800 011 511 *NSW Mental Health Line* number as part of their treatment plan, the Mental Health Service must forward information about the consumer, including a Consumer Wellness Plan, to the triage service.

Clinicians receiving the triage referral are expected to appropriately provide ongoing feedback and evaluation regarding triage practices. Any concerns regarding the quality of the triage are to be documented on the Incident Information Management System (IIMS).

3. THE TRIAGE PROCESS

Triage is a clinical process to assess and identify the needs of the person and the appropriate response required.

The most important element of triage is the identification of risk.

Following this brief assessment, a recommendation for treatment and an interim management plan is formulated including a response timeframe for those accepted for care in public mental health services.

Triage can be completed for all prospective consumers, existing consumers whose condition may have deteriorated and who require further assessment and intervention, and other service users.

Mental health triage can be conducted in person (face-to-face) or on the telephone. Telephone contact is often more timely and convenient for many service users. Telephone triage has the additional consideration of limited observation capacity, not being able to physically assess the person's behaviour, mannerisms, body language, demeanour or distress.

Frequently referrals are made by third parties (concerned friends, carers, and health professionals). Every attempt should be made to speak to the referred party in order to complete the triage assessment process.

All triages are to be completed using the NSW Health Mental Health Clinical Documentation triage protocol and module.

The triage clinician must collect and document sufficient demographic, social and clinical information to determine whether there is a need, or potential need, for further intervention by the Mental Health Service, particularly face to face follow up, or whether referral to another service should be considered. The aim of the triage process is to obtain sufficient information from the person making the referral (including self-referral) to:

- Determine whether the person requires a mental health service intervention;
- Identify symptoms of acute psychosis;
- Identify possible suicidal behaviour or thoughts;
- Determine the level of risk of harm to self or others;
- Determine the level of risk of harm to children including pregnancy;
- Initiate emergency response where extreme and high urgency is identified;
- When a public mental health service intervention is not required, identify the service most likely to meet the needs of the person (e.g. refer to ServiceLink);
- Identify local community health services and other relevant services (e.g. refer to ServiceLink);
- Give the person clear and concise information about the services available and options for further assessment or treatment including to call back should the situation escalate;
- Refer the person to the service likely to meet the identified need for further assessment or treatment;
- Ensure inclusion of explanatory models which may be culture bound;
- Ensure that the client/consumer has a clear understanding of the triage process and subsequent follow up actions.

4. RISK ASSESSMENT

4.1 Clinical Risk Assessment

Triage clinical risk assessment encompasses two components: initial alerts; and a specific clinical risk assessment.

A brief risk assessment screening tool is incorporated in the triage document.

Possible risk factors include:

- Significant past history of risk.
- Recent thoughts, plans, symptoms indicating risk.
- Recent behaviour suggesting risk.
- Concern from others about risk.
- Current problems with alcohol or substance misuse.
- Major mental illness or disorder.
- At risk mental state:
  - Deterioration due to untreated illness
  - Non-adherence to treatment
  - Lack of support systems
  - Emergence of early warning signs
- Unrecognised acute medical illness presenting as delirium (esp. older people).
- Significant circumstances that create volatile behaviour.
- Concern that a child or young person is being abused or neglected.
- Refugee experience, migration and acculturation stressors, minority ethnic status, intergenerational conflict and concerns with multiple identity issues.

Alerts/risks identified are to be recorded on the front page of the triage document in the Alerts/Risks section.

Clinical risk is rated as Low, Medium or High, and includes but is not limited to:

- Child Wellbeing
- Suicide
- Harm to others
- Elder abuse
- Absconding/wandering
- Falls risk
- Accommodation
- Sexual abuse
- Exploitation
- Cultural risks and barriers
- Isolation
- Aboriginality/"Stolen Generation"
- Member of minority group
- Immigrant/refugee status
- Acute Psychosis
- Self-harm
- Domestic Violence
- Substance use
- Fire risk
- Drug reaction/medical/allergy
- Domestic safety issues
- Physical abuse
- Reputation
- Access to firearms
- Sexual identity conflicts
- Stress related to significant life stage transition
- Unemployment

4.2 Occupational Health and Safety Risk Assessment

Triage OHS risk assessment encompasses initial alerts recorded, and must be incorporated within any action plan undertaken to facilitate information to community services relating to possible risk during home visit identified at point of triage.

Alerts include:

- Animals on premises
- Location issues
- Weapons
- Poor lighting
- Unwanted visit
- Other:……...

5. COMPLETING THE TRIAGE DOCUMENT

As a minimum, the NSW Health Mental Health Clinical Documentation Triage module (**see Appendix 12.1**) is to be used as a basis upon which to complete a triage. Local Health Districts/Health Networks may elect to incorporate the triage document within an electronic medical record or equivalent.

A triage form must be completed whenever it is indicated that the caller may need further mental health service intervention, including but not limited to: referral to community mental health services or other health provider, admission to a hospital, ongoing phone contact or gathering information for future referral.

All sections of the triage document must be completed. When it is not possible to gather all the requisite information on the first point of contact, clinicians must document this on the triage document.

Consumer demographics:
All consumer demographic details should be completed. This information is essential for current and future contact with the consumer. It must be noted if the consumer is a current client of mental health services.

Alerts/Risks:
Any alerts/risks identified during the triage must be clearly documented, including examples/evidence, and summarised in this section. Some examples: ‘High risk for suicide’, ‘Child at risk’, ‘Fire risk – smokes in bed’.

Alerts identified during the triage **must** be addressed in the Action Plan.

Triage Details:
Includes date, time, location, communication issues, referrer details and reason for referral.

‘Location’ refers to the place where the triage is delivered and is described at Ward, Clinic, or Unit level, e.g. emergency department.

‘Location’ and *‘Site’* information complement each other - for example an ambulatory mental health facility can be described as: *Site: XYZ Community Health Centre, Location: Adult Mental Health*.

‘Communication issues’ includes issues such as preferred language required or cultural and gender considerations or any sensory impairment. If an interpreter is required, then the preferred language should be noted, for example, ‘Arabic interpreter is required’. Where cultural issues are present, a brief summary should be noted, for example: ‘Cultural issues may be present, Aboriginal Liaison Officer may be required’.

Reason for referral (include whether client is opposed to referral):
Summarise reason for service being sought by self or other, including a brief outline of what is happening in their current situation that has caused them to call.

History:
History of mental illness or disorders (including Behavioural and Psychological Symptoms of Dementia (BPSD)), family history of mental illness or disorders and past treatments, experience of torture and trauma (post traumatic stress disorder (PTSD)). If there are problems that may be BPSD, family history of dementia is relevant. History of treatment/s including any alternative, traditional or culturally relevant treatments.

Medical Issues:
Medical history of significant illness, drug reactions, current medical concerns. Consider whether any issues suggesting delirium may be present (e.g. especially in older people; sudden onset of change in behaviour, cognition, or ability to care for self, fluctuating symptoms or level of alertness, possible acute medical problems).

Current Treatments:
Service providers, prescribed medication, therapy. Have these had any effect or side effects? Is GP aware of, or supporting the referral? If possible BPSD, have any triggers been identified, or behavioural strategies attempted?

D & A use:
Past and current (include current intoxication), treatment, type substance, frequency.

Current functioning and supports:
Family and carer supports or responsibilities, (including children), accommodation issues (if in residential aged care, note if high or low level).

If a carer or support person is present, it is important to check with that person that they are capable of providing the support to the consumer for the level of distress the consumer is in until the mental health service is able to make face-to-face contact with the consumer.

Legal status/Forensic issues:
Current legal issues, charges, convictions, custodial sentences, Guardianship Orders, visa/migration status.

Mental State impressions:
A brief description of the person's current state, e.g. upset, cheery, crying, calm, verbally aggressive.

Possible Risks
Thoughts of harming self and/or others, neglect, at risk behaviours, acute medical illness.

All tick boxes in this section of the triage document must be completed.

Overall Risk
Suicide, violence and other risks including child safety, self-harm, absconding, exploitation, domestic violence, abuse, neglect, environmental risks.

Summary:
Formulation of presentation including reason for referral, current reported concerns, risk issues, and indications for further assessment and treatment.

Action Plan:
Action plan/interventions includes assigning the Urgency of Response and an overview of all services provided and follow up services being arranged during triage process. Include any actions initiated that address risks and needs previously identified. Include details of interim management plan negotiated with the caller.

- Community Services/Child Wellbeing Unit notified
- Police notified
- Ambulance notified
- Referred to Inpatient Mental Health Service
- Referred to Community Mental Health Service
- Referred to specialist mental health services
- Referred to Emergency Department
- Referred to Community Health
- Interpreter booked
- Aboriginal Liaison Officer notified
- Consult with bilingual/bicultural mental health clinicians (local or state-wide pool)
- Other:

Consumers who are accepted for care into the mental health service should be advised of the anticipated timeframe for response by the receiving mental health team including the option to call back if the situation changes or escalates.

Contacts:
Clinicians should document details of any communications undertaken during the triage to identify any corroboration undertaken, as well as provide contact details to aid any subsequent communication. The prompts provided in the 'Contacts' table are not meant to be definitive or exhaustive and provision is made for clinicians to specify 'Other' contacts.

6. CRISIS TRIAGE RATING SCALE

The Crisis Triage Rating Scale (CTRS) (**see Appendix 12.2**) is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984). NSW Health has adopted this tool to be used within ambulatory services to indicate Urgency of Response (UoR).

The scale evaluates the consumer according to three factors: (1) whether they are a danger to themselves or others, (2) their support system, and (3) their ability to cooperate.

The CTRS is available to assist decision-making regarding the determination of the UoR at triage once the clinician has gathered **ALL** the required information and has made the determination that a consumer requires mental health care. The guidelines regarding the completion of the UoR is that the clinician should use **ALL** available information (including the assistance availed by the CTRS), to inform their decisions regarding the UoR and the resulting action plan. A clinician can make a decision on the UoR on the basis of available information, without having to use the CTRS.

Rating A: Dangerousness

1) Expresses or hallucinates suicidal/homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive and violent.
2) Expresses or hallucinates suicidal/homicidal ideas without conviction. History of violent or impulsive behaviour but no current signs of this.

3) Expresses suicidal/homicidal ideas with ambivalence or made only ineffectual gestures. Questionable impulse control.
4) Some suicidal/homicidal ideation or behaviour or history of same, but clearly wishes to control behaviour.
5) No suicidal/homicidal ideation/behaviour. No history of violence or impulsive behaviour.

Rating B: Support System

1) No family, friends or others. Agencies cannot provide immediate support needed.
2) Some support can be mobilised but its effectiveness will be limited.
3) Support systems potentially available but significant difficulties exist in mobilising it.
4) Interested family/friends, or others but some question exists of ability or willingness to provide support needed.
5) Interested family, friends, or others able and willing to provide support needed.

Rating C: Ability to Cooperate

1) Unable to cooperate or actively refuses.
2) Shows little interest in or comprehension of efforts made on her/his behalf.
3) Passively accepts intervention strategies.
4) Wants help but is ambivalent or motivation is not strong.
5) Actively seeks treatment, willing to cooperate.

Ascertainment guidelines
The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to a client is of extreme urgency and should be followed with appropriate indication on the urgency of response scale and appropriate action. Note that if in residential aged care, Rating B can still be in range 2 to 5.

Crisis triage rating scale

A. Dangerousness = _____

B. Support System = _____

C. Ability to Cope = _____

Triage Rating (A+B+C) = _____

CTRS: A + B + C

Scores are:

Category A =	3 – 9
Category B =	10
Category C =	11
Category D =	12 – 13
Category E =	14 – 15
Category F =	NA
Category G =	NA

The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984) subsequently determining required level of response.

The following minimum action/interventions have been compiled to assist the triage clinician respond to consumer/referrer needs:

Category A Extreme Urgency: Immediate response requiring Police/Ambulance or Other Service (e.g. overdose, siege, imminent violence).

Category B High Urgency: See within 2 hours/present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress).

Category C Medium Urgency: See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).

Category D Low Urgency: See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).

Category E Non Urgent: See within 2 weeks.

Category F: Requires further triage contact/follow up.

Category G: No further action required.

6.1 Responding to Urgency of Response

The mental health triage should clearly indicate which service is required to act on the Urgency of Response (UoR), e.g. the receiving mental health team.

The receiving mental health team at the time of referral, will be responsible for follow up of non-presenting consumers, e.g. consumer fails to present to Emergency Department or is not present on home visit.

There may be occasions when the receiving mental health team is unable to respond within the assessed UoR timeframe. In these instances it is the responsibility of the Mental Health Service to ensure that local processes are in place to manage and support the consumer until such time as the local mental health team is able to assume responsibility and make face-to-face contact with the consumer.

The key principle is to ensure, as much as is practicable, that the consumer is safe until face-to-face contact is made by the local mental health team clinician.

6.2 Crisis Triage Rating Scale/Urgency of Response Review

Confidence of assessment may indicate the need to review the CTRS either increasing or decreasing the urgency of response. Any changes to the CTRS/UoR must be comprehensively and clearly documented as to the reason for the change.

7. CLINICAL DOCUMENTATION

Mental health care is especially dependent on good clinical documentation.

Ministry of Health Policy Directive PD2010_018 specifies the mandatory implementation of standardised mental health clinical documentation within public mental health services.

Clinicians must complete the Ministry of Health Mental Health Clinical Documentation Triage document, or equivalent electronic medical record file.

All records of calls, including clinical documentation, form part of the patient's medical record and can be used in courts of law.

The use of the triage document should always be guided by the clinician's informed judgement regarding the consumer's clinical status and needs at the time.

The bottom of every page of the triage document must be signed off by the clinician completing the document including the name (PRINT), signature, designation (PRINT) and date.

If a section is unable to be completed, the clinician should document why the information has not been collected. For example, the clinician can document that 'the information was unavailable at triage'. If the information was not available at the time of triage, clinicians should document any follow up actions planned to obtain that information.

Clinicians must also meet other requirements of record keeping as outlined by:

- Australian Standard AS2828-1999 Paper-based health care records
- PD2012_069 Health Care Records - Documentation and Management

8. REFERRAL PATHWAYS

8.1 Mental Health Service

The Mental Health Service must identify clear referral pathways that facilitate adherence to achieving CTRS and UoR and standardise clinical information so that it can be shared across multiple sites, where applicable.

Pathways should include linkages to the NSW Dementia Behaviour Management Advisory Service (DBMAS) State Telephone Assistance Line 1800 699 799; and Mental Health DBMAS and/or Behavioural Assessment and Intervention Services (BASIS).

8.2 Emergency Department Referral – General Hospital

When a consumer has been asked to self-present to an emergency department, or is to be brought to an emergency department by police or ambulance, the triage clinician is to ensure that the emergency department staff are notified by telephone of the expected presentation and provided with a copy of the completed triage. The responsible local mental health team is also to be notified of the presentation.

8.3 Health Service other than Mental Health

Clear referral pathways are to be identified that facilitate the sharing of clinical information and linkage of triage processes to other relevant services within the Local Health District/Health Network. These may be dependent upon local delineation of service responsibilities, but may include services for older or younger people, intellectual disability or community health.

In the event that a child, young person and their family has been identified as being at risk of harm, it is important to engage with services that provide advice on the need for statutory child protection intervention (Child Wellbeing Units), or services that can assess the needs of vulnerable children, young people and families that present with complex issues (Family Referral Services).

Services must be aware of local interpretation of Ministry of Health Guideline GL2006_013 that defines a collaborative role for NSW Health Aged Care services and SMHSOP for older people who present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include:

- major depression,
- severe physical and/or verbal aggression,
- severe agitation,
- screaming,
- psychosis.

8.4 Specialist Mental Health Services

Mental health presentations often include a range of complexities and sensitivities that are exacerbated by the prevalence of additional cultural, language and mental health literacy barriers. The availability of specialist cross cultural clinical consultants is aimed at addressing these complexities and facilitating culturally responsive early intervention for the purpose of increasing service use, compliance and improved clinical outcomes. Use of specialist assessment tools developed for indigenous and culturally and linguistically diverse populations are used for determining appropriate referral pathways for clients.

8.5 Managing callers from other Local Health Districts/Health Networks or other States and Territories

All callers to a Local Health District/Health Network mental health telephone triage service are handled at the first point of contact and will receive a triage (using the NSW Health Mental Health Clinical Documentation Triage module) and a risk assessment.

If there is an immediate risk, emergency services are to be activated to take the person to a place of safety where a comprehensive mental health assessment can be conducted.

If the situation does not require an immediate **000** response, the completed triage document is to be made available to the relevant Local Health District/Health Network mental health telephone triage service immediately and the receiving service must be advised by telephone that the triage referral is being forwarded. All Local Health District/Health Network MHTTS have a landline number, details of which are available to all Local Health District/Health Network MHTTSs.

Callers who are making general enquiries and are not seeking assistance for themselves or others may not require referral to their local service but must be treated appropriately and provided with appropriate information.

9. MONITORING AND REPORTING

All Mental Health Telephone Triage Services are to ensure that there are quality assurance processes in place to review and improve triage practices. This should include an ongoing system of data reporting; analysis and action, linked to the Standards for Mental Health Telephone Triage Services (**see Appendix 12.3**).

Opportunities to identify the experience of consumers, carers and other users of the service, including the appropriateness of the response process are acknowledged as important elements of ongoing performance monitoring processes.

All Local Health Districts/Health Networks are required to provide routine reports to the NSW Ministry of Health via the Mental Health and Drug and Alcohol Office, as set out in the SMHTAL Reporting Template (**see Appendix 12.4),** at three monthly intervals, which report on the operation of their mental health telephone triage service in complying with the Standards.

10. RELATED DOCUMENTS

2003: NSW Police Force Disclosure of Information by Health Professionals version 1.2 March 2003.
2005: NSW Health Suicidal Behaviour – Management of Patient with Possible Suicidal Behaviour PD2005_121.
2013: NSW Health Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2013_007.
2013: NSW Health Management of NSW Police Force Officers' Firearms in Public Health Facility and Vehicles GL2013_002.
2006: NSW Health Interpreters - Standard Procedures for Working with Health Care Interpreters PD2006_053.
2006: NSW Health Identifying and Responding to Domestic Violence. See also Policy and Procedures for responding to Domestic Violence PD2006_084.
2007: *Mental Health Act (NSW) 2007*.
2007: NSW Health Aboriginal Mental Health and Well Being Policy 2006-2010 PD2007_059.
2014: NSW Health Mental Health Clinical Documentation Guidelines GL2014_002.
2008: NSW Multicultural Mental Health Plan 2008-2012 PD2008_067.
2010: NSW Health Mental Health Clinical Documentation PD2010_018.
2011: NSW Health Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines PD2011_001.

11. REFERENCES

Auditor General's NSW (2005) Auditor General's NSW Report Performance Audit Emergency Mental Health Services NSW Department of Health [The Audit Office of New South Wales].

Broadbent, M., Jarman, H., & Berk, M., (2002). Improving competence in emergency mental health triage, *Accident and Emergency Nursing*, 10, 155 – 162.

Erdman, C. 2001. The Medicolegal Dangers of telephone Triage in Mental Health Care. *The Journal of Legal Medicine*, 22:553-579.

Happell, B., Summers, M., & Pinikahana, J. (2002). The triage of psychiatric patients in the hospital emergency department: a comparison between emergency department nurses and psychiatric nurse consultants. *Accident and Emergency Nursing*, 10, 65 – 71.

Happell, B., Summers, M., & Pinikahana, J., (2003). Measuring the effectiveness of the national Mental Health Triage Scale in an emergency department. *International Journal of Mental Health Nursing* 12, 288-292.

Kevin, J., (2002) An examination of telephone triage in a mental health context. *Issues in Mental Health Nursing*, 23:757-769.

Lee, S. (2006) The characteristics of police presentations to an emergency department in a community hospital. *Australasian Emergency Nursing Journal* 9, 65—72.

National Institute of Clinical Studies (2006) Victorian Emergency Department Mental Health Triage Project August 2005 – March 2006, National Institute of Clinical Studies (NICS) & Victorian Department of Human Services.

National Standards for Mental Health Services (2010).

NSW Health (2004) Your guide to MH-OAT Clinicians' reference guide to NSW Mental Health Outcomes and Assessment Tools, NSW Health North Sydney.

NSW Health (2005) Clinical Services Redesign Program (CSRP) Emergency Mental Health Project (CSRP-DOH-05-003) Statewide Mental Health Project Final Report [Accenture & NSW Health].

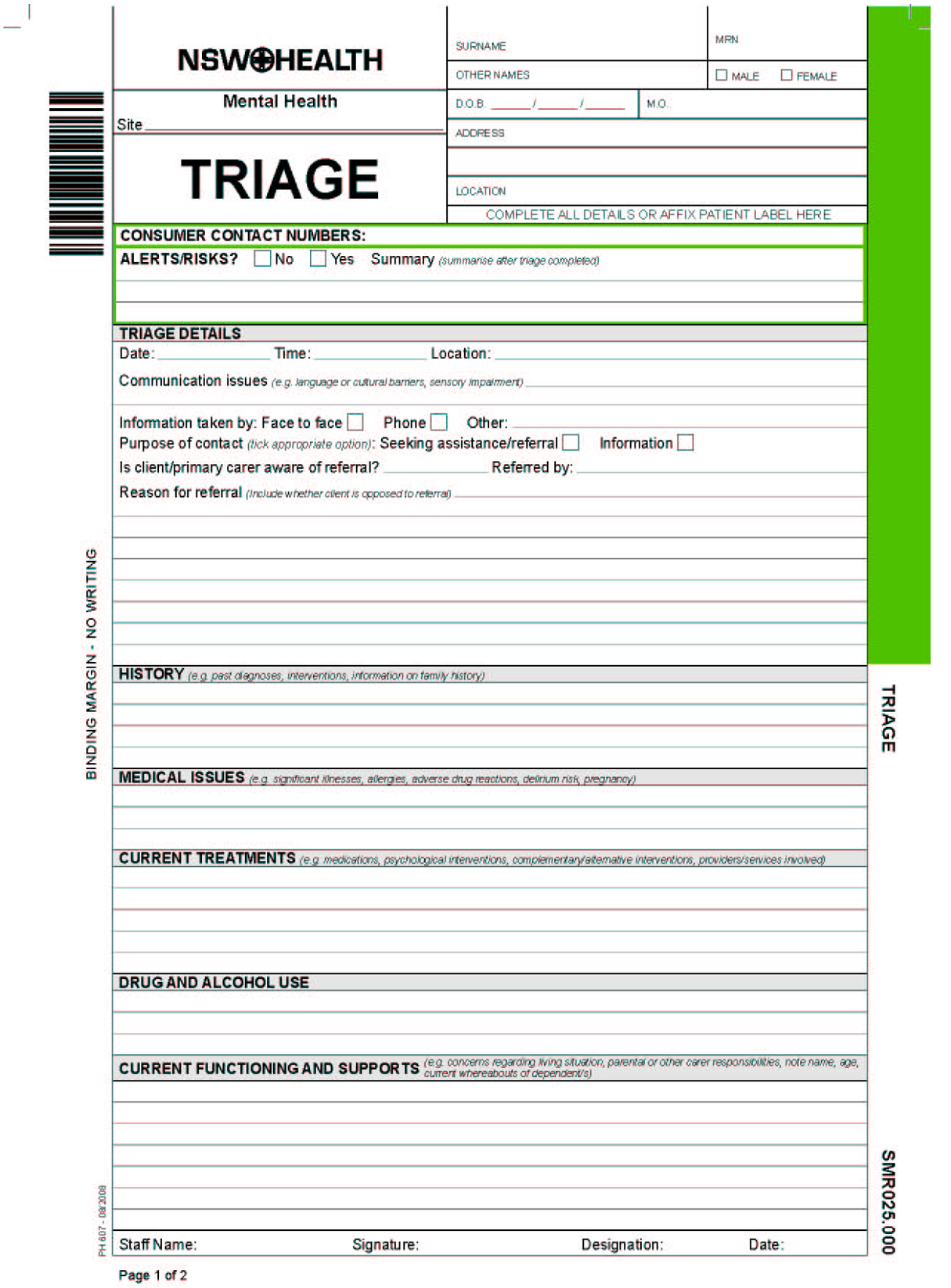
NSW Health (2006) GL2006_013 Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005–2015 NSW Health North Sydney.

Sands, N. (2004) Mental health triage nursing: an Australian perspective. *Journal of Psychiatric and Mental Health Nursing* 11, 150–155.

Sands, N., (2007) Mental health triage: towards a model for nursing practice, *Journal of Psychiatric and Mental Health Nursing* 14, 243–249.

12. APPENDICES

12.1 NSW Health Mental Health Triage Module



NSW HEALTH

Mental Health

Site _____

TRIAGE

SURNAME | MRN

OTHER NAMES | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONSUMER CONTACT NUMBERS:

ALERTS/RISKS? ☐ No ☐ Yes Summary *(summarise after triage completed)*

TRIAGE DETAILS

Date: _____ Time: _____ Location: _____

Communication issues *(e.g. language or cultural barriers, sensory impairment)* _____

Information taken by: Face to face ☐ Phone ☐ Other: _____

Purpose of contact *(tick appropriate option)*: Seeking assistance/referral ☐ Information ☐

Is client/primary carer aware of referral? _____ Referred by: _____

Reason for referral *(Include whether client is opposed to referral)* _____

HISTORY *(e.g. past diagnoses, interventions, information on family history)*

MEDICAL ISSUES *(e.g. significant illnesses, allergies, adverse drug reactions, delirium risk, pregnancy)*

CURRENT TREATMENTS *(e.g. medications, psychological interventions, complementary/alternative interventions, providers/services involved)*

DRUG AND ALCOHOL USE

CURRENT FUNCTIONING AND SUPPORTS *(e.g. concerns regarding living situation, parental or other carer responsibilities, note name, age, current whereabouts of dependent/s)*

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

TRIAGE

SMR025.000

PH 607 - 09/2008

Page 1 of 2

MH_OAT Triage.indd 1 21/08/2008 11:13:31 AM

MANDATORY

First Name: _____ Surname: _____ DOB: _____ MRN: _____

LEGAL STATUS/FORENSIC ISSUES *(e.g. Mental Health Act involuntary patient orders, Guardianship)*

MENTAL STATE IMPRESSIONS *(consider information provided by client and other sources)*

POSSIBLE RISKS *Y=Yes, N=No, UK=Unknown*

	Suicide Y	Suicide N	Suicide UK	Violence Y	Violence N	Violence UK
Significant past history of risk	☐	☐	☐	☐	☐	☐
Recent thoughts, plans, symptoms indicating risk	☐	☐	☐	☐	☐	☐
Recent behaviour suggesting risk	☐	☐	☐	☐	☐	☐
Concern from others about risk *(assessment should include corroboration where possible)*	☐	☐	☐	☐	☐	☐

	Y	N	UK
Current problems with alcohol or substance misuse	☐	☐	☐
Major mental illness or disorder	☐	☐	☐
At risk mental state *(e.g. depressed, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)*	☐	☐	☐
Person's level of risk appears to be highly changeable	☐	☐	☐
Significant uncertainty in the assessment of the level of risk	☐	☐	

Overall Risk *(current/immediate)*	High	Med	Low
Suicide	☐	☐	☐
Violence	☐	☐	☐
Other* *(specify)* _____	☐	☐	☐
Other* *(specify)* _____	☐	☐	☐

*Consider other risks e.g. self-harm, child safety, absconding, exploitation, domestic violence, abuse, neglect, environment risks

SUMMARY *(overall clinical impression, including possible risks; please also document any 'Alerts/Risks' on Page 1)*

ACTION PLAN

Urgency of response *(see CTRS Guideline)*

☐ **A** Immediate	☐ **D** Within 48 hours	☐ **F** Requires further triage contact/follow up
☐ **B** Within 2 hours	☐ **E** Within 2 weeks	☐ **G** No further action required
☐ **C** Within 12 hours		

☐ Department of Community Services notified	☐ Referred to Emergency Department
☐ Police notified	☐ Referred to Community Health
☐ Ambulance notified	☐ Intepreter booked
☐ Referred to Inpatient Mental Health service	☐ Aboriginal Liaison Officer notified
☐ Referred to Community Mental Health service	☐ Other: _____

Details of Action Plan: _____

CONTACTS

Communication undertaken with	Name	Contact details	Comments/issues
Yes ☐ Primary carer/family			
Yes ☐ General practitioner			
Yes ☐ Referrer			
Yes ☐ Other *(specify)*			

Staff Name: Signature: Designation: Date:

SMR025.000 Page 2 of 2

BINDING MARGIN - NO WRITING

12.2 Crisis Triage Rating Scale

The **Crisis Triage Rating Scale** (CTRS) may be used by clinicians as a guide in the determination of urgency of response.

Definition: The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It helps differentiate between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984). The scale evaluates the consumers according to three factors: (A) whether they are a danger to themselves or others, (B) their support system and (C) their ability to cooperate. The clinician chooses the appropriate number under each scale that best describes the consumer's presentation. The total score (A+B+C) can be useful in predicting whether hospitalisation would be required. For example, a consumer scoring below 9 requires hospitalisation, whereas for those scoring above 9 another intervention could be recommended. The Scale was originally based on a telephone triage scale and has been modified and expanded to cover a broader range of response options in inpatient and community services. This Scale should be used by a clinician in conjunction with the available triage information to make an informed decision about the urgency of response.

RATING A: Dangerousness

1	Expresses or hallucinates (hears commands) suicidal/homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive, violent.
2	Expresses or hallucinates suicidal/homicidal ideas, without conviction, or the behaviour is somewhat dependent on the stress in the environment. History of violence or impulsive behaviour, but no current signs of this.
3	Expresses suicidal/homicidal ideas with ambivalence, or made only ineffectual gestures. Questionable impulse control.
4	Some suicidal/homicidal ideation or behaviour, or history of same, but clearly wishes and is able to control behaviour.
5	No suicidal/homicidal ideation/behaviour. No history of violence or impulsive behaviour.

RATING B: Support system

1	No family, friends or others. Agencies cannot provide the immediate support needed.
2	Some support can be mobilised, but its effectiveness will be limited.
3	Support system potentially available, but significant difficulties exist in mobilising it.
4	Interested family, friends or others, but some question exists of ability or willingness to provide support needed.
5	Interested family, friends or others able and willing to provide support needed.

RATING C: Ability to cooperate

1	Unable to cooperate or actively refuses.
2	Shows little interest or comprehension of efforts made on their behalf.
3	Passively accepts intervention strategies.
4	Wants help but is ambivalent or motivation is not strong.
5	Actively seeks treatment, willing and able to cooperate.

Ascertainment guidelines: The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to the consumer should be one of extreme urgency, with appropriate documentation in the *Triage's* 'Action Plan' and 'Urgency of response' on page 2.

URGENCY OF RESPONSE SCALE (CTRS: A+B+C)

Category A 3 — 9	Extreme Urgency	Immediate response requiring Police/Ambulance or Other Service (e.g. overdose, siege, imminent violence)
Category B 10	High Urgency	See within 2 hours/present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress)
Category C 11	Medium Urgency	See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour)
Category D 12 — 13	Low Urgency	See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous)
Category E 14 — 15	Non Urgent	See within 2 weeks
Category F		Requires further triage contact/follow up
Category G		No further action required

MENTAL HEALTH — CRISIS TRIAGE RATING SCALE

12.3 Standards for NSW Health Mental Health Telephone Triage Services

1) Callers across NSW are able to access mental health (MH) services by calling a one number, state-wide MH telephone triage service. This service is to operate 24/7.

2) Mental Health Telephone Triage Service (MHTTS) operators are experienced MH clinicians who are appropriately trained in conducting standardised telephone mental health triage and have a working knowledge of the operating protocols of the service.

3) MHTTS operators have, when possible, access to the history and recent status of current and past clients of the MH service and access to resources about referral points. In the interim and as a minimum, MHTTS operators are to have access to a record of clients' previous contact with the MHTTS.

4) Each MHTTS is governed by detailed local polices and operational protocols which can be reliably interpreted.

5) Each MHTTS systematically monitors the accuracy of the telephone triage decision.

6) Each MHTTS is integrated with local services and permitted to mobilise emergency assistance, and local MH assessments within the specified urgency of response timeframe.

7) Each MHTTS is able to:
   a. Provide advice and information relating to the availability of public or private MH services.
   b. Provide direction to callers who raise non-MH concerns.

8) Each MHTTS conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities made publicly available.

9) Each MHTTS is subject to sophisticated cost and output determination to determine its efficiency.

10) Calls to MHTTS are answered promptly. Benchmark figures are set for:

Grade of service: Average time to answer calls on average over a calendar month	70% of Calls, answered within 30 seconds, when averaged over a calendar month.
Maximum Speed to Answer (MSA)	Not more than 1% of calls wait more than 2 minutes prior to being answered by a MH clinician. The 1% standard will be consistently achieved regardless of time of day or day of week. (The time to answer a call is measured from the time the call starts ringing to when it is answered by a MH clinician; not from the time a call is answered by a voice recording or placed in a queue.)
Call Abandonment rate	Not more than 5% of calls are abandoned. A call is "abandoned" if the caller terminates the call having waited at least 10 seconds from the completion of an announcement message.

12.4 SMHTAL Reporting Template

The following report is to be completed each three months and sent to the Mental Health and Drug and Alcohol Office of the NSW Ministry of Health.

Reporting periods and their due dates are shown below:

Period	Due Date
1 January – 31 March	14 April
1 April – 30 June	14 July
1 July – 30 September	14 October
1 October – 31 December	14 January

.....LOCAL HEALTH DISTRICT/HEALTH NETWORK

FOR THE PERIOD: ..... TO .....

1. Call Activity

(a) In-call volume x month
Only includes calls received by the LHD/Health Network Mental Health telephone triage service from the 1800 011 511 NSW Mental Health Line.
(b) Calls received (i.e. call volume – abandoned calls) per month
(c) Calls received during business hours (i.e. 8.30am –5pm M to F)
(d) Calls received outside business hours
(e) Average duration of calls

Call Activity Summary

Month	In-bound call volume	In-bound calls handled	Bus Hours	Outside Bus Hours	Average duration of calls handled
Month XX					
Month XX					
Month XX					
TOTAL					

Comments

2. Compliance with the Standards

(a) Telephony Standards

i. Grade of Service
(70% of calls answered in 30 seconds averaged over a calendar month)

Percent of calls answered in 30 seconds or less x month.

ii. Maximum speed to answer (MSA)
(Not more than.1% of calls waiting over 2 minutes. The time to answer a call is measured from the time the call starts ringing to when it is answered by a MH clinician; not from the time a call is answered by a voice recording or placed in a queue)

Percent of calls waiting over 2 minutes per month.

iii. Call Abandonment rate
(Not more than 5% of calls are abandoned. A call is "abandoned" if the caller terminates the call having waited at least 10 seconds from the completion of an announcement message).

Percent of calls abandoned.

Telephony Standards Summary

Month	% of calls answered in 30 seconds	% of calls waiting over 2 minutes	% of calls abandoned
Month 1			
Month 2			
Month 3			
TOTAL			

Comments

(b) Non –telephony standards

Comment on the performance of the non-telephony Standards.

Standard	Comments on adherence to Standard
1. Callers across NSW are able to access mental health (MH) services by calling a one number, state-wide MH telephone triage service. This service is to operate 24/7.	
2. Mental Health Telephone Triage Service (MHTTS) operators: - are experienced MH clinicians who are appropriately trained in conducting standardised telephone mental health triage; and - Have a working knowledge of the operating protocols of the service.	• Number of MHTAL clinicians who have received specialist MH telephone triage training YTD. • % of all MHTAL clinicians who have received specialist MH telephone triage training.
3. MHTTS operators have, when possible, access to the history and recent status of current and past clients of the MH service and access to resources about referral points. In the interim and as a minimum, MHTTS operators are to have access to a record of clients' previous contact with the MHTTS.	
4. Each MHTTS is governed by detailed polices and operational protocols which can be reliably interpreted.	
5. Each MHTTS systematically monitors the accuracy of the telephone triage decision.	
6. Each MHTTS is integrated with local services and permitted to mobilise emergency assistance, and local MH assessments within the specified urgency of response timeframe.	
7(a) Each MHTTS is able to provide advice and information relating to the availability of public or private MH services. 7(b) Each MHTTS is able to provide direction to callers who raise non-MH concerns.	
1.1 Each MHTTS conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities made publicly available.	
9. Each MHTTS is subject to sophisticated cost and output determination to determine its efficiency.	

3. Quality Monitoring

(a) Complaints

Number of complaints x Source of Complaint (e.g. Client/Carer, GP, MH staff, Other Health staff, Emergency Services, Other) x Month

Summary Number of Complaints

Month	**Source of Complaint**					
	Client/Carer	GP	MH staff	Other Health	Emergency Services	Other
Month 1						
Month 2						
Month 3						
TOTAL						

Briefly describe the more serious or common complaints received and how they were resolved

Nature of the Complaint	**Resolution**

(b) Incidents

Reporting and resolution of incidents. (Incidents should be reported in IIMS)
Number of incidents x IIMS SAC Severity Rating x Month

Summary Number of Incidents

Month	**Severity rating (SAC)**			
	1	2	3	4
Month 1				
Month 2				
Month 3				
TOTAL				

Briefly describe the more serious incidents or common incidents and how they were resolved

Nature of the Incident	Resolution

(c) Quality Monitoring and Improvement Activities

Describe other quality monitoring or improvement activities conducted, e.g. file audits, staff supervision.

Other quality monitoring or improvement activity	Description	Date

CALL HANDLING GUIDELINES FOR NSW HEALTH MENTAL HEALTH TELEPHONE TRIAGE SERVICES (GL2012_008)

PURPOSE

In *NSW: a new direction for mental health (June 2006)*, a commitment was made to establish a 24 hour state wide mental health telephone advice, triage and referral service, staffed by mental health clinicians and which would link with the National Health Call Centre Network, operating as *healthdirect* Australia. The NSW Ministry of Health developed the State Mental Health Telephone Access Line (SMHTAL) Program to fulfil this commitment.

The aim of the SMHTAL Program is to facilitate access to appropriate mental health services by the people of New South Wales.

The SMHTAL Program is being implemented via an Improvement Project. The Improvement Project will facilitate access to appropriate mental health services through the establishment of a 1800 state wide mental health telephone number operating 24 hours a day, 7 days a week (the 1800 011 511 *NSW Mental health Line*); and by improving the operation of Local Health District/Health Network mental health telephone triage services so that they meet state-wide performance Standards.

The 1800 011 511 *NSW Mental Health Line* provides universal and equitable access to mental health triage and referral to the most appropriate point of care.

This Guideline will assist clinicians undertaking the mental health telephone triage function to manage particular call situations. This Guideline is to be read in conjunction with the Mental Health Triage Policy (PD2012_053). Both the Policy and this Guideline have been developed in collaboration with Local Health Districts/Health Networks.

KEY PRINCIPLES

- Effective and equitable access to mental health services for the people of New South Wales.
- All callers are managed at first point of contact.
- Where a mental health triage indicates that a specialist mental health assessment is required, the Local Health District/Health Network is responsible for ensuring that a mental health assessment is provided within the urgency of response timeframe.
- As an entry point to mental health support and treatment, triage services are to take responsibility for the management of a caller until transfer to the appropriate agency or person for follow-up. This includes:
  - Delivery of timely and consistent services for all people seeking assistance for a mental illness or mental disorder.
  - Facilitation of access to advice and information on other services where a public mental health service intervention is not required.
- To facilitate effective responses across a culturally and linguistically diverse NSW, professional interpreter services are engaged in accordance with Ministry of Health policy requirements.

USE OF THE GUIDELINE

- Local Health District/Health Network policies, procedures, protocols, guidelines and other documents relating to mental health telephone triage must be consistent with the Mental Health Triage Policy (PD2012_053) and this Guideline.
- Staff undertaking the mental health telephone triage function are responsible for reading and understanding these guidelines and for complying with Local Health District/Health Network protocols and guidelines in relation to telephone triage services.

To download the rest of this Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2012/GL2012_008.html

PSYCHIATRIC EMERGENCEY CARE CENTRE MODEL OF CARE GUIDELINE (GL2015_009)

PURPOSE

Psychiatric Emergency Care Centres (PECCs) were introduced in NSW from 2005 as one component of a series of strategies designed to enhance Mental Health (MH) Emergency Care services alongside community mental health teams, Emergency Department mental health clinicians, consultation liaison psychiatry services, psychiatry registrars and consultant psychiatrists.

The earlier version of the PECC Operational Model of Care Guideline attempted to articulate a consensus regarding detailed aspects of PECC operations. The facilities in which PECCs operate differ from each other including with regards to governance, overall mental health resources and how these resources are configured and managed and the physical location and design of the PECC and it has become apparent that it is neither desirable nor possible to standardise resourcing or service delivery arrangements for managing the care of people with mental health problems including those presenting to Emergency Departments (ED).

This updated PECC Model of Care Guideline provides high level guiding principles and basic components from which each service can develop and monitor their own more detailed operating procedures and governance processes which will contribute to best patient care and to the structure of each services' model of care.

KEY PRINCIPLES

MH care in the ED is a collaborative process, with shared responsibility between Emergency Department and MH clinicians and managers and other specialities (e.g. Toxicology, Drug and Alcohol), where relevant. The relative portion of this shared responsibility varies according to individual patient needs and local service arrangements.

PECCs are integrated with a range of community-based and inpatient care options and represent the least restrictive hospital-based inpatient care option. It is intended to be utilised by consumers with low to medium acuity mental health problems for whom less restrictive care (e.g. community based care), is considered inappropriate and unsafe and who are likely to require only a brief (up to 48 hours) period of time in hospital.

The guiding principles for PECCs are:

1. Collaborative decision-making
2. Least restrictive, short-term inpatient care
3. Outcome based monitoring.

USE OF THE GUIDELINE

It is the intention of this guideline that individual PECCs represent a locally determined service collaboration and configuration, based on the guided principles contained within this document. Services should monitor, evaluate and if necessary re-design these agreements by way of carefully chosen outcome and process data reflective of important aspects of mental health emergency care.

This document will assist in the process of establishing, monitoring or reviewing PECC services, their role in the emergency space and in relation to the remainder of community - inpatient MH services.

Download the Guidelines at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2015_009

OLDER PEOPLE'S MENTAL HEALTH (OPMH) ACUTE INPATIENT UNIT MODEL OF CARE (GL2022_003)

GL2022_003 rescinds GL2016_016

GUIDELINE SUMMARY

This Guideline promotes evidence-based good practice in older people's mental health (OPMH) acute inpatient units across NSW, supporting consistent, high quality and safe care. It includes guidance around relationships and processes, clinical interventions, facility design, staffing and performance.

KEY PRINCIPLES

This Guideline reflects current best practice for older people's mental health acute inpatients units and findings from consumer and carer consultation, including a strong preference for direct admission pathways.

It provides recommendations with supporting evidence to guide implementation of a good practice model of care in older people's mental health acute inpatient units. It includes service development guidance to support implementation of core elements of good practice in all units, while informing the development of advanced practice where appropriate.

Emphasises recovery-focused, person-centred, biopsychosocial and trauma-informed care. It promotes timely triage, intake and admission, comprehensive assessment, collaborative care planning with the older person and their carers, and clinical review and transfer of care that maximises consumer engagement, choice and control.

It promotes access to a range of clinical interventions to achieve the older person's treatment goals and support their recover.

It highlights the importance of appropriate care for specific population groups, integrated care (including mental health and physical health care), multidisciplinary staffing and care, minimising seclusion and restraint, and appropriate physical environments.

It promotes alignment of older people's mental health acute inpatient unit practice with national and state practice and performance standards.

This Guideline aligns with NSW Health Guideline NSW Older People's Mental Health Services Service Plan 2017-2027 (GL2017_022) and reflects findings from the NSW OPMH Recovery-Oriented Practice Improvement Project (2017).

USE OF THE GUIDELINE

This Guideline is intended to support ongoing quality improvement and service development in existing older people's mental health acute inpatient units and to inform planning of new units.

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_003

ENGAGEMENT & OBSERVATION IN MENTAL HEALTH INPATIENT UNITS (PD2017_025)

PURPOSE

The purpose of the policy is to identify the minimum requirements for mental health inpatient units relating to levels of observation. The policy will guide and direct clinicians in relation to their responsibilities pertaining to observation.

The aims of these requirements are to ensure that observation levels and engagement are adequate to assess and address the risk of harm to patients or others.

MANDATORY REQUIREMENTS

The policy mandates the practice of assessments by Medical Officers to provide direction to nursing staff regarding the level and purpose of observation required for individual patients.

Nursing staff actively contribute to this assessment, and may increase the level of observation for a patient if required.

If a patient's observation level is increased by nursing staff due to clinical deterioration or concern, this must be escalated and result in a medical review as soon as possible.

The policy requires ongoing multidisciplinary reviews of observation and engagement levels for individual patients to ensure they are responsive to the needs of the consumer.

The outcomes of patient observation and engagements must be contemporaneously documented to inform the continuing and regular review of the observation level.

Observation levels must take into account other risk mitigation factors of the mental health inpatient unit such as ward programs, allied health programs and the clinical environment.

Local procedures must include an evaluation process that mandates audits of observation and engagement practice. These audits will include random inpatient unit visits.

Reports on the outcomes of these audits should be reported to the mental health director.

IMPLEMENTATION

Chief Executives ensure that mental health directors are aware of the policy directive and have a timeframe for full implementation.

Mental health directors review local procedures and practices to determine alignment with this policy and if differences are found, local procedures are updated or developed that clearly outline mandated responsibilities for medical and nursing staff in accordance with this statewide policy.

Mental health directors ensure that an evaluation process is adhered to to ensure compliance to this policy.

Mental health directors ensure that all staff are aware of this policy and procedures which must include random inpatient unit visits and documentation audits.

BACKGROUND

About this document

This policy identifies the minimum standards of observation and engagement to consumers within mental health inpatient units.

This policy replaces previous guidance on mental health nursing observations within the Suicide Risk Assessment and Management Protocols – Mental Health Inpatient Unit (NSW Department of Health, 2004).

The policy ensures that engagement and observation levels continue to assess and manage the risk or concern of harm to a consumer or others.

The policy enables a shared definition and understanding across NSW to improve consumer safety and focus upon consumer centred care.

Local procedures should be developed that align with the procedures, definitions and documentation requirements outlined within this policy.

The policy is relevant to all mental health clinicians involved in the engagement, observation, assessment and review of consumer's within NSW mental health inpatient units.

Key definitions

Observation
Observation through engagement is the purposeful gathering of information from consumers to inform clinical decision making. It is the formal and objective assessment of a person's condition – physical, mental, social. Observation is not passive nor does it predominantly include watching consumers from a distance. Undertaking observations requires nurses to be person centred and engage therapeutically with inpatients.

Observations through engagement are for safety, protection from harm and maintenance of wellbeing. It provides an opportunity to develop rapport and contribute to ongoing assessment and recovery.

The purpose of observation is to provide optimum care, to escalate and manage deterioration in a timely way and to ensure safety of the environment in which the care is being provided.

Observation is indelibly linked with clinical assessment. Observation informs ongoing decisions about care and must be a continuous feature of the care of people in mental health inpatient units.

The principles of observation in mental health inpatient care include engaging with people during purposeful observation which actively contributes to comprehensive care. There are several principles that underlie the practice of observation:

- Observation is multifaceted
- Observation and assessment are interrelated
- Observation is grounded in therapeutic engagement with the person
- Appreciation of how inpatient environments influence behaviour
- Observations are communicated between colleagues
- There is a clear process of documentation that is timely and descriptive.

Ongoing engagement with the consumer, family and carers support shared decision making around continued observation and care planning

Nursing Observation through engagement in psychiatric inpatient care, Victoria Department of Health, 2013.

The following definitions of observation levels are designed to provide a common language and state wide understanding of the differing levels and requirements for the management of each observation level.

Level 1: Constant Observation
Arm's length: The most restrictive form of observation to mitigate the highest risk or concern for a consumer. At all times a nurse must be within one metre of the consumer; or
Visual: A highly restrictive form of observation to mitigate a consumer assessed at high risk of harm. At all times, the consumer must remain under the visual observation of a nurse.

Level 2: Observation every 15 minutes – this level of observation is significantly restrictive to mitigate risks for consumers who are assessed as being at a high level of concern. Nurses must regularly engage and randomly observe consumer's on this level at least every 15 minutes (at a minimum).

Level 3: Observation every 30 minutes
This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 30 minutes (at a minimum).

Level 4: Observation every hour
This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 60 minutes (at a minimum).

Level 5: Observation every two hours
This level of observation should include random and regular checks of the location and activity of the consumer every two hours (at a minimum).

Policy context

This policy aligns with Standard 2 of the *National Standards for Mental Health Services, 2010*.
This policy supports the implementation of Standard 2: Safety which promotes the optimal safety and wellbeing of consumers in all mental health settings.

This Policy identifies the requirements of staff to regularly review the level of risk or concern related to a consumer and their level of observation. This policy does not relate to the Physical health care of consumers and/or physical observations required. Directives and Guidance for the Physical Health care of mental health consumers may be found in the Physical Healthcare within Mental Health Services Policy (PD2009_027).

This policy is supported by the Transfer of Care from Mental Health Inpatients Policy (PD2016_056); Aggression, Seclusion and Restraint in Mental Health Facilities Policy (PD2012_035) and Clinical Care of People who may be Suicidal Policy (PD2016_007).

Responsibilities and minimum requirements relating to observation of consumers during episodes of restraint and seclusion are attended to within the Policy Directive Aggression Seclusion and Restraint in Mental Health Facilities in NSW (PD2012_035).

OBSERVATION AND ENGAGEMENT

2.1 Observation includes engagement with the consumer as well as visual observation.

2.1.1 Consumer observation must be purposeful and include person centred engagement.

2.1.2 Levels of observation must be allocated according to an individual's assessments and needs and not at set levels for a whole unit or a point of care (e.g. at admission).

2.1.3 Staff allocating and maintaining observations should explain to the consumer their level of observation and the requirements relating to this level of observation to ensure engagement and participation of the consumer in their health care.

2.2 A consumer's assessment, management and care plan need to reflect the multidisciplinary teams planning and inform the level of observation and engagement required for individual consumers.

Nurses must record the observation and engagement in the medical record. This documentation must include:

- the level of observation
- the observation and engagement undertaken
- assessment of the consumer's mental state

Consumer's identified as being at higher levels of concern or changeability require more frequent observation, engagement and assessment.

2.3 Clinical handovers between multidisciplinary teams must include assessments of observation and engagement levels.

2.4 Nursing clinical handover for each consumer must include the level of observation and the engagement and assessments undertaken to ensure a safe transfer of care and clear understanding of the plan for the receiving nurses.

2.5 The Nursing Unit Manager (or delegate), along with the medical director (or delegate) are responsible for determining if the levels of observation set for all consumer's in that unit are appropriate, and are reviewed.

2.6 Where there are insufficient nursing resources to undertake observation and engagement, the Nursing Unit Manager (or delegate) will escalate to the responsible Nurse Manager. Where avenues for staffing are exhausted a collaborative decision by the Nursing Unit Manager (or delegate) and local nursing administration will direct distribution of current resources while other arrangements are made.

NURSING SPECIFIC RESPONSIBILITIES

3.1 The Nursing Unit Manager or delegate is responsible for ensuring that all nursing staff are aware and able to fulfil their responsibilities for completing the agreed observation of all inpatients within the unit. This includes the prioritisation of observations within the unit and ensuring nurses are allocated and where required (e.g. Observation level 1, fatigue management, etc.) share the observation responsibilities.

3.2 The Nursing Unit Manager or delegate must randomly review throughout a shift that observation levels are being undertaken and documented as prescribed.

3.3 Nurses may at any time increase the level of observation for an individual consumer based on assessment or concern.

3.4 This increase must be escalated to the responsible medical officer and/or through nursing management and result in a medical review as soon as practicable in line with local clinical deterioration procedures.

3.5 Documentation of observations are to be recorded on locally developed forms that align with the requirements of this policy. Each Level of Observation (i.e. 1, 2, 3, 4 and 5) will require a separate form. These forms must form part of the consumer's medical record when completed.

3.6 Engagement and assessment must be recorded contemporaneously in the medical record in line with the documentation requirements listed within this policy.
3.7 Tick box observation forms must not be used because they do not adequately document the consumer's level of risk or record the observation.

3.8 The Observation form must allow the nurse to document the actual time the observation took place and clearly identify the nurse completing the observation.

3.9 Minimum observations documented on the observation form must include the consumer's location and activity at the time of being seen.

3.10 The medical record will reflect the engagement with the consumer and the resulting assessment.

3.11 The documentation of each engagement and assessment must be inclusive of the consumers' mental state, current risks and concerns (both subjective and objective), interactions with staff and other persons, and be reflective of the targeted rationale for observation.

3.12 Observations must be conducted regularly according to the assessment of the level of risk or concern. It is recommended that staff occasionally undertake additional rounds between the prescribed times so that consumers cannot discern a pattern/set routine. The risk of set routines in observation is that a consumer may harm themselves, or others, between regular and predictable observation times.

3.13 Where an observation has been missed, the reason must be documented on the consumers observation form by the responsible nurse.

3.14 The observation level, engagement and resulting assessments of each consumer must form part of each clinical handover.

MEDICAL OFFICER RESPONSIBILITIES
4.1 Assessments must be conducted and documented by medical officers to determine the level of observation required for individual consumers. Decisions should be made with the multidisciplinary team, consumer and where possible the family and or carers to ensure collective input and decision making.

4.2 Active feedback to the consumer, family and carers regarding observation levels and assessment ensures ongoing and collective engagement of all parties within care planning.

4.3 The level of observation, its rationale and reviews of the level of observation must be clearly documented by the responsible medical officer within the medical record so clinicians may easily identify the level of observation and the ongoing targeted nursing assessments required as part of this observation level.

4.4 Only medical officers may reduce an observation level, this should occur in consultation with the multidisciplinary team.

5 LEVELS OF OBSERVATION

Level	Description of level of supervision	Documentation requirements	Review
Level 1 - Constant Observations (Arms Length)	At all times a nurse must be within one metre of the consumer. Assessment of the safety of the consumer and nursing staff must be taken into account when allocating this level of observation. The observation of a consumer on this level should where possible be inclusive of gender and culturally appropriate allocation of nursing staff. This level of observation requires a skilled and knowledgeable nurse as the indication and outcome of this level of observation is constant assessment. A consumer on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the consumer's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
Level 1 - Constant Observations (Visual)	At all times the consumer must be within the line of sight of the nurse responsible for undertaking the observation. This level of observation requires a skilled and knowledgeable nurse as the indication and outcome of this level of observation is constant assessment. The observation of consumers on this level should where possible be inclusive of gender and culturally appropriate allocation of nursing staff. Consumers on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.

Level 2 - 15 Minute Observations	This level of observation should only be used infrequently due to: • the challenge it poses to regular engagement. • the pattern of this observation becoming easily identifiable by consumer's who may use the time between observation opportunistically and impulsively. Therefore, this level may be used as a step down from Level 1 observations or a step up from Level 3. Should escalation from Level 3 to Level 2 be instigated by nursing staff, discussion with the Nursing Unit Manager (or delegate) and medical officer should occur immediately to assess whether an observation Level 1 is required to mitigate the identified risk or concerns. This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 15 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Consumers on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.

Level 3 - 30 Minute Observations	This level of observation should include random and regular checks by nursing staff of a consumer's location and activity within the unit at least every 30 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through two contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least weekly, led by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
Level 4 - Hourly Observations	This level of observation should include random and regular checks by nursing staff of a consumer's location and action within the unit at least every 60 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through a contemporaneous documented assessment per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least weekly, led by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
Level 5 - Two Hourly Observations	Consumers on this level of observation are considered by the treating team to be at minimal risk. Consumers on this level of	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through a	At least weekly, led by the responsible medical officer in collaboration with

	observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians. The nursing staff should check the location and action of the person preceding and following the point of nursing handover and at least every two hours. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive)	contemporaneous documented assessment per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	the Nursing Unit Manager or delegate.

SERVICE / DISTRICT LEVEL POLICES AND REVIEWS OF EFFECTIVENESS

6.1 Local procedures are to be developed which include the directions within this policy.

6.2 The local procedure should clearly outline the importance and purpose of overnight nursing observations and balance the consumer's need for sleep hygiene with safety.

6.3 The local procedure must outline the minimum standard of documentation relating to night time observations in relation to description and respiration as identified within this policy.

6.4 Services must ensure that observations are undertaken effectively.

6.5 Random inpatient unit visits and documentation audits should be conducted to ensure that observations and regular engagement are being undertaken effectively. The results of these audits will form an ongoing component to the monitoring and evaluation of this Policy Directive. Services must build the capacity of their workforce to ensure that observations are:

a. Grounded in therapeutic engagement that is facilitated through empathy and understanding of a persons lived experience

b. Conducted in a way that fosters a therapeutic relationship between nurses and the people for whom they provide care.

LIST OF ATTACHMENTS

Attachment 1: Implementation Plan – Engagement and Observation within Mental Health Inpatient Units

ADULT MENTAL HEALTH INTENSIVE CARE NETWORKS (PD2019_024)

PURPOSE

This Policy Directive sets out the NSW Mental Health Intensive Care Unit (MHICU) Referral Networks. It defines the referral pathway for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to access more intensive care for patients experiencing high acuity mental illness and complex needs, within an integrated model of care.

MHICUs are centres of specialist expertise in the management of people presenting with highly acute and complex mental illness. MHICUs operate as supra LHD services, and are state-wide referral facilities. Referral to a MHICU occurs from an inpatient mental health facility as the least restrictive option when the patient can no longer be safely cared for due to the risk that their behaviour poses to themselves or others

Each MHICU is a part of a local clinical referral Network and the state wide integrated Network of clinical services that provide timely access to appropriate care.

This Policy Directive also sets out the principles and procedures each LHD should develop and monitor for the care of consumers requiring mental health intensive care.

MANDATORY REQUIREMENTS

- All options for consumer placement to other mental health facilities should be explored before seeking a referral to a MHICU.
- LHDs to admit consumers with the highest acuity or most complex clinical needs from their designated zone into the MHICU
- MHICUs only provide care to those consumers with the highest acuity or most complex clinical needs.
- Referral and transfer to a MHICU is a time-limited episode of care. On stabilisation of symptoms and/or reduction in the level of clinical risk, consumers will be repatriated to the referring LHD.
- The referring LHD will facilitate the transfer to the MHICU.
- The MHICU will facilitate return transfer back to the referring LHD.
- LHDs must inform relevant clinical staff of this policy directive.

IMPLEMENTATION

- This Policy Directive applies to all adult mental health inpatient facilities.
- LHDs/SHNs must have local policies and procedures in place that are consistent with the principles and procedures identified in this policy by August 2019

Local Health District/Network Chief Executives are responsible for:

- Ensuring implementation of the Policy Directive, with the Chief Executive as the final point of arbitration and escalation.
- Documenting and implementing local governance and escalation plans to ensure the appropriate accommodation of patients who need to access a MHICU bed. This must include procedures for clinicians to obtain timely clinical advice and/or support to expedite the review. Escalation plans must include procedures for clinicians to follow in instances where an appropriate bed is not available within the zone or difficulties are experienced with patient acceptance and placement.
- Meeting the MHICU needs of their LHD and linked LHDs including the provision of clinical advice and ensuring access to appropriate treatment.

Local Health District/Network Mental Health Directors are responsible for:

- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe.
- Ensuring that all options for placement of the referring LHD's patient within the originating LHD have been explored, and that transfer to a MHICU is clinically appropriate.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.
- Ensuring timely repatriation. On stabilisation of symptoms and/or reduction in the level of clinical risk, MHICU patients must be repatriated to the referring LHD. Repatriation is the responsibility of the referring LHD.
- Ensuring that compliance with this policy is audited and regularly monitored in collaboration with intra and inter-LHD stakeholders.

Mental Health Intensive Care Units are responsible for:

- Ensuring information in the Patient Flow Portal and/or Emergency Access View is current and correct at each shift handover

Patient Flow Units/Bed/ After Hours Managers are responsible for:

- Facilitating referrals for Statewide MHICU transfers in consultation with the local MHICU

Adult Mental Health Intensive Care Networks Procedures

1 BACKGROUND

1.1 About this document

This Policy Directive provides guidance to ensure that patients with high acuity mental illness and complex clinical needs receive timely treatment in the most appropriate setting.
Mental Health Intensive Care Units (MHICUs) are units with a small number of beds and high staff to patient ratios that provide a highly specialist and intensive multidisciplinary mental health care to patients who present with clinical complexity and risks that cannot be safely and effectively managed in an acute mental health inpatient unit.
In NSW there are six MHICUs that currently provide tertiary level intensive mental health care and operate as part of a state wide Network.
This procedure describes key processes of MHICUs as follows

- Inclusion and exclusion criteria for referral
- Referral processes
- Transfer of patients between MHICUs and LHD inpatient mental health units
- Roles and responsibilities of MHICUs and referring inpatient mental health units in relation to the transfer and return transfer of patients
- Roles and responsibilities of referring inpatient mental health units during a patient's admission to a MHICU

1.2 Key definitions

Complex clinical needs: Complex clinical needs refers to the care that a patient requires to manage their acute presentation. Complex needs require significant intervention and ongoing support in a range of biomedical, psychological, social and occupational domains.
High acuity: a high acuity patient is a patient that is acutely unstable in their clinical presentation and require increased multidisciplinary review, intervention and care.

MHA: *Mental Health Act 2007*
Patient: It is noted that the preferred terminology for people with a lived experience of mental distress and/or mental illness is "consumer", however for the purposes of this document "patient" has been used to refer to this population. This term is used to identify that the patient is an admitted inpatient and is accessing mental health intensive care services.

Referring inpatient mental health unit: A LHD/SHN based public inpatient mental health unit that has referred a patient to a MHICU for intensive management or stabilisation.

1.3 Legal and legislative framework

This Policy Directive refers to the care of people who are subject to the restrictions and directions of the *NSW Mental Health Act, 2007*. In cases where this policy and the MHA are in conflict, the directions of the MHA are to be followed in the first instance. Transfer procedures, detainment of patients and communication with designated carers are all included in the MHA.

1.4 Relevant Information

This Policy Directive has been informed by, and is designed to be read in conjunction with the following NSW Health Policy Directives and frameworks:

- Australian Health Ministers' Advisory Council (2003). *A National Framework for Recovery-Oriented Mental Health Services*. Author, Canberra
- Blue Knot Foundation (2012). *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.* Author, Sydney
- Mental Health Commission of NSW (2014). *Living Well: Putting People at the Centre of Mental Health Reform in NSW: A report.* Author, Sydney
- NSW Health. *NSW Ministry of Health Demand Escalation Framework.*
- NSW Health (2006). *Aboriginal Mental Health and Wellbeing Policy 2006- 2010.* Author, Sydney
- NSW Health PD2018_011: *NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults)*
- NSW Health PD2017_025: *Engagement and Observation in Mental Health Inpatient Units*
- NSW Health PD2016_056: *Transfer of Care from Mental Health Inpatient Services*
- NSW Health PD2016_007: *Clinical Care of People Who May Be Suicidal*
- NSW Health PD2012_035: *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW.*
- NSW Health PD2011_015: *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*
- NSW Health PD2009_060: *Clinical Handover- Standard Key Principles*
- NSW Health PD2014_025 - Departure of Emergency Department Patients

2 ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

The Adult Mental Health Intensive Care Network defines the links between LHDs/ SHNs and MHICUs. The Networks take into account established clinical referral relationships which may include referral patterns across LHD boundaries.

There are six (6) local mental health intensive care Networks (Networks), each served by one MHICU. In addition, the Forensic Hospital acts as a second tier referral facility where the patient demonstrates a very high risk of harm to themselves or others, or if a patient requires admission to a MHICU and no other beds are available.

Table 1: State Wide Adult Mental Health Intensive Care Network

MHICU	Referring LHD
Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby	Northern Sydney
	Central Coast
Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)	Hunter New England
	Mid North Coast
	Northern NSW
Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange	Western NSW
	Far West
	Murrumbidgee
McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord	Sydney
	South Western Sydney
Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta	Western Sydney
	Nepean Blue Mountains
	Southern NSW
Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick	South Eastern Sydney
	Illawarra Shoalhaven
	St Vincent's Health Network
Forensic Hospital, Justice and Forensic Mental Health Network, Malabar	Second tier referral for all LHDs/SHNs

3 OVERARCHING PRINICPLES OF CARE

3.1 Guiding principles for the Adult MHICU Network

The operation of the Adult MHICU Network, and arrangements for patient referral and transfer between referring inpatient mental health units and MHICUs is to be guided by the following principles:

1. The care of the patient is to be collaborative, recovery oriented, trauma informed and person centred, respecting the patient's human rights and dignity whilst being provided in the least restrictive environment alongside input from the patient's family and support people.
2. Referral and transfer to a MHICU is a time-limited episode of care for the intensive management of high acuity and complex symptoms. On the stabilisation of symptoms and/or reduction in the level of clinical risk, the patient is repatriated to the referring inpatient mental health unit as soon as practicable.
3. Admissions are determined with consideration to the existing patient mix in each Network Zone, and then within the broader Adult MHICU Network.
4. In cases of significant distance between the referring inpatient mental health unit and the MHICU, the benefits of admission to the MHICU must outweigh the risks associated with transferring the patient and their separation from family, carers and identified support people.
5. Determination and coordination of safe and timely patient transfer relies on current and accurate clinical handover between senior clinicians at each site. Relevant service executives and patient flow units should be included in all communication.
6. All processes must comply with the Adult Mental Health Intensive Care Network Policy (PD 2019_024).

3.2 Defining the MHICU patient

A MHICU patient is an existing patient of an acute mental health unit, who requires a high level of multidisciplinary care, observation and review to remain safe in the acute inpatient environment. A patient appropriate for a MHICU may demonstrate the following risks or behaviours

- Significant risk or continued attempts to harm themselves, with the intent of self-harm and/or suicide.
- Significant risk or actions of violence, physical, sexual or verbal abuse and/or harassment towards other patients, visitors or staff.
- Deterioration of mental health, or increasing symptoms of mental illness including disinhibition, disorganisation, disruption of others and/or significant distressing symptoms of psychosis leading to increased vulnerability
- Repeated attempts to leave the unit without authorisation, if detained under the MHA.

Patients admitted to MHICU are generally categorised as the "most unwell". That is, these patients demonstrate the highest level of risk, are at the most risk and/or whose symptoms are not resolving to a lower level of acuity in acute inpatient wards. These are patients for whom accessing a higher level of care will provide the resources, observation and structure to contain their experience of distress.

4 REFERRAL TO MHICUS

4.1 Referral to a MHICU

4.1.1 Referral Documentation

The referring inpatient unit will provide a comprehensive clinical handover and package of clinical documentation to the MHICU at the time of referral and transfer.
Referral documentation will include:

- Referral form
- Current assessment by treating psychiatrist
- A care plan, including the expected goals and length of MHICU admission and a plan for return transfer to the referring inpatient unit
- MHA documentation, including designated carer form
- Contact details of family/ carers and support people
- Medication charts
- Risk Assessment
- 7 days of progress notes
- Details of management and medication strategies trialled and outcomes of these

4.1.2 Assessment

Each LHD must have documented and implemented escalation plans to ensure the appropriate accommodation of the highest acuity patients. Escalation plans must also include procedures for clinicians to follow in instances where an appropriate bed is not available within the Network or difficulties are experienced with patient acceptance and placement.
It is the responsibility of the receiving MHICU to assess whether a referral is appropriate or not, considering the inclusion and exclusion criteria and the current patient population. The receiving MHICU will confirm receipt of referral documentation to the referring inpatient unit, and will assess referrals and respond to referrals within six hours of referral, or next day in business hours if the referral is received after 11am.
If a referral is not accepted for admission, the MHICU will provide a rationale for this. The MHICU clinical team will also be available to provide clinical consultancy to the referring inpatient unit as required to enable safe care and management of the patient.

4.1.3 Inclusion Criteria

Patients admitted to MHICU are:

- Aged 18 or over
- Detained under the NSW Mental Health Act 2007
- Requiring an intensive level of observation and care to manage deterioration of mental health, increased acuity of mental health symptoms and significant risk of violence, suicide or vulnerability
- Presenting with behaviour that severely compromises the patient's or another person's physical or psychological wellbeing and safety
- Medically stable

4.1.4 Exclusion Criteria

Patients not appropriate for admission have:

- A diagnosis of dementia, intellectual disability, substance misuse or intoxication in the absence of a primary diagnosis of a mental illness
- Physical frailty that affects the patient's care in an intensive care environment
- Medical conditions, including intoxication or detoxification from alcohol or other substances that cannot be safely managed in a MHICU

4.1.5 High Risk Presentations from Emergency Departments or Community

A MHICU admission from an Emergency Department or a community mental health tea, may occur after a psychiatrist's assessment in the following exceptional circumstances:

- To avoid further deterioration and in cases of significant and ongoing risk of violence and aggression, patients should not progress through the usual admission pathway of trialling acute unit care.

Where a patient is referred to a MHICU from an Emergency Department the mental health service has a responsibility to assist the Emergency Department in the proactive management of the patient until the patient is able to be transferred.

4.1.6 Local referral

Referrals from inpatient units will be made to the MHICU in their Local Network in the first instance (Table 1). If a referral is considered appropriate, every effort is to be made by the receiving MHICU to facilitate timely access. This may require a patient with less intensive health care needs in the MHICU to be repatriated to the patient's referring inpatient unit, or another bed in the referring LHD.

4.1.7 State Wide referral

State Wide referrals will only occur when a local MHICU bed is unavailable, and following an assessment of MHICU and referring LHD resources to ensure that only patients meeting the inclusion criteria at the time of assessment are receiving MHICU care. In this case, all patients currently being treated in the Local MHICU will have higher health care needs than the patient being referred. Following consultation with the referring LHD, the Local MHICU is responsible for finding a State Wide MHICU bed for the referred patient. The Local MHICU liaises with the relevant hospital patient flow processes and State Wide MHICU to identify a bed, and forwards the referral to the State Wide MHICU. The Local MHICU will inform the referring inpatient unit of the State Wide referral, and will provide the contact details of the State Wide MHICU.

Once a bed is identified in the state wide Network, the referring inpatient unit will contact the State Wide MHICU and liaise for the transfer of clinical care. The referring inpatient unit remains responsible for the transfer of the patient to a MHICU.

4.1.8 Clinical Handover

The referring inpatient unit will provide a comprehensive clinical handover and package of care documentation to the MHICU at time of transfer. The package of documents will include

- Original MHA documentation, including a signed Section 78
- Medication Charts (including current PRN medication)
- Contact details of family and carers

If no access to the referred patient's electronic medical records are available by the MHICU, the package of documents will also include:

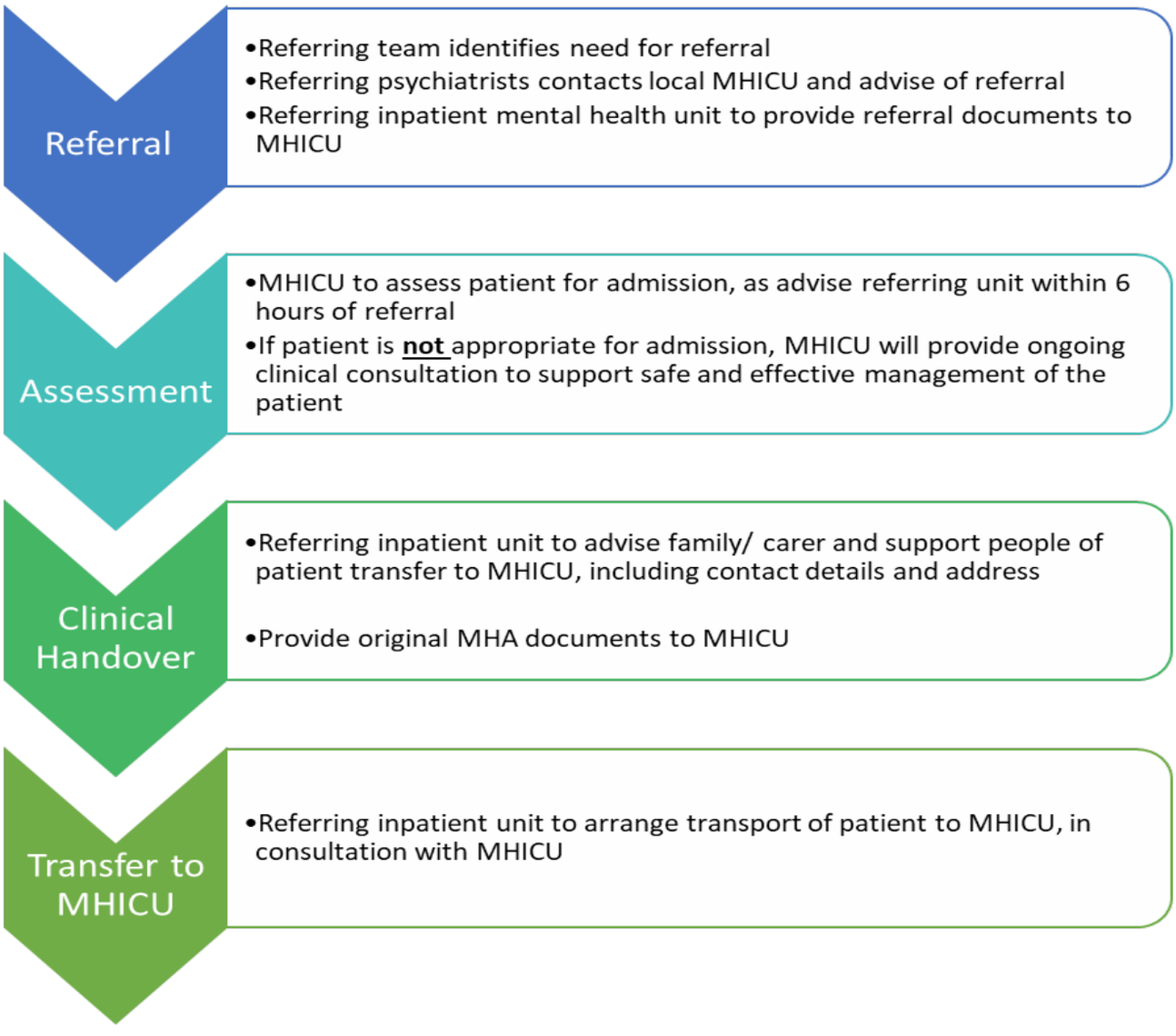
- Current assessment by treating psychiatrist
- Patient History
- A care plan, including the expected goals and length of MHICU admission and a plan for return transfer to the referring inpatient unit
- Risk Assessment
- 7 days of progress notes
- Details of management strategies trialled and outcomes of these
- Any available allied health assessments and reports

4.2 Transfer to a Mental Health Intensive Care Unit

It is the responsibility of the referring inpatient unit in consultation with MHICU to arrange for the timely and safe transfer of a patient. Transport arrangements should be in accordance with local policy and resources, and may require coordination with hospital security services, the NSW Ambulance Service and NSW Police consistent with the NSW Health- NSW Police Memorandum of Understanding 2018.

Family, carers and designated support people should be involved in any care planning and informed of any referral. *PD 2016_056 Transfer of Care from Mental Health Inpatient Services* details the principles and requirements for the safe transfer of a patient's care across settings. The referring inpatient unit must ensure the continued involvement of family and carers by providing information about options for contact and visits.

Figure 1: MHICU Referral Flowchart



Inclusion Criteria	Exclusion Criteria
Aged 18 or over	A diagnosis of dementia, intellectual disability, substance misuse or intoxication without a primary diagnosis of a mental illness
Detained under the *NSW Mental Health Act 2007*	Physical frailty that affects the patient's care in an intensive care environment
Requires an intensive level of observation and care to manage deterioration in mental health AND significant risk of violence, suicide, absconding or vulnerability	Medical conditions that cannot be safely managed in a MHICU

4.3 MHICU processes

4.3.1 Daily Multi-disciplinary Team (MDT) Handover

Clinical Handover refers to the safe transfer of professional responsibility and accountability for some or all aspects of a patient's care to another person or professional group
Consistent with intensive care practices, MHICU teams are to undertake a daily MDT handover, which provides the opportunity to discuss and review the presentation of each patient.
Handover meetings will review the EDD, care strategies, clinical incidents and care plans for each patient. Handover meetings must include prioritisation of patients for transfer or return transfer in the case of a higher acuity referral and identification of patients ready for return transfer to referring inpatient units. Following the daily handover meeting, MHICU updates Emergency Access View to accurately reflect bed status and vacancies.
Regular (at least weekly) communication must occur between the MHICU clinical team and the referring inpatient unit clinical team of admitted inpatients. Best practice is to invite a member of the referring inpatient unit team to the MDT clinical review, in person or using videoconference or teleconference facilities. This includes where referrals have been referred from a lower acuity ward in the same facility. If this is not feasible, an identified MHICU clinical team member is to liaise with the referring inpatient team regarding treatment progress, achievement of care plan goals, changes to the EDD and plans for the return transfer of the patient to the referring inpatient unit.

4.3.2 Identification of patients for transfer

Each LHD that hosts a MHICU is responsible for meeting the mental health intensive care needs of that LHD and linked LHDs within their local Network.
It is the responsibility of the MHICU to identify appropriate patients for transfer to LHD inpatient units in order to create capacity for acceptance of higher acuity referrals. Ideally, the identified patient will be transferred to their referring inpatient unit in this instance. If a bed is not available and cannot be made available by the referring inpatient unit, then the patient may be transferred to an available bed within the patient's host LHD with return transfer to the referring LHD to be expedited
Patients identified for transfer will be those who:

- Have demonstrated a reduction in the level of clinical risk to themselves and others as assessed by MDT in consultation with the patient
- No longer require intensive supervision and observation

4.4 Return transfer of patients

4.4.1 Roles and responsibilities of MHICU and inpatient units

It is the responsibility of the MHICU senior clinicians, following discussion with the referring LHD senior clinicians, to return transfer a patient when the clinical risk has reduced and/ or the exacerbation of mental health symptoms has stabilised. The MHICU is responsible for arranging the timely and safe return transfer of a patient as it is clinically indicated.

The referring inpatient unit will initiate appropriate local patient flow processes to ensure a bed is available to facilitate the return transfer of a patient from a MHICU. The referring inpatient unit will advise MHICU of the appropriate timing of return transfer (of no more than 24 hours from the time of request). MHICU will arrange transport of the patient and advise the inpatient unit of these arrangements, including the anticipated time of arrival.

If no bed is available for return transfer, the MHICU will contact the LHD mental health patient flow manager and identify an alternative bed for transfer within the patient's host LHD. Once the patient has reached an acute inpatient unit, the process for return transfer and/or discharge of the patient to the referring inpatient unit and/or community mental health team will progress consistent with existing local policies and procedures.

4.4.2 MHICU Clinical Handover

MHICU will provide a comprehensive clinical handover to the inpatient unit, including the following:

- Successful management strategies
- Outcomes of agreed care goals
- Medication changes
- Therapeutic interventions
- Recommendations for ongoing management

MHICU will provide a package of documents to the inpatient unit, including:

- Original MHA documentation
- Medication Charts
- Contact details of family and carers

If no access to the referred patient's electronic medical records created by MHICU are available by the inpatient unit, the package of documents will also include:

- Current assessment by treating psychiatrist
- Patient History
- Risk Assessment
- 7 days of progress notes

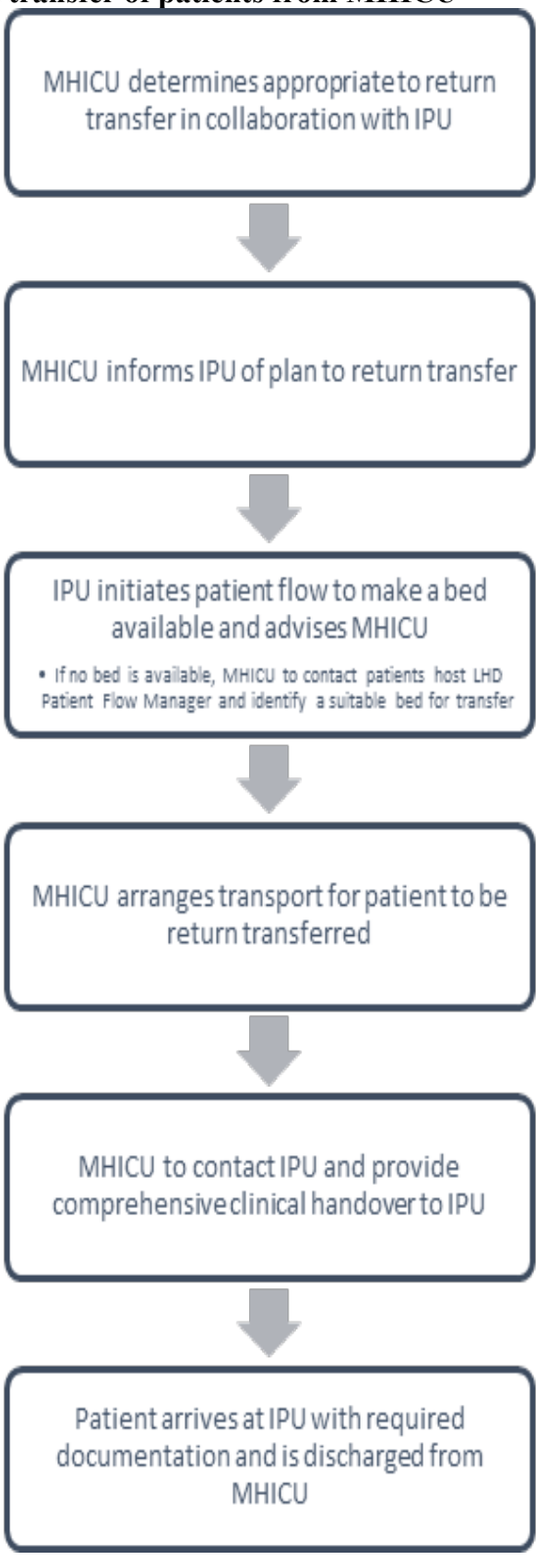
For further information regarding clinical handover, please refer to NSW Health PD2009_060: *Clinical Handover- Standard Key Principles.* \

4.4.3 Discharge from MHICU to a community setting

MHICUs do not have usually have access to the full range of service resources for each LHD/region to enact and monitor appropriate community referrals in order to facilitate an effective and sustainable discharge to the community.

It is not usually appropriate for a patient to be discharged from a MHICU to the community. However, in rare situations where patients are discharged from a MHICU to a community setting, it will be with the clear collaboration and consent of the relevant accepting community mental health team.

Figure 2: Return transfer of patients from MHICU



5 PATIENT FLOW THROUGH THE ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

5.1 Use of the Patient Flow Portal and Emergency Access View applications

Patient Flow Portal (PFP) and Electronic Patient Journey Boards (EPJB)
The PFP and EPJB are electronic patient flow tools that supports teams to manage their units demand and capacity planning by providing a highly visual tool to facilitate multidisciplinary care, standardising inter-facility transfer processes and supporting the implementation of demand escalation.

It is expected that the EPJB is used by all acute mental health inpatient services, including MHICUs.

At a minimum, each MHICU is required to update the EPJB every four hours, including the Estimated Date of Discharge (EDD) and Waiting for Waiting for What (W4W) functions. Patients identified as ready for return transfer to their referring inpatient unit will be highlighted using the Inter Ward Transfer (IWT) or Inter Hospital Transfer (IHT) functions.

The MHICU EPJB includes the "MHICU Bed Status tool", which is used to provide detail of MHICU bed status (staffed and available beds), the on-call details of the MHICU consultant, and patient acuity to assist in the location and access of beds for patients in the greatest need of higher level care.

A daily "MHICU Bed Status" report can be automatically generated and emailed to LHD mental health executive, patient flow managers and clinical directors.

Emergency Access View
The Emergency Access View (EAV) is a real time dashboard displaying the live position against a number of patient demand and patient flow measures. The EAV includes a MHICU Dashboard, and is linked to the PFP to draw information from a single source.

The MHICU Dashboard will support MHICU demand through improved visibility of Network beds, highlighting available beds and the contact details to access these beds. The MHICU Dashboard also provides increased visibility of people in "depart ready" beds, and issues of exit block and delays in transfers.

The MHICU Dashboard will be accessible by LHD executive, Patient Flow Managers and MHICU staff to facilitate the timely access to beds.

5.2 Access to MHICU Beds

MHICUs are tertiary, specialised facilities. MHICUs should not be used to assist in the management of patient flow or clinical capacity for patients who do not meet the criteria for a MHICU admission.
The highest acuity patients in the Network will have access to a MHICU, with lower acuity patients to be transferred from MHICUs to referring inpatient units to facilitate the care of people who have greater clinical needs. To do this, inpatient units will access the MHICU Bed Status link on the EPJB, to identify the appropriate contact for referral.
Where the local MHICU is full and unable to identify a lower acuity patient to transfer from the MHICU, that MHICU will use EAV to identify an available MHICU bed outside of the local Network, and then link the referring inpatient unit with the receiving MHICU to facilitate the transfer and care of patients.

5.3 Patient Flow Process

Usual MHICU patient flow processes are outlined in Section 4: Common MHICU Processes. Consistent with the NSW Ministry of Health Demand Escalation Framework, MHICUs will have a demand escalation framework and pathways in place to manage peak variation and changes in patient flow.

As part of a demand escalation framework, MHICUs will require the following plans to be in place to support effective patient flow:

- Short Term Escalation Plan (STEP)
- Facility Demand Escalation Matrix
- Capacity Escalation Plan

These plans will need to interact with facility and LHD demand escalation plans, as well as with regular review by the Zone.

5.3.1 Estimated Date of Discharge

The Estimated Date of Discharge (EDD) predicts the likely date that a patient will be transferred from MHICU to the referring inpatient unit. It provides everyone involved with the patients care, including the patient and their family with a projected date to coordinate the patient's care needs. While for some patients the EDD may change due to clinical issues; review of best practice confirms that an accurate EDD can be set for most patients.
The use of an EDD will assist patient flow managers and referring inpatient units to plan the return transfer of patients into appropriate wards, prevent MHICU delays in returning patients to appropriate wards and reduce patients receiving care outside their home mental health service.

5.4 "Depart Ready" and "Good to Go" Identification

5.4.1 Depart Ready

Patients identified as "Depart Ready" will be patients that have been identified for return transfer, have been accepted by the appropriate inpatient unit and have patient transport booked to return the patient to the referring inpatient unit.
Exit block will occur when G2G patients have not been transferred within 24 hours of identification.

5.4.2 Good to Go

Patients identified through the EPJB as "Good to Go" (G2G) are those that have been identified as appropriate for transfer to a lower acuity inpatient unit. These patients should be identified using the G2G cell on the EPJB, and should be flagged with the referring inpatient unit to begin preparing for return transfer, this may include creating appropriate capacity.

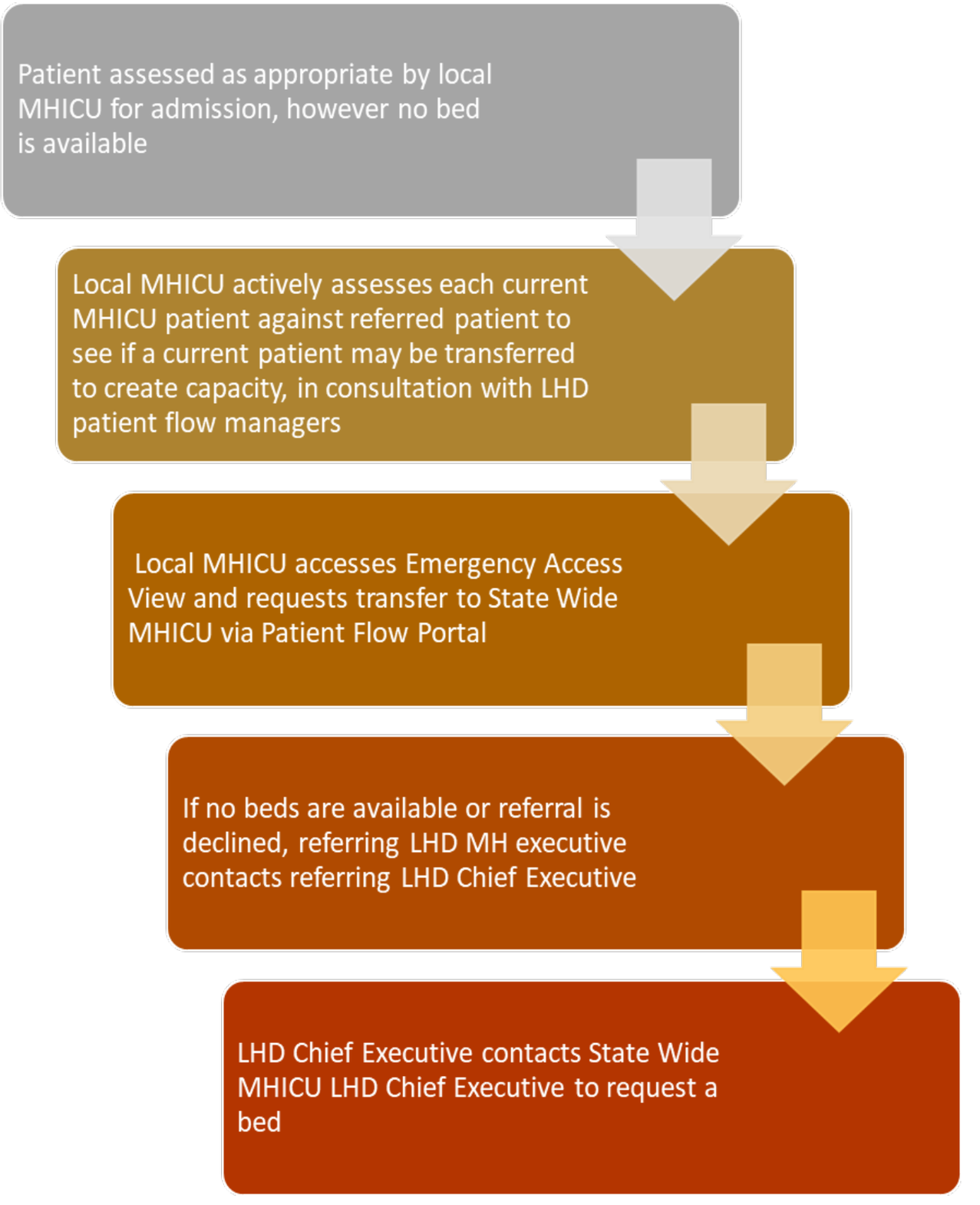
5.5 Network Coordination, Escalation and Management of Delays

LHDs and SHNs will develop formal specialist clinical referral Network procedures to guide clinicians and facilitate patient flow, ensuring appropriate, safe and timely patient referrals, return transfers and clinical consultancy to the Network. LHDs and SHNs will establish processes, led by the Clinical Director for the following purposes:

- Patient referral and priority of referrals in relation to the existing Network and MHICU patient mix
- Patient assessment by MHICU
- To support the LHD with clinical consultancy and management strategies in circumstances where there is a delay in transfer, where it is unsafe to transport the patient or when no MHICU bed is available
- To ensure the referring inpatient unit maintains active engagement in the care of the patient following referral and transfer, including clinical review and case conferences
- To arrange return transfer and support patient transfers
- For the operational review of processes to improve collaboration between services and the operation of both the local and statewide Network

Should issues arise in coordinating the care and treatment of a patient within the Network, issues should be escalated to the LHD executive and Chief Executive, following local guidelines. Resolution of issues will occur at this level.

Figure 1: Escalation Pathway



6 LIST OF ATTACHMENTS

1. Implementation Checklist
2. Adult Mental Health Intensive Care Network Flowchart

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Development and documentation of LHD clinical governance and escalation pathways and demand escalation frameworks to ensure patient flow	❑	❑	❑
	Notes:		
2. Development of pathways and communication processes between zoned LHDs and MHICUs to ensure streamlined referral and tranfer of MHICU patients	❑	❑	❑
	Notes:		
3. Development of local procedures for MHICU referral, care and transfer that are consistent with this policy directive	❑	❑	❑
	Notes:		
4. Appropriate identfiication and training of clincial and administrative staff in Patient Flow Portal and Emergency Access View applications	❑	❑	❑
	Notes:		
5. Identfication of the LHD Chief Executive as the final point of arbitration and decision making	❑	❑	❑
	Notes:		
6. Audits to review compliance with this document are conducted annually (minimum)	❑	❑	❑

Attachment 2: Adult Mental Health Intensive Care Network Flowchart

MHICU	Referring LHD
Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby	Northern Sydney
	Central Coast
Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)	Hunter New England
	Mid North Coast
	Northern NSW
Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange	Western NSW
	Far West
	Murrumbidgee
McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord	Sydney
	South Western Sydney
Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta	Western Sydney
	Nepean Blue Mountains
	Southern NSW
Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick	South Eastern Sydney
	Illawarra Shoalhaven
	St Vincent's Health Network
Forensic Hospital, Justice and Forensic Mental Health Network, Malabar	Second tier referral for all LHDs/SHNs

MANAGEMENT OF PATIENTS WITH ACUTE SEVERE BEHAVIOURAL DISTURBANCE IN EMERGENCY DEPARTMENTS (GL2015_007)

PURPOSE

The purpose of this Guideline is to address the management and initial sedation requirements of patients who present to emergency departments (ED) with acute severe behavioural disturbance (ASBD). This Guideline includes information for children, adolescents (children and adolescents includes those under16 years) and adults under 65 years.

Management of older persons over 65 years is not contained in this Guideline as comprehensive management of these patients is available in other NSW Health documents (please see Section 1.1 Key Documents).

KEY PRINCIPLES

The focus for this Guideline is patients, both adult and paediatric, who are unable to have a medical assessment completed due to the ASBD and may require the administration of sedation before initial assessment can occur.

This document is guided by the principles of least restrictive, collaborative, patient centred care and offers guidance on the following aspects of behavioural management and sedation:

1. Assessment of the patient with ASBD in a safe environment.
2. Use of de-escalation techniques that focus on engagement of the person with ASBD to allow for assessment.
3. Ensuring that legal requirements are adhered to, particularly in relation to the *Mental Health Act 2007*, the *Guardianship Act 1987*, *The Children and Young Persons (Care and Protection) Act 1998* and the clinician's duty of care to the patient.
4. Sedation of the patient whose behaviour puts them or others at immediate risk of serious harm and which is unable to be contained by other means. There is also reference to physical restraint of the patient if required.
5. Post sedation care of the patient including observations and documentation.
6. Disposition decisions and transport of the patient from the ED to the most appropriate area for continuation of their care.

USE OF THE GUIDELINE

This Guideline supplements PD2015_004 Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint, however focuses on patients who present to EDs with ASBD. This is a Guideline only and the protocol is based on available scientific evidence of drug safety profiles on sedation of acute behaviour disturbance patients in the ED [4,5] and clinical advice.

This Guideline does not replace clinical judgement; the decision to proceed with emergency sedation is made on clinical grounds and is authorised by appropriately trained medical and/ or nursing staff, depending on the type of intervention being ordered. Local decision making and procedures should be developed in conjunction with this Guideline and local stakeholder groups. Further detail on use of this Guideline can be found in the Guideline document.

To download the Guideline please go to http://www0.health.nsw.gov.au/policies/gl/2015/GL2015_007.html

[4] Geoffrey K. Isbister, Leonie A. Calvera, Colin B. Page, Barrie Stokes, Jenni L. Bryant, Michael A. Downes, (2010), Randomized Controlled Trial of Intramuscular Droperidol Versus Midazolam for Violence and Acute Behavioral Disturbance: The DORM Study, *Ann Emerg Med* 2010; 56(4): 392-401 (available)

[5] Leonie Calver, Colin B. Page, Michael A. Downes, Betty Chan, Frances Kinnear, Luke Wheatley, David Spain, Geoffrey Kennedy Isbister. The Safety and Effectiveness of Droperidol for Sedation of Acute Behavioral Disturbance in the Emergency Department. Annals of Emergency Medicine, 2015; DOI: 10.1016/j.annemergmed.2015.03.016

SUPPORTING YOUNG PEOPLE DURING TRANSITION TO ADULT MENTAL HEALTH SERVICES (GL2018_022)

PURPOSE

Continuity of care is the cornerstone of good clinical practice. Transitional care is recognised as potential risk factors for anyone receiving health care. In the case of young person with mental health issues or challenges, suboptimal transition can lead to disruption of critical developmental milestones and have adverse impacts on their health, social and educational/vocational outcomes.

This Guideline supports local health districts and specialty networks in developing local policies and protocols that support the optimal transition of young people. In particular, from community-based or inpatient specialist Child and Adolescent Mental Health Service (CAMHS) care or Youth Mental Health Service (YMHS) care to Adult Mental Health Service (AMHS) care.

This Guideline focuses on the ongoing health care needs of young people in the context of their evolving and changing developmental needs and pathways to recovery. It outlines responsibilities of NSW specialist mental health services to ensure continuity of care and safety are maintained during the period of service transition.

KEY PRINCIPLES

The following principles are adapted from NICE guidance on transition for young people1 and the NSW Agency for Clinical Innovation/Trapeze key principles2.

- Young people and their families and/or carers are listened to, are engaged in and guide the transition process.
- Service delivery, culture and practice incorporate a recovery focus with an emphasis on hope.
- Young people who are likely to require transition should be identified as early as possible in their contact with CAMHS or YMHS and preparation for transition should be included in early care planning.
- Services work closely together to recognise the developmental stage of the young person and to facilitate a transition process between the services that takes account of the pace that the young person is comfortable with and the need they have for the continued age-appropriate involvement of their family/carers.
- Transition planning and support should be developmentally appropriate and flexible, recognising that the young person’s circumstances and autonomy are continuing to evolve.
- Transition planning and support should be strengths-based, using a language of hope, empowering, engaging and enabling young people and their families and/or carers while working towards meaningful goals throughout the transition process.
- Transition planning and support should use person-centred approaches with an individualised transition plan for each young person that includes support provided by their family and/or carers, general practitioner, education and other government agencies, Primary Health Networks and other non-government organisations and services providers that are culturally relevant and safe.
- Local CAMHS/YMHS and AMHS should partner in the development and review of transition protocols, communication processes and tools and the identification of transition coordinators/facilitators.
- Young people and their families and/or carers should be involved in service design, delivery and evaluation related to transition and in planning and coproducing transition policies, supporting materials and tools.

USE OF THE GUIDELINE

This Guideline outlines the principles and actions that aim to optimise the outcomes and experiences of young people and their families and carers during periods of service transition. Services are encouraged to develop their own local policies and protocols for the period of service transition for young people.

This Guideline provides a framework and, where available, evidence based guidance to assist NSW Health mental health services to:

- support a safe and effective transition for young people (Section 2)
- manage essential components and phases of transition (Section 3)
- select from a range of evidence informed approaches and implementation resources that support transition (Section 4 and 5)

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_002

325(12/10/18)

USE OF AUDIO-VISUAL LINK FOR MENTAL HEALTH ASSESSMENTS UNDER THE MENTAL HEALTH ACT 2007 (GL2022_007)

GUIDELINE SUMMARY

This Guideline provides guidance on the use of audio-visual link to conduct mental health assessments under section 19A and section 27A of the *Mental Health Act 2007* (NSW). This Guideline provides information on clinical considerations when using audio-visual links.

KEY PRINCIPLES

The *Mental Health Act 2007* (NSW) allows for mental health assessments under section 19A and section 27A to be conducted via audio-visual link when it is not reasonably practicable for the examination to occur in-person as per the requirements under section 19 and section 27.

This Guideline provides information about factors clinicians can consider when deciding whether it is not reasonably practicable for the examination to be conducted in-person including clinician availability, the impact of a delayed assessment and risk assessment principles.

It provides information about the key principles that clinicians are to consider when conducting an assessment via audio-visual link which includes:

- The principles of care and treatment under the *Mental Health Act 2007* (NSW).
- Maintaining the dignity and privacy of the person undergoing the assessment.
- Maintaining the safety of staff and the person undergoing assessment.
- Seeking consent from persons undergoing assessment where possible.
- Carers are to be consulted where reasonably practicable.
- Mental health services are to offer and support interventions to promote and sustain a person's physical health.
- Provision of culturally appropriate and safe care to Aboriginal people.
- Audio-visual link must be carried out using secure channels approved by NSW Health.

Local Health Districts and Specialty Health Networks are responsible for ensuring staff are trained to conduct assessments via audio-visual link.

Monitoring data and information is to be recorded and stored in the person's medical record. Monitoring and data collection directives must be adhered to.

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_007

342(12/07/22)

FORENSIC PATIENT ELECTRONIC MONITORING (GL2022_008)

GUIDELINE SUMMARY

This Guideline is for treating teams applying for and managing forensic patients with an order for electronic monitoring. It has been issued based on sections 85(1) and 94(4) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).

KEY PRINCIPLES

Electronic monitoring is defined as the use of an electronic device to monitor or track the location of a person at any given time, including by Global Positioning System.
The purpose of electronic monitoring is to focus on improving community safety and improving outcomes for forensic patients.

The *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) expressly allows the Mental Health Review Tribunal to order electronic monitoring as a condition of a forensic patient's leave or conditional release.

When considering making an application to the Mental Health Review Tribunal for electronic monitoring, the treating team are to adhere to the following key principles:

- Be the least restrictive practice in the patient's circumstances.
- Not become routine practice.
- Facilitate leave or release opportunities.
- Facilitate consent-based approaches by all parties.
- Be one of a suite of options available to monitor the patient.
- Have a clear planned approach and a clear purpose.
- Be determined by a risk assessment.
- Incorporate an agreed evaluation process for monitoring and reporting.

Monitoring data and information is to be recorded and stored in the patient's health record.

Use of the Guideline

This Guideline is a resource to support treating teams when considering and/or implementing electronic monitoring for forensic patients on leave or release across Local Health Districts and Specialty Health Networks.

This Guideline details each of these principles in more depth, guiding Local Health Districts and Specialty Health Networks to better align their services with the principles to deliver safe care for forensic patients and the community when undertaking electronic monitoring.

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_008

DOMESTIC VIOLENCE ROUTINE SCREENING (PD2023_009)

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning.

All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

The full Domestic Violence Routine Screening policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_009

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

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PATIENT MATTERS MANUAL

CHAPTER 14 – MIGRANT HEALTH

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Standard Procedures Working with Health Care Interpreters	PD2017_044
Domestic Violence and Migration Regulations: Relevance for Health Workers	IB2018_017
NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023	PD2019_018

Updated 4/08/2020

INTERPRETERS - STANDARD PROCEDURES FOR WORKING WITH HEALTH CARE INTERPRETERS (PD2017_044)

PD2017_044 rescinds PD2006_053

PURPOSE

Effective communication between patients, families and their carers and health services is critical to ensure accessible, safe and high quality services for people who are not fluent in English or who are Deaf. It is also essential to ensure equitable social and health care outcomes.

Working with professionally accredited or certified interpreters (referred to as 'health care interpreters' – refer to Section 1.4) aims to overcome the communication barriers faced by people who are not fluent in English or who are Deaf.

The Policy Directive provides clear direction to health care staff and services about when and how to work with health care interpreters, including in an emergency or if a health care interpreter is not available.

The detailed standard procedures for working with health care interpreters are set out in the attached *Interpreters – Standard Procedures for Working with Health Care Interpreters*. This Policy Directive has been updated and replaces PD2006_053, but retains the same title.

MANDATORY REQUIREMENTS

All Health organisations are required to comply with this Policy Directive. They are required to develop systems and procedures which ensure that patients who are not fluent in English or who are Deaf are provided with access to a health care interpreter when they access health care services.

Health care interpreters are to be engaged in all health care situations where communication is essential for patients/clients who are not fluent in English, including people who are Deaf.

Working with health care interpreters allows health professionals to fulfil their duty of care and ensures that the quality of communication is the best it can be when a language other than English is involved.

In particular, working with an interpreter is essential when patients/clients are required to give valid consent for medical treatments, such as an operation, medical or surgical procedures or blood transfusion, or to participate in medical research, except where immediate treatment is necessary to save the person's life or prevent serious injury to health.

The Policy Directive is not to be amended, added to or otherwise altered or rebadged.

IMPLEMENTATION

Roles and responsibilities of the NSW Ministry of Health:

- Provide NSW Health Organisations (including affiliated health organisations) with advice and assistance on implementation of this Policy Directive.
- Monitor and review the implementation of this Policy Directive.

Roles and responsibilities of Chief Executives:

- Assign responsibility, personnel and resources to implement the Standard Procedures for Working with Health Care Interpreters.
- Ensure that this Policy Directive is communicated to, and complied with, by all staff caring for patients/clients who are not fluent in English or are Deaf.
- Report annually on access to, and the use of, Health Care Interpreter Services.

Roles and responsibilities of all staff caring for patients/clients who are not fluent in English or are Deaf:

- Ensure their work practices comply with the Standard Procedures for Working with Health Care Interpreters.

Key Performance Indicators:

- Proportion of patients/clients with an 'interpreter' or 'interpreter required' flag who are offered and receive the assistance of a health care interpreter.

Procedures

1 BACKGROUND

1.1 Introduction

A significant proportion of the NSW population require language assistance when accessing health services.

NSW is the most culturally and linguistically diverse state in Australia. According to the 2016 Census, approximately 25% of the NSW population speak a language other than English at home, including people who use a sign language. About 4.5% of people in NSW reported that they are unable to speak English well or are unable to speak English at all.

Effective communication between patients, families and their carers and health services is critical to ensure accessible, safe and high quality services. It is also essential to ensure equitable social and health care outcomes.

Inability to communicate effectively in a service provider/client interaction can have an adverse impact on access to services. NSW Health considers reducing language barriers integral to its business planning processes, risk management strategies and operational and clinical practices.

Working with professionally accredited or certified interpreters (referred to as 'health care interpreters' – refer to 'Key definitions' in Section 1.4) aims to overcome the communication barriers faced by people using health services who are not fluent in English or who are Deaf.

Communication with the assistance of a health care interpreter allows people from culturally and linguistically diverse backgrounds, including people who are Deaf, to use mainstream services effectively and to be able to communicate with health practitioners as if they were fluent in English.

Through a health care interpreter a patient is able to ask questions about the health system, and any treatment, operation or procedure recommended and to understand the risks involved.

Working with health care interpreters also ensures that the quality of communication for the service provider is the best it can be when a language other than English is involved.

Health Care Interpreter Services (HCIS) provide access to 24 hours a day, 7 days a week interpreting services within the NSW public health system. Interpreting services are available in over 120 languages, including Australian Sign Language (Auslan) and are available to public health patients free of charge.

The Commonwealth Translating and Interpreting Service (TIS) also provides after hours services or emergency interpreting services.

Services are provided face-to-face, by telephone and in some locations by video. Appendix 8 provides a list of HCIS and TIS contact numbers.

This Policy Directive should be read in conjunction with current NSW policies for Consent for Medical Treatment and Privacy.

1.2 Principles and Scope of this Policy

The governing principles underlying this Policy Directive include:

- Recognition of the rights of people from culturally and linguistically diverse backgrounds to full and equal participation in NSW society. This includes people who are Deaf, people who speak a language other than English and/or are not fluent in English, including speakers of Australian Aboriginal English and users of Auslan. It also includes their carers and families;
- Organisational commitment to ensuring that all patients have equal access to health services and programs;
- Recognition that effective communication and equitable access to services are the responsibilities of all health staff;
- The duty of care of NSW Health and its funded services to minimise the risk of harm or injury to a person's physical and mental well-being.

This policy aims to support:

- safe, effective and clear communication between health staff and patients, their carers and families;
- the health system to meet its legislative requirements;
- the health system to build staff capacity to work cross culturally;
- the delivery of a standard of service which meets NSW Health's duty of care obligations; and
- patients, carers and families to make well informed decisions and to avoid risk of harm.

1.3 Key definitions

ASLIA means The Australian Sign Language Interpreters' Association.

AUSIT means The Australian Institute of Interpreters and Translators.

Accredited means a person who is formally accredited by the National Accreditation Authority for Translators and Interpreters (NAATI). Note that from 1 January 2018 NAATI will "certify" interpreters rather than provide accreditation.

Auslan means Australian Sign Language, which is the language of the Deaf community in Australia.

Bilingual means the ability to speak two languages fluently. In the context of this Policy Directive it refers to someone with verbal fluency in English and one or more other language(s). Often the bilingual person speaks English as a second language.

Bilingual health practitioner means a health practitioner who has verbal fluency in English and at least one other language. A bilingual health practitioner may be formally certified or accredited by NAATI as an interpreter and/or translator, but NAATI accreditation is not a requirement for the role.

CALD means 'Culturally and Linguistically Diverse'.

Certified means a person who is formally certified by NAATI.

Consent in the context of this Policy Directive means the patient's consent to undergo an operation, procedure, treatment or blood transfusion or to participate in research in a public health facility. Consent can be implied or expressed (verbal or written).

Deaf means a person who cannot understand speech (with or without hearing aids or other devices) using sound alone (i.e. no visual clues such as lip-reading). Further information is provided in Appendix 2.

Emergency in the context of this Policy Directive means a situation where obtaining consent is required by law. It does not refer to situations where life saving treatment can be provided without any consent (i.e. with or without the assistance of an interpreter).

Hard of hearing refers to all people who have a hearing loss and use speech as their primary means of communication.

Health care interpreter means a person who is accredited or certified by NAATI as an interpreter.

Health Care Interpreter Service(s) (HCIS) provide interpreters for patients in the public health system. Contact details and further information is provided in Appendix 8.

Health organisation means a Local Health District, Specialty Network, Affiliated Health Organisation or unit of the Health Administration Corporation that provides health services (for example the Ambulance Service of NSW or Health Pathology) as part of the NSW public health system.

Health practitioner means an individual who practices in a health profession (e.g. medical practitioner, nurse, allied health professional, dentist) and who is registered under the *Health Practitioner Regulation National Law* and authorised by a Health organisation to provide clinical care to a patient.

Interpreting means the transmission of messages between two spoken languages, between a sign language and a spoken language, or between two sign languages.

NAATI means the National Accreditation Authority for Translators and Interpreters. NAATI sets the national standards in translating and interpreting for Australia. NAATI also accredits or certifies interpreters and translators under the national standards.
Not fluent in English means that a person has hesitation or difficulty in understanding and communicating in English.

Patient (also "client", "consumer") means any person accessing a health service in the NSW public health system.

Person responsible means:

- An appointed guardian (including enduring guardian) with the function of consenting to medical, mental health and dental treatment; or
- A spouse or de facto spouse (including same sex partners) who has a close and continuing relationship with the person; or
- The carer who regularly provides or arranges services and supports or did so before the person went into residential care, and who is unpaid; or
- A close friend or relative.

Professional translator means a person who is accredited or certified by NAATI as a translator.

Sight translation means the immediate translation of written material into a spoken language.

TIS means the Commonwealth Translation and Interpreting Service. Contact details and further information is provided in Appendix 8.

Translating means the transmission of messages between two written languages.

Valid consent - The following four criteria for a valid consent must be met irrespective of whether the consent is in writing or verbal:

- the patient giving consent must have capacity;
- the consent must be freely given;
- the consent must be sufficiently specific to the procedure or treatment proposed; and
- the consent must be informed.

1.4 Legal and legislative framework

NSW legislation requires that public sector agencies and services provide equitable access to people who are not fluent in English, or whose preferred language is not English, and people who are Deaf (*Anti-Discrimination Act 1977 (NSW), Mental Health Act 1890, Multicultural NSW Act 2000).*

Refer to Appendix 1 for a list of relevant government policies and legislation that impact on language services and policy development.

2 KEY PRINCIPLES

2.1 Person-centred approach

A person-centred approach puts the patient at the centre of decision-making. A patient needs to be capable of understanding communication about their treatment to be able to make genuine decisions and participate in their care.

2.2 Quality and safety

All patients are entitled to expect that they will receive safe, high-quality care and treatment. With respect to patients who are not fluent in English or who are Deaf, working with health care interpreters is essential to avoid incidents such as incorrect identification of patient, procedure or treatment site. Failure to work with a health care interpreter or engaging an untrained interpreter (including family or friends) poses an unacceptable risk to both the patient and the health practitioner. Access to a health care interpreter can support accurate diagnosis and treatment and help people to achieve better health and care outcomes.

2.3 Communication

Effective communication between health staff and patients has a critical impact on a patient's experience of their treatment. Information about the communication needs and preferences of patients who are not fluent in English or who are Deaf must be clearly recorded in written or electronic patient records.

2.4 Equity
Patients who are not fluent in English or who are Deaf, must be able to participate in their care and access health services and treatments that are responsive to their cultural, language and communication needs. They have the same right to make informed choices about their treatment as English-speaking patients. NSW Health services have a responsibility to provide health care interpreters to support informed decision-making.

2.5 Privacy
Each patient has the right to have their personal health information safeguarded from loss, misuse and unauthorised disclosure. Refer to the Privacy Manual for Health Information (2015) for further details.

3 STANDARD PROCEDURES

All Health organisations are required to implement these standard procedures.

All health staff should be made aware of the existence of the HCIS.

Training about working with health care interpreters should be provided to all staff who have direct contact with patients who are not fluent in English or are Deaf.

Health care interpreters are professional trained interpreters and abide by a professional code of ethics. Fluency in a language other than English does not equate to a person being able to interpret. Apart from exceptional circumstances (refer to Section 3.8) bilingual health practitioners or other bilingual people (e.g. administrative and support staff, family or carers) should not interpret for other staff unless they are formally accredited or certified by NAATI.

Exceptional circumstances include when there is a medical emergency and a health care interpreter is not available, in person or by telephone.

In such a situation, a health care interpreter must be engaged within the earliest possible timeframe to confirm that information has been accurately communicated and to ensure high quality communication for ongoing treatment.

Bilingual health practitioners, who are highly proficient in a language other than English, may consult and communicate directly with their patients in that language in the ordinary course of patient care. As noted above, this does not equate to an ability to interpret information for others.

3.1 Access to the HCIS

All NSW Health organisations are required to develop systems and procedures which ensure that patients who are not fluent in English or who are Deaf are provided with access to a health care interpreter.

Treating health practitioners are responsible for assessing a patient’s need for an interpreter.

The treating health practitioner is also responsible for documenting the requirement for an interpreter, and language and communication needs, in the patient record.

All health facilities are to display in public contact areas multilingual information about:

- Availability of interpreter services;
- How patients, families and carers can request a health care interpreter.

All patients who are not fluent in English or who are Deaf must be informed that they have the right to request a health care interpreter.

A health care interpreter is also to be provided when the patient or the patient's person responsible requests an interpreter, even if the health practitioner does not consider one is required.

Health practitioners are entitled to request an interpreter if they believe that communicating in English is not appropriate, even if the patient does not wish to engage a health care interpreter.

The health practitioner is responsible for ensuring the timely attendance of a health care interpreter has been arranged. In practice, administrative staff are often delegated responsibility for booking interpreters and therefore it is critical that they follow the relevant sections of these standard procedures.

3.2 Eligibility to access the HCIS

Interpreter services are provided on-site, face-to-face, by telephone or by video (depending on the facility and clinical priority) for:

- Patients of Health organisations;
- People interacting with other NSW government organisations in situations where a public health professional is the lead professional, for example child protection;
- Patients of Non-Government Organisations (NGOs) which receive 50 per cent or more of their funding from NSW Health;
- Patients of the Justice Health and Forensic Mental Health Network;
- The Mental Health Review Tribunal;
- Staff of health services in relation to non-clinical activities such as disciplinary interviews, as well as clinical care;
- The Health Care Complaints Commission;
- Official Visitors under the *Mental Health Act 2002*

The HCIS may provide a service and charge for the service on a cost recovery basis in the following circumstances:

- The HCIS has a Service Agreement with a provider;
- Interpreter requests from NGOs partially (less than 50%) funded by NSW Health;
- The provision of care to patients / clients covered by workers' compensation, compulsory third party or any other form of insurance;
- A program / activity (e.g. research or health promotional campaigns) is wholly or partially funded by NSW Health;
- Health care interpreting for overseas visitors from countries that do not have a reciprocal health care agreement with Australia.

3.3 When to engage health care interpreters

When patients who are not fluent in English or who are Deaf access health care services, they must be provided access to a health care interpreter.

As a guide, a patient can be said to be not fluent in English if they hesitate or have difficulty in understanding and communicating in English.

Assessing the Need for an Interpreter

To determine whether a patient requires the assistance of an interpreter, you will need to:

- Assess if the patient is able to fully understand and communicate in a health care situation. Just because they can manage to give you their personal details and talk about everyday topics such as the weather, do not assume that they have enough English to cope in a medical situation;
- Establish if the patient would like to be assisted by an interpreter. Stress that their services are free and confidential.

Health practitioners who are uncertain whether a patient requires an interpreter should seek advice from their local HCIS.

Health care interpreters are to be engaged in all health care situations where communication is essential (*Privacy Manual for Health Information, Consent to Medical Treatment - Patient Information*).

This includes, but is not limited to:

- Admission/initial assessment;
- Advance Care Planning;
- Allied health services including speech therapy;
- Consent for operations, procedures, treatment (including day-only surgery) and research;
- Counselling;
- Death of a patient and bereavement counselling;
- Discharge;
- Domestic Violence Routine Screening;
- End of Life discussions;
- Explanation of treatments and medications, including risks and side-effects;
- Health and medical information and medical instructions;
- Health education and promotion programs (both individual and group);
- High-risk/life-threatening situations;
- Identifying the correct patient, correct procedure and correct site;
- Maternity care;
- Mental Health Review Tribunals and Mental Health Inquiries;

- Organ or tissue donation;
- Pre-operative and post-operative instructions;
- Psychiatric assessment and treatment;
- Psychological assessment;
- Research conducted in public health facilities;
- Taking a medical history, undertaking follow-on assessments and developing treatment plans;
- Transfer of Care;
- Treatment or counselling for sexual assault, physical and emotional abuse.

3.4 Initial assessment of a patient

The treating health practitioner or administrative officer should ensure that information relevant to the patient's linguistic, cultural, religious and social needs are recorded in the patient's medical record.

At admission, intake, or transfer of care for every patient, the treating health practitioner or administrative officer must record:

- Country of birth;
- Language spoken at home (or preferred language and dialect);
- Whether an interpreter is required.

For detailed information about how to assess if an interpreter is required, please contact your local HCIS (refer to Section 3.3).

When an interpreter is required, an alert should be recorded in the patient's record (refer to Section 3.6.1).

Procedures differ across facilities and settings, but common ways to record this includes, but is not limited to:

- Placing a sticker stating "interpreter needed/required" in the written record and specifying the patient's language;
- Selecting the interpreter alert in the electronic record.

When a health practitioner determines that a health care interpreter is needed, but the patient's medical record does not accurately reflect this, the health practitioner must update the patient's medical record.

Initial assessments may take place in a variety of contexts; including emergencies (refer to Section 3.7). When an admission is unplanned and the initial assessment takes place without the assistance of a health care interpreter, the treating health practitioner should arrange for the reassessment of the patient with the assistance of a health care interpreter as a priority.

3.5 Booking a health care interpreter

Interpreters are in high demand, and may not be available at short notice.
Health practitioners should book interpreters as far in advance as possible, and may need to negotiate the time and date of the appointment. Bookings should be made with their local HCIS office.

If a HCIS interpreter is not available, the Commonwealth Translation and Interpreting Service (TIS) should be used. When a TIS interpreter is engaged the TIS job reference number should be recorded in the medical record.

In the event that a TIS interpreter is also unavailable, this must be noted in the medical record.

When booking an interpreter, health practitioners need to:

- establish the preferred language or dialect;
- establish any other relevant details, e.g. gender preference.

For example, the preferred language may not always be the main language spoken in the patient's country of birth.

The HCIS will accommodate specific requests whenever possible, e.g. for a female interpreter or an interpreter from a specific cultural background.

Refer to Appendix 5 for detailed information to have ready when booking a health care interpreter.

Health practitioners need to allow additional time for the appointment, which is:

- typically twice that of an appointment in English;
- adequate for a pre-interview briefing and post-interview debriefing, especially when scheduling appointments for situations known to be difficult or sensitive (refer to Sections 3.10 and 3.14).

Some outpatient or other clinics may have a significant number of patients who speak the same community language. In such cases, it is recommended that interpreters are booked for a block of time to see the patients in succession and make efficient use of health care interpreters.
As there are varying systems for making block bookings, it is recommended that health practitioners or administrative staff contact their local HCIS to confirm what information is required to make a block booking.

3.5.1. Booking a sign language interpreter

Before booking a health care interpreter for a Deaf person, health practitioners need to ascertain a patient's preferred mode of communication, which may be:

- Auslan;
- Signed English (usually used by Deaf children and adolescents only); or
- Fingerspelling only (usually only used by elderly Deaf people).

Deaf/Blind patients may use:

- Hand over hand (adaptation of Auslan);
- Visual frame (adaptation of Auslan); or
- Tactile fingerspelling.

If a Deaf patient lacks fluency in Auslan, Signed English or fingerspelling, a Deaf relay interpreter may also be required to work in a team with an Auslan interpreter. In this situation, the relay interpreter is a

Deaf person who transfers meaning between Auslan and a highly visual form of communication that can be understood by the patient.

If a sign language interpreter is not available from the HCIS, a sign language interpreter can be booked through the Sign Language Services, Deaf Society of NSW. This service incurs a fee and booking requests must be submitted online at https://deafsocietynsw.org.au/interpreting. For assistance please contact your local HCIS.

For information on booking interpreters for patients, carers and families who are Deaf and from a culturally and linguistically diverse background, e.g. a deaf child who uses sign language (Auslan or another sign language) and their family does not speak English, please contact your local HCIS for assistance.

3.6 Working with health care interpreters

The health practitioner should explain the interpreting process to the patient at the earliest opportunity. It is crucial that the health care practitioner informs the patient that interpreter services are confidential.

The role of the health care interpreter is to facilitate communication between two parties who do not speak the same language. If cultural advice is required please contact your local HCIS service for assistance before booking a health care interpreter. Refer to Appendix 5 for Tips on working with a health care interpreter.

Whenever possible, health care interpreters must be briefed before commencing the interpreting session. The briefing should include:

- The context of the consultation;
- An outline of the health professional's objective(s) for the consultation;
- Parameters for the session, mode of interpreting, seating arrangements and communication control strategies;
- Whether cultural background information is required;
- Any forms and/or assessment tools that may be used during the session;
- Any potential risks (e.g. where the patient has behavioural issues);
- Whether the matter is sensitive (e.g. sexual assault).

Briefing is particularly crucial in situations such as domestic violence, sexual assault, elder abuse, and torture and trauma counselling, and in areas where formal cognitive assessments are performed, including speech pathology and neuropsychology (for debriefing refer to Section 3.10).

With respect to the interpreting session, health practitioners should be aware that:

- Interpreters speak in the first person, that is, in the same grammatical form as the speaker and will say (for example) "I am unwell" rather than "The patient says she is unwell";
- The health practitioner is responsible for making the seating arrangements to facilitate direct communication between the health practitioner and the patient, taking into account the purpose of the session. Specific seating arrangements apply in the case of Auslan interpreting;

- The interpreter may provide cultural information at the health practitioner's request, or when the cultural gap is affecting communication during the interpreting session. Interpreters recognise that every patient is an individual and take care to avoid cultural stereotyping;
- Interpreters may need to sight translate documents essential to a specific patient consultation. When you know that you need written translation of documents essential to a patient's care, you should contact your local HCIS for assistance before booking an interpreter, as not all health care interpreters are qualified to translate documents (refer to Section 3.12);
- Translations of short written material not essential to individual patient care are undertaken at the discretion of each HCIS. For further information, contact your local HCIS.

Health education sessions or group interpreting
Where a health care interpreter is interpreting at health education sessions for a group of patients, the group facilitator should provide the interpreter with the material to be used at the session well in advance, to allow the interpreter time to prepare. The facilitator should brief the interpreter before the session and discuss matters such as the target audience, communication management, terminology issues and interpreting techniques.

3.6.1 Documenting attendance of a health care interpreter in Medical Records and ensuring future arrangements

In the case of a paper record, the health care interpreter should document their attendance in the patient's medical record. The health care interpreter should be given access to the medical record of the patient for this purpose.

In the case of an electronic medical record (eMR), the health practitioner is responsible for recording that they engaged an interpreter.

In each case, the following information must be recorded:

- an 'interpreter alert' (for eMR) or an interpreter sticker/note (for paper);
- the purpose of the consultation and reason for engaging the interpreter;
- the interpreter's name and employee number;
- the date and time of the attendance.

When a TIS interpreter is engaged, the TIS booking officer provides a TIS job reference number and not the name of the interpreter. This reference number should be recorded in the medical record.

The treating health practitioner is also responsible for:

- identifying any future need for interpreting for the patient;
- ensuring arrangements are made so that a health care interpreter is booked
- to attend all future appointments.

3.7 Bilingual staff in emergencies

Except in emergencies (refer to Section 3.8), bilingual staff, who are not certified or accredited by NAATI, must not be engaged to interpret information for another health worker that is clinical, legally binding or puts at risk either the organisation or the patient.

Interpreting is a professional skill and language fluency does not mean that a staff member has the ability to interpret at a professional level.

When a bilingual person assists in an emergency, this must be clearly documented in the medical record.

In such situations, a health care interpreter must be engaged within the earliest possible timeframe to ensure high quality communication for ongoing diagnosis and medical treatment.

Engaging bilingual staff to interpret for purposes other than emergencies may constitute a breach of duty of care.

3.7.1 Bilingual communication for direct patient care (i.e. not interpreting)

Bilingual health practitioners, who are highly proficient in a language other than English, may consult and communicate directly with their patients in that language in the ordinary course of patient care. As noted above, this does not equate to an ability to interpret information for others.

Health organisations should have appropriate risk management processes for bilingual health practitioners speaking a language other than English in direct patient care, in particular for high risk communication, e.g. where bilingual health practitioners are communicating clinical information such as consent (refer to Section 4.1).

38 Emergencies

Most of the HCIS have an emergency priority line that is made available to targeted or critical facilities, e.g. Emergency Departments, Birth Units and Intensive Care Units only. If you work for one of these units please enquire with your local HCIS about their emergency hotline or using TIS as a back-up service. Always contact your local HCIS for all your interpreting needs first.

In the case of life threatening emergencies, health care interpreters may not always be available within a clinically appropriate timeframe.

In such an emergency, a bilingual health practitioner, an accompanying adult family member or friend may assist in obtaining information from the patient for immediate diagnosis or medical treatment.

Use of bilingual persons should be considered in the following order of preference:

- Recognised interpreters for languages where accreditation is not possible;
- NSW Health staff (health practitioners and other health employees); and
- Adult relatives or friends.

Assistance from a person under 18 years of age should only be considered when no one described above is available.

In circumstances where a bilingual person has been asked to interpret, it should be clearly documented in the medical record that it was not possible to access a health care interpreter and the reasons why.

In any of these situations, a health care interpreter must be engaged within the earliest possible timeframe to confirm the information communicated has been understood and to ensure high quality communication for ongoing diagnosis and medical treatment.

3.9 Working with health care interpreters by telephone and video

It is sometimes appropriate to engage a health care interpreter by telephone.

Depending on the facility and clinical priority, it may also be possible to work with an interpreter by video.

Please consult your local HCIS as to whether telephone or video interpreting is suitable for your type of appointment. For example, face-to-face interpreting is preferable for mental health and speech pathology patients, or for patients who are hard of hearing.

When working with an interpreter by telephone where the patient and the health practitioner are in the same location, it is preferable to use a speakerphone or dual handsets.

It is a responsibility of the health care interpreter to ensure that they remain in a private area with no one else present while they perform telephone or video interpreting. If interpreting is provided by video, consideration must be given to easy access by the patient and their carer or family member to the video equipment, whilst still maintaining privacy and confidentiality, e.g. using a tablet or smartphone at a patient's bedside or in a private consultation room.

Health care interpreters should be briefed before and debriefed after each telephone interpreting session.

At the commencement of the session, the health practitioner should set the context and introduce the participants. The health practitioner is responsible for establishing the rules of communication and ensuring that everyone can hear and understand each other.

The health practitioner should record the medium of the interpreting session in the patient's medical record (i.e. telephone or video).

When a TIS interpreter is engaged the TIS job reference number should be recorded in the medical record.

When telephone interpreting is used in emergencies, the health practitioner should assess the need to arrange a face-to-face follow-up session. If a follow-up session is required this should be scheduled as soon as possible to ensure information, such as medical history, is captured in full and the patient gets an opportunity to ask further questions.

Health practitioners should also be aware of the following issues:

- As telephone interpreting is non-visual, the health practitioner should explain what is happening if there are pauses in the flow of conversation. For example, they can advise that they are making notes and will be silent for a while;
- Interpreters normally use the first person during telephone interpreting, but when multiple speakers are involved this may cause confusion as to who is speaking. The interpreter may then explicitly identify the speaker and then interpret in the first person, or occasionally interpret in the third person for clarity;

If reception is poor, the line drops out, the patient speaks quietly and cannot be heard, or is hard of hearing, the interview may need to be rescheduled as a face-to-face session.

3.10 Debriefing the health care interpreter

Interpreters must be offered the opportunity to debrief after an interpreting session, especially if they are emotionally affected by the interpreting assignment. After the appointment, the health practitioner should:

- Seek feedback from the interpreter about the interview;
- Discuss any issues experienced in the interview about the role of the health practitioner or health care interpreter;
- Provide feedback about the interpreting session and the ways in which the health care interpreter assisted the interview to run smoothly;
- Clarify any issues or questions.

The health practitioner should seek feedback from the health care interpreter about any language or speech matters with the patient. This may include:

- Cultural issues, including if they may have influenced the consultation;
- Matters relating to words or vocabulary, grammar or speech errors;
- Assessment issues, e.g. language or speech errors in speech pathology or neuropsychology assessments.

It is not appropriate for the health practitioner to ask the interpreter to express an opinion about the patient or what they have said beyond the issues set out above.

Health care interpreters may also suffer vicarious trauma as a result of their work, for example when they communicate about domestic and family violence, sexual assault, and torture and trauma (refer to Section 3.14).

For interpreting sessions identified as potentially traumatic additional time should be scheduled to allow sufficient time for pre-briefing and debriefing the interpreter and other health practitioners.

It is important that interpreters are provided with support via the Employee Assistance Program and are encouraged to use this support following any traumatic work.

3.11 Patients who refuse the assistance of an interpreter

The patient has the right to refuse the assistance of a health care interpreter.

When a patient declines to communicate through a health care interpreter, the health practitioner should discuss the reasons for the refusal with the patient and explain that:

- The health practitioner is obliged to ensure that all communication is accurate and impartial. This duty applies equally to communication from the health practitioner to the patient, as to communication from the patient to the health practitioner;
- The treating health practitioner has the right to work with a health care interpreter to ensure clear communication even if the patient has refused the service;
- Sub-optimal treatment or adverse outcomes may result from misunderstandings arising from inaccurate communication;

- The service is free to the patient;
- Health care interpreters have a duty to keep all communication confidential and private.

Some patients may request or insist that a friend or relative acts as an interpreter, or they might insist that a bilingual health practitioner or other health staff act as an interpreter. The health practitioner should inform them that bilingual friends/relatives/health workers are not appropriate substitutes for a health care interpreter, for the reasons listed above.

When a patient has declined the services of a health care interpreter or has insisted that a bilingual person act as an unaccredited interpreter, the health practitioner must record this in the medical record. They should also record the details of any discussions about engaging a health care interpreter, and inform the patient that this has been done.

Patients from culturally and linguistically diverse communities with smaller populations may know a health care interpreter personally, and may refuse to communicate through a specific person due to confidentiality concerns. If the HCIS cannot provide an alternative health care interpreter, a telephone interpreter should be engaged.

If the health practitioner continues to have concerns about the patient's reason for declining a health care interpreter, for example if they have concerns about domestic or family violence (DFV) being present, they should in the first instance attempt to speak to the patient privately and ask this again (where possible having an interpreter available to do this). They should use an interpreter to explain that it is NSW Health Policy that an interpreter be used, and that arrangements can be made to use an interpreter when suitable and safe to do so (i.e. when alone).

Trust and rapport will often need to be built before a patient discloses DFV and accepts any assistance for an interpreting service. Consequently, it is important that even if the patient refuses an interpreter upon initial consultation that she is asked each and every time she presents.

3.12 Working with translators

Translation is the process of transferring written words or text from one language into another.

Translating is a different process to interpreting, with translators and interpreters trained and certified in different ways by NAATI. Not all health care interpreters are qualified to perform translations and vice versa.

When you know that written translation of documents is required for a patient's care, you should contact your local HCIS for assistance before booking an interpreter, as professional translators should be used for translations.

During the course of an interpreting assignment, health care interpreters may be asked to provide very brief translations of instructions essential to patient care on request. Sight translation essential to the health care of an individual patient must take place in the presence of a health practitioner. As noted above, if they are not appropriately qualified, health care interpreters cannot be expected to sight translate documents within a clinical setting.

In particular, professional translators with the appropriate credentials should be engaged to translate lengthy, complex or high risk documents.

Best practice translation requires the highest available level of NAATI accredited/certified translator in the required language, and checking by a second accredited translator to ensure linguistic and conceptual accuracy and patient safety.

For further information contact your local HCIS, in particular if you need an urgent translation of a medical document. Contact details for translating services can also be found at Appendix 8.

For translated resources for health promotion or other non-urgent purposes, contact the Multicultural Health Communication Service.

Translating versus Interpreting

- Translators receive extensive practice with representative texts in various subject areas, learn to compile and manage glossaries of relevant terminology, and master the use of current document-related software such as word processors, desktop publishing systems, and graphics or presentation software;
- Interpreters are trained in precise listening skills under taxing conditions, memory and note-taking techniques for consecutive interpreting (in which the interpreter listens and takes notes while the speaker speaks, and then after several minutes provides the version in the other language), and split-attention for simultaneous interpreting (in which the interpreter, usually in a booth with a headset and microphone, listens and speaks at the same time, usually producing the interpreted version only seconds after the speaker provides the original).

3.13 Mobile phone apps and machine translation

Health organisations and staff should not use apps or other online machine translation services (such as Google Translate) to translate any health information which is clinical or 'official', as current evidence indicates they are not sufficiently accurate.

For example, machine translation tools are unable to take into account language variations, appropriate and polite translation, or linguistic preferences. There are especially high risks around the accuracy of using such services to translate non-European languages.

It is NSW Government policy to provide the highest quality of translation services and the accuracy of machine or online translation tools is not sufficiently proven.

3.14 Trauma-informed approach

A patient experiencing domestic or family violence, sexual assault and/or child abuse and neglect should be provided with an interpreter who has received relevant training in these areas, where possible.

Having the assistance of a professionally trained, trauma-informed interpreter is critical to help victims make first contact with frontline services, feel safe to disclose the abuse, and access help for themselves and their children.

The NSW Health Education Centre Against Violence (ECAV) offers specialist courses for HCIS to understand the dynamics, common beliefs and impact of the different forms of interpersonal violence and how these may impact on victims' ability and/or confidence to disclose their experiences of violence, abuse and neglect.

If you are working with refugees who have experienced torture and trauma, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors and the NSW Refugee Health Service may be able to provide advice.

For interpreting sessions identified as potentially traumatic, the health practitioner or other health worker (e.g. administrative or support staff) should ensure that extra time is scheduled to pre-brief and

debrief the interpreter and other health practitioners.

As noted in Section 3.10, interpreters may also suffer vicarious trauma as a result of their work. It is important that interpreters are provided with support via the Employee Assistance Program and are encouraged to use this support following any traumatic work.

3.15 Conduct of interpreters and translators

NSW Health Care Interpreters and Translators are required to comply with the NSW Health Code of Conduct and their respective Codes of Ethics (refer to Appendix 7):

- Australian Institute of Interpreters and Translators (AUSIT) Code of Ethics; or
- Australian Sign Language Interpreters Association (ASLIA) Code of Ethics.

If a health practitioner has any concerns about unprofessional conduct or unsatisfactory practices by a health care interpreter or professional translator they should raise these with the relevant Manager of the appropriate service, e.g. their local HCIS.

Complaints and incidents are managed by respective organisations in accordance with the NSW Health *Complaints Management Policy* [PD2006_073].

4 CONSENT TO MEDICAL TREATMENT

The following section should be read in conjunction with the current NSW Health consent policy: *Consent to Medical Treatment – Patient Information* [PD2005_406].

It is imperative that a health care interpreter is present to ensure patient consent is valid and that the patient has understood the information provided when a recommendation for surgery, medical procedure or participation in medical research is communicated to a person who is not fluent in English or who is Deaf.

4.1 Requirements for obtaining valid consent

Consent for medical treatment is distinct from consent for disclosure of patient information.

It is the legal responsibility of the health practitioner carrying out the treatment to ensure that a valid consent has been obtained.

A valid consent requires that health practitioners adequately inform patients about an operation, procedure or treatment including material risks and alternatives in a way that patients can understand.

Patients are entitled to make their own decisions about their medical treatment and, as a general rule, no operation, procedure or treatment may be undertaken without the consent of the patient if the patient is a competent adult.

A bilingual health practitioner who is confidently proficient in the patient's language may make a professional assessment that they could fully discharge their professional duty to obtain the patient's consent in the patient's preferred language (refer to Section 3.8 for further information about bilingual communication for direct patient care).

An interpreter must be engaged if a parent/guardian or person responsible who is not fluent in English or who is Deaf, is required to give consent to treatment on behalf of someone who doesn't have the

capacity to do so. A patient may lack capacity for a number of reasons, for example because they have experienced brain damage or are a child under the age of 14.

Consent for treatment which is not obtained through health care interpreters who are professionally accredited or certified – such as family members, other patients, visitors, or bilingual health practitioners acting as interpreters – may not be valid. Consent should only be obtained through someone other than a health care interpreter when an interpreter is not available in an emergency situation (refer to Sections 3.7 and 3.8).

See the consent manual for further information.

4.2 Procedure for obtaining valid consent

The health practitioner should engage a health care interpreter to ensure that the patient has been given all necessary information, including risks associated with the operation, procedure or treatment, so that the patient may give valid consent.

When the health practitioner is satisfied that the patient understands the information, the health practitioner should then read out the consent form and the interpreter should interpret this.

On occasion, an interpreter may be required to provide sight translation of the content of the consent form to the patient. If sight translation is required, it must take place in the presence of the health practitioner so that they can clarify questions which may arise. If a sight translation has taken place, it must be recorded in the patient's medical record that "the form has been sight translated for the patient in the presence of a health practitioner". See Section 3.1 for further information on sight translation.

When consent has been obtained with the assistance of an interpreter, the interpreter must sign and date the relevant section of the consent form.

Non-English consent forms are not used by NSW Health due to a number of risks, including problems with the consistency of content and compatibility with medical record systems.

If telephone or video interpreting is used to obtain consent, the health practitioner should read out the consent form and the interpreter should interpret to the patient. This must be recorded in the patient's medical record and include the interpreting medium used.

If at any time the interpreter believes the patient does not understand the content of the form, the interpreter should advise the health professional of this.

If a patient does not sign the consent form, the interpreter must write in the patient medical record that he/she was present during the interview and witnessed the patient's decision not to sign the consent form.

If the health practitioner or treating practitioner is not present to communicate all information relating to the consent, including during sight translation of the consent form, the interpreter will not sign the form, even if the patient is willing to do so.

5 TRAINING FOR HEALTH PRACTITIONERS

All health practitioners and relevant NSW Health administrative and support staff should be informed of the existence of the HCIS through orientation programs, written procedures, or in-service training programs as soon as possible after commencing employment.

Each Health organisation is to ensure that staff are aware of this Policy Directive, and that all staff are required to adhere to it and be proficient in its application.

Training on working with health care interpreters should be provided to all staff who are in direct contact with patients.

This training is provided by the HCIS, and may also be provided by staff within Multicultural Health Services in consultation with the HCIS.

6 MONITORING AND EVALUATION

To ensure patient safety and quality of care, NSW Health organisations are responsible for monitoring and reviewing the implementation of this Policy Directive.

To ensure the efficient and effective engagement of health care interpreters, Multicultural Heath Services, the HCIS and other stakeholders in Multicultural Health can assist with support for monitoring of implementation. This may include projects to monitor and report on access to and satisfaction with health care interpreters, both from the perspective of health practitioners and health staff, as well as patients who are not fluent in English or who are Deaf.

In the context of regular reporting in relation to the Multicultural Policies and Services Program, relevant Chief Executives are also responsible for reporting on access to, and the engagement of health care interpreters and the HCIS, in particular the proportion of patients with an 'interpreter' or 'interpreter required' flag who are offered and receive the assistance of a health care interpreter.

7 LIST OF APPENDICES

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Appendix 2 – Communicating with Deaf people
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Appendix 4 – Responsibilities of health care interpreters
Appendix 5 – Information to have ready when booking a health care interpreter and
Tips on working with a health care interpreter
Appendix 6 – Benefits of working with health care interpreters
Appendix 7 – Interpreter Codes of Ethics

- Australian Sign Language Interpreter's Association (ASLIA) Code of Ethics
- Australian Institute of Interpreters and Translators (AuSIT) Code of Ethics for Interpreters and Translators (extract)

Appendix 8 – Health Care Interpreter Services – Contact details
References and Related documents

7.1 Appendix 1: Legal and legislative framework

Relevant policies and legislation that impact on language services and policy development of the Commonwealth Government, State Government and NSW Health include:

Commonwealth Government

- *Disability Discrimination Act 1992*
- *Human Rights and Equal Opportunity Act 1986*
- *Racial Discrimination Act 1975*
- Australia's Multicultural Statement - Multicultural Australia: United, Strong, Successful 2017
- The People of Australia: Australia's Multicultural Policy 2011
- National Safety and Quality Health Service (NSQHS) Standards

NSW Government

- *NSW Carers (Recognition) Act 2010*
- *Mental Health Act 2007*
- *Health Records and Information Privacy Act 2002*
- *Multicultural NSW Act 2000*
- *Anti-Discrimination Act (NSW) 1977*
- Multicultural Policies and Services Program (MPSP) Framework 2016

NSW Health

- NSW Health State Plan: Towards 2021
- NSW Rural Health Plan: Towards 2021
- Clinical Procedure Safety [PD2014_036]
- Consent to Medical Treatment – Patient Information [PD2005_406]
- NSW Aboriginal Health Plan 2013-2023 [PD2012_066]
- NSW Health Complaints Management Policy [PD2006_073]
- NSW Health Framework for Women's Health 2013
- NSW Health Privacy Manual for Health Information
- NSW Multicultural Mental Health Plan 2008-2012 [PD2008_067]
- NSW Health and Equity Statement: In All Fairness
- Policy and Implementation Plan for Culturally Diverse Communities 2012-2016 [PD2012_020]
- Refugee Health Plan 2011-2016 [PD2011_014]

7.2 Appendix 2: Communicating with Deaf people

"Deaf" with a capital "D" refers to people who are born deaf or became deaf at an early age (before language acquisition). Deaf people identify themselves as part of a sociolinguistic minority group with a Deaf Culture and Community.

"deaf" with a small "d" refers to people with a condition that has led to them acquiring a hearing loss to whatever degree regardless whether signing or oral methods of communication are used.

"Hard of hearing" refers to all people who have a hearing loss and use speech as their primary means of communication. It includes children who are born with hearing loss as well as people who experience deterioration of hearing at a later stage in life having always used speech to communicate.

English is a second or non-preferred language for most Deaf people. Communicating via lip-reading or written notes is therefore inappropriate for most Deaf people.

The need for an interpreter should be considered even if the person has good speech skills.

If born in Australia, Deaf people are likely to use Australian Sign Language (Auslan) as a first or preferred language.

If born overseas, they may use a foreign sign language. For example American Sign Language (ASL) is quite different from British Sign Language (BSL), despite the fact that English is the spoken language of both countries.

Appropriate terminology should be used to refer to Deaf patients – for example, the term 'signing Deaf' is preferable to 'Deaf and dumb' or 'Deaf-mute', which are considered offensive.

7.3 Appendix 3: Privacy information for health care interpreters

Interpreters and translators engaged by NSW Health are considered staff for the purposes of the Privacy Manual for Health Information, and must be familiar with their obligations regarding the privacy of patients, their family members and staff.

Guidelines for staff regarding the core privacy principles are set out in the *NSW Health Privacy Manual for Health Information*.

The work of interpreters significantly contributes to a health organisation meeting the following two Health Privacy Principles contained in the *Health Records and Information Privacy Act 2002*:

Health Privacy Principle 3: An organisation must collect health information about an individual only from that individual, unless it is unreasonable or impracticable to do so.

> Where a patient does not speak English fluently or is Deaf, it may be impossible to collect health information from the patient directly, unless an interpreter is available.

Health Privacy Principle 9: Before using health information, organisations must take reasonable steps to ensure that the personal information they hold is relevant, accurate, up to date, complete and not misleading.

> Where a patient does not speak English fluently or is Deaf, a health organisation may not be able to be sure that the health information they have meets the terms of Health Privacy Principle 9, without the services of an interpreter.

With respect to patients who are not fluent in English or are Deaf, the assistance of interpreters in the collection and use of health information is essential for the health organisation to meet its privacy obligations.

NSW Health Privacy Leaflet for Patients

Patients should be provided with a copy of the *NSW Health Privacy Leaflet for Patients* leaflet in their own language, or the interpreter should note key points with the patient, advising that staff have an obligation to protect the privacy of the patient's health information.

This leaflet has been translated into 28 community languages and is available on the NSW Health Multicultural Health Communication Service website at: http://www.mhcs.health.nsw.gov.au/

7.4 Appendix 4: Responsibilities of health care interpreters

Anyone engaged in the act of interpreting should be aware of:

- *the expected standards and relevant ethical principles involved, and*
- *their boundaries and limitations, which should be defined according to the complexity, context and requirements of the interpretation setting, and the messages to be conveyed. (National Accreditation Authority for Translators and Interpreters, 2017)*

1. Statutory requirements

Health care interpreters are required to comply with applicable legislation.

2. Code of ethics

Health care interpreters are at all times required to abide by a code of professional ethics, which includes confidentiality, accuracy and impartiality.

3. Skilled interpretation

Health care interpreters provide professional language support services. Their bilingual/multilingual and interpreting skills are tested and certified. Health care interpreters are required to complete an approved medical terminology course, abide by the NSW Health Code of Conduct, AUSIT Code of Ethics, and participate in ongoing professional development programs. Most health care interpreters are accredited, certified or recognised by the Commonwealth Government's National Accreditation Authority for Translators and Interpreters (NAATI).

4. Provision of cultural information

Interpreting requires a thorough knowledge of cultural differences, value and belief systems expressed through the use of language, as well as an understanding of the cultural contexts within which the health practitioner and the patient interact. Accordingly, health care interpreters may be asked to provide specific culturally related information that is relevant to the clinical and social needs of patient care. However, the health practitioner should direct all initial enquires regarding culture and its impact on clinical care to the patient and their family.

5. Completion of records

In the case of face-to-face interpreting and where there is a paper record, the health care interpreter should document their attendance in the patient's medical record. The health care interpreter should be given access to the medical record of the patient for this purpose.
In the case of an electronic medical record (eMR), the health practitioner is responsible for recording that they engaged an interpreter into the eMR.

Where telephone or video interpreting has taken place, the health practitioner is responsible for documenting this in the patient's file (paper or eMR) and the medium used.

6. Sight translation

From time to time, health care interpreters may be required to provide sight translations of information written in English or other languages essential to the health care of an individual patient. Sight translation essential to the health care of an individual patient must take place in the presence of a health practitioner.

The translation of lengthy and technically complex documents may require extra time and resources and should be undertaken by professional translator.

7. Completion of questionnaires/forms

Interpreters **cannot** complete questionnaires/forms on behalf of patients or health practitioners. If the patient cannot complete a questionnaire /form independently, the health practitioner is to enter

the information on their behalf while the interpreter provides interpreting assistance.

8. Translations

During the course of an interpreting assignment, health care interpreters may provide very brief translations of instructions essential to patient care on request, if they are appropriately qualified (refer to Section 3.12).

7.5 Appendix 5: Information to have ready when booking an interpreter and Tips on working with a health care interpreter

When making a booking have the following information ready:

- Patient Details: Name and MRN
  Date of Birth
  Telephone number(s)

- Person Booking the Interpreter – name and contact number
- Health care practitioner - name and contact number (including mobile phone)
- Date and time interpreter is required
- Length of the Interpreter session (hours/minutes)
- Location of the appointment (e.g. facility location or patient's address for home visits)
- Nature of the appointment – to help the interpreter prepare for the appointment record any specific requirements:
  - If it is sensitive (e.g. domestic violence, sexual assault)
  - Preferred gender of the Interpreter and reason for the request
  - Specific ethnic background of interpreter
- Risk alert – note any safety concerns, such as behavioural issues or presence of a dog in the case of a home visit
- When making a booking with TIS, the Client Code will be required.

Tips on working with a health care interpreter

- Working with an interpreter is a learned skill, like taking a client history or putting in a drip.
- When booking the interpreter, be aware of issues like **gender**, or **dialect**.
- Explain **confidentiality** to the patient; this reassures them that they can speak freely and interpreters are bound by a professional code to maintain confidentiality.
- **Speak directly to the patient** not the interpreter, i.e. "*Do **you**...*" not "*Does **she**…*"
- Use **short sentences**, with frequent pauses.
- Use simple words; **avoid jargon**; avoid slang, which may be misunderstood.
- Before the interpreter finishes, ask the patient "*Do you have any other questions?*"
- If the session has dealt with difficult or traumatic subject matter, after the patient leaves, check in with the interpreter if they are OK. A brief discussion with the interpreter can be important for their emotional well-being.

Additional tips with an on-site interpreter:

- Maintain **eye contact with the patient** when you are speaking.
- If it's a long session, give the interpreter and yourself frequent, **short breaks** (e.g. a 5 minute break every hour).
- Allow the interpreter to choose whether to leave the room with the client, or to remain in the room. This may vary depending on the setting, situation etc.

7.6 Appendix 6: Benefits of working with health care interpreters

The **clinical benefits** to health practitioners include:

- Facilitation of accurate communication of diagnosis and/or treatment plan
- Improvement in patient engagement in, understanding of, and adherence to, medication and treatment plans
- Reduction in the incidence of avoidable readmissions to hospital/health services by ensuring that the patient clearly understands how to manage his/her health condition post-discharge, including correct use of medications and any follow-up treatment required
- The ability to offer health promotion and prevention programs.

The **benefits to patients** who are not fluent in English and those who are Deaf include the ability to:

- Understand the information imparted by care practitioners
- Participate in decisions about their care
- Ask questions about their condition, the proposed medical treatment/procedure and its associated risks
- Make an informed choice and provide valid consent before treatment.

Working with health care interpreters can bring efficiency benefits to the health system such as:

- Reduction of patient readmission rates
- Savings in health personnel time and the avoidance of unnecessary diagnostic tests and procedures
- Avoidance of litigation
- Improving safety and reducing adverse events such as incorrect patient identification, incorrect procedure or postponement of procedures due to (for example) incorrect administration of medication.

Communicating through a non-accredited interpreter may have serious consequences, including:

- Inferior quality of interpreting
- Inaccuracies in interpreting due to a lack of skills and familiarity with ethics, medical concepts and terminology
- Altering, censoring, distortion and suppression of messages, especially when relatives act as interpreters
- Breach of patient confidentiality
- Invalid consent to medical treatment/procedure
- Incorrect patient identification, undertaking an incorrect procedure, treating an incorrect site
- Inappropriate responsibilities being placed on family members and health practitioners.

The need for an interpreter should be recorded prominently in the patient's written or electronic medical record.

7.7 Appendix 7: Interpreter Codes of Ethics

Australian Sign Language Interpreters' Association (ASLIA) Code of Ethics

The full version is available at https://aslia.com.au/code-of-ethics/

An obligation of gaining NAATI accreditation is that practitioners adhere to the professional Code of Ethics. For Auslan-English interpreters, this is the ASLIA Code of Ethics. A summary of the core values in the ASLIA Code of Ethics includes:

1. Professional accountability: Accepting responsibility for professional decisions and actions.
2. Professional competence: Committing to provide quality professional service throughout one's practice.
3. Non-discrimination: Approaching professional service with respect and cultural sensitivity.
4. Integrity in professional relationships: Dealing honestly and fairly with participants and colleagues.
5. Integrity in business practices: Dealing honestly and ethically in all business practices.
6. Practitioners are to understand that each of these core values and accompanying sections are to be considered when making ethical and professional decisions in their identity and capacity as an interpreter. These values are of equal weight and importance.

Australian Institute of Interpreters and Translators (AUSIT) Code of Ethics for Interpreters and Translators [extract]

The full version is available at http://ausit.org/AUSIT/Documents/Code_Of_Ethics_Full.pdf

General Principles

1. Professional conduct

Interpreters and translators shall at all times act in accordance with the standards of conduct and decorum appropriate to the aims of The Australian Institute of Interpreters and Translators (AUSIT).

Explanation:
Interpreters and translators take responsibility for their work and conduct; they are committed to providing quality service in a respectful and culturally sensitive manner, dealing honestly and fairly with other parties and colleagues, and dealing honestly in all business practices. They disclose any conflict of interest or any matter that may compromise their impartiality. They observe common professional ethics of diligence and responsiveness to the needs of other participants in their work.

2. Confidentiality

Interpreters and translators maintain confidentiality and do not disclose information acquired during the course of their work

Explanation:
Interpreters and translators are bound by strict rules of confidentiality, as are the persons they work with in professional or business fields.

3. Competence

Interpreters and translators only undertake work they are competent to perform in the languages for which they are professionally qualified through training and credentials.

Explanation:
In order to practise, interpreters and translators need to have particular levels of expertise for particular types of work. Those who work with interpreters and translators are entitled to expect that they are working with appropriately qualified practitioners. Practitioners always represent their credentials honestly. Where formal training or accreditation is not available (e.g. in less frequently used language combinations and new and emerging languages), practitioners have an obligation to increase and maintain skills through their own professional development (see Principle 8 below) or request employers, agencies or institutions to provide it.

4. Impartiality

Interpreters and translators observe impartiality in all professional contracts. Interpreters remain unbiased throughout the communication exchanges between the participants in any interpreted encounter. Translators do not show bias towards either the author of the source text or the intended readers of their translation.

Explanation:
Interpreters and translators play an important role in facilitating parties who do not share a common language to communicate effectively with each other. They aim to ensure that the full intent of the communication is conveyed. Interpreters and translators are not responsible for what the parties communicate, only for complete and accurate transfer of the message. They do not allow bias to influence their performance; likewise, they do not soften, strengthen or alter the messages being conveyed.

5. Accuracy

Interpreters and translators use their best professional judgement in remaining faithful at all times to the meaning of texts and messages.

Explanation:
Accuracy for the purposes of this Code means optimal and complete message transfer into the target language, preserving the content and intent of the source message or text without omission or distortion.

6. Clarity of role boundaries

Interpreters and translators maintain clear boundaries between their tasks as facilitators of communication through message transfer and any tasks that may be undertaken by other parties involved in the assignment.

Explanation:
The focus of interpreters and translators is on message transfer. Practitioners do not, in the course of their interpreting or translating duties, engage in other tasks such as advocacy, guidance or advice. Even where such other tasks are

mandated by particular employment arrangements, practitioners insist that a clear demarcation is agreed on between interpreting and translating and other tasks. For this purpose, interpreters and translators will, where the situation requires it, provide an explanation of their role in line with the principles of this Code.

7. Maintaining professional relationships

Interpreters and translators are responsible for the quality of their work, whether as employees, freelance practitioners or contractors with interpreting and translating agencies. They always endeavour to secure satisfactory working conditions for the performance of their duties, including physical facilities, appropriate briefing, a clear commission, and clear conduct protocols where needed in specific institutional settings. They ensure that they have allocated adequate time to complete their work; they foster a mutually respectful business relationship with the people with whom they work and encourage them to become familiar with the interpreter or translator role.

Explanation:

Interpreters and translators work in a wide variety of settings with specific institutional demands and a wide range of professional and business contexts. Some settings involve strict protocols where the interpreter or translator is a totally independent party, while others are marked by cooperation and shared responsibilities. Interpreters and translators must be familiar with these contexts, and endeavour to have the people they work with understand their role.

For practitioners who work through agencies, the agency providing them with the work is one of their clients, and practitioners maintain the same professional standards when working with them as when working with individual clients. At the same time agencies must have appropriate and fair procedures in place that recognise and foster the professionalism of interpreting and translating practitioners.

8. Professional development

Interpreters and translators continue to develop their professional knowledge and skills.

Explanation:

Practitioners commit themselves to lifelong learning, recognising that individuals, services and practices evolve and change over time. They continually upgrade their language and transfer skills and their contextual and cultural understanding. They keep up to date with the technological advances pertinent to their practice in order to continue to provide quality service. Practitioners working in languages where there is no standard training or credential may need to assess, maintain and update their standards independently.

9. Professional solidarity

Interpreters and translators respect and support their fellow professionals, and they uphold the reputation and trustworthiness of the profession of interpreting and translating.

Explanation:

Practitioners have a loyalty to the profession that extends beyond their individual interest. They support and further the interests of the profession and their colleagues and offer each other assistance.

7.8 Appendix 8: Health Care Interpreter Services – Contact Details

Metropolitan Health Care Interpreter Services

South Western Sydney Local Health District
Health Language Services – Interpreting and Translating

Interpreter Services:	(02) 8738 6088 for bookings
Fax:	(02) 8738 6090
Email:	Interpreters.Bookings@sswahs.nsw.gov.au (non-urgent bookings only)
Postal Address:	PO Box 7103 LIVERPOOL BC 1871
Hours of Service:	HCIS is a 24 hour service, 7 days per week
Coverage:	South Western Sydney LHD
Translations:	http://www.swslhd.nsw.gov.au/services/Interpreter/translation.html

Sydney Local Health District HCIS

Interpreter Services:	(02) 9515 0030 for bookings
Fax:	(02) 9515 9577 (non-urgent bookings only)
Email:	sydneyinterpreters@health.nsw.gov.au (non-urgent bookings only)
Street Address:	Level 8 South, Missenden Road CAMPERDOWN NSW 2050
Hours of Service:	SHCIS is a 24 hour service, 7 days per week
Coverage:	Sydney LHD, South Eastern Sydney LHD, St Vincent's (Darlinghurst), Sydney Children's Hospital (Randwick) and Justice Health and Forensic Mental Health Network.
Translations:	SHCIS.Translations@health.nsw.gov.au (for enquiries) www.slhd.nsw.gov.au/interpreters/

Western Sydney Local Health District HCIS

Interpreter Services:	(02) 9912 3800 for bookings
Fax:	(02) 9840 3789
Email:	wslhd-hcis@health.nsw.gov.au
Street Address:	Building 61, Cumberland Hospital, 5 Fleet Street NORTH PARRAMATTA NSW 2150
Postal Address:	Locked Bag 7118, NORTH PARRAMATTA BC 2124
Hours of Service:	HCIS is a 24 hour service, 7 days per week
Coverage:	Western Sydney LHD, Northern Sydney LHD, Nepean Blue Mountains LHD, the Children's Hospital Westmead, St Joseph's Hospital, and Justice Health and Forensic Mental Health Network.
Translations:	http://www.wslhd.health.nsw.gov.au/Translation-Service (02) 8838 6210

Rural and Regional Health Care Interpreter Services

Hunter New England Local Health District HCIS

Interpreter Services:	**Call 1800 674 994 Freecall** for health services in the Mid North Coast, North Coast, Tablelands, Western and Far Western NSW
	Call (02) 4924 6285 (business hours) or **(02) 4921 3000** (after hours) for Hunter Valley, Newcastle, Maitland, Port Stephens, Lake Macquarie, Taree, Great Lakes and Central Coast.
Fax:	(02) 4924 6287
Email:	HNEMulticulturalHealth@hnehealth.nsw.gov.au
Street Address:	HNE Multicultural Health Service Level 2 Harker Building, Wallsend Campus Longworth Avenue WALLSEND NSW 2287
Hours of Service:	HCIS is a 24 hour service, 7 days per week
Coverage:	Hunter New England LHD, Central Coast LHD, Mid North Coast LHD, Northern NSW LHD, Far West LHD and Western NSW LHD Bookings from agencies outside NSW Health can be made by submitting a request form available on request.
Translations:	http://www.hnehealth.nsw.gov.au/multiculturalHealth/Pages/Health-Care-Interpreter-Service.aspx

Illawarra Shoalhaven Local Health District HCIS

Interpreter Services:	**Call (02) 4223 8540** for Illawarra area
	Call 1800 247 272 for Shoalhaven area, Murrumbidgee LHD and Southern NSW LHD
Fax:	(02) 4276 2487
Teletypewriter:	(02) 4223 8556
Email Address:	ISLHS-HCIS@health.nsw.gov.au
Street Address:	Ground floor, Nurses Home (Block E) Cowper Street WARRAWONG NSW 2502
Postal Address:	PO Box 21 WARRAWONG NSW 2502
Hours of Service:	Monday to Friday – 8.30 am to 5.00 pm
Coverage:	Illawarra Shoalhaven LHD,

NSW Translation Services for non-urgent purposes

For translated resources for health promotion or other non-urgent purposes, contact the:

- Multicultural Health Communication Service at http://www.mhcs.health.nsw.gov.au/ or at (02) 8753 5047.

Commonwealth Translating and Interpreter Service (TIS)

Call TIS National on **131 450** or **1300 655 030** for the hospital priority line
Information is available online at https://www.tisnational.gov.au/en

8 REFERENCES

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Related Documents:

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Ageing, Disability & Home Care 2012, ***Using interpreter services when working with refugees / asylum seekers fact sheet***, NSW Department of Human Services, Strawberry Hills, NSW.

Australian Government 2013, ***Multicultural Language Services Guidelines: For Australian Government Agencies,*** Department of Social Services, Canberra.

Queensland Health 2007, ***Working with Interpreters***, Brisbane, Australia

Queensland Health 2011, ***Queensland Multicultural Policy 2011 and Language Services Policy – in a health context***, Brisbane, Australia

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Western Australia Health 2011, ***WA Health Language Services Policy***, Perth, Western Australian

DOMESTIC VIOLENCE AND MIGRATION REGULATIONS: RELEVANCE FOR HEALTH WORKERS (IB2018_017)

IB2018_017 rescinds Information Bulletin 2005/4

PURPOSE

This Information Bulletin outlines the special provisions relating to domestic and family violence (DFV) contained in the *Migration Regulations 1994* (the provisions) of the *Migration Act 1958.* It also describes support which can be offered to victims of DFV, in addition to clinical services, by certain professional experts within NSW Health.

This Information Bulletin expands on issues raised in the NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence 2006*, regarding clients from culturally and linguistically diverse backgrounds affected by DFV, who hold certain temporary visas.

KEY INFORMATION

The provisions ensure that persons in Australia on certain temporary visas do not feel compelled to remain in abusive relationships in order to stay in Australia.

The provisions are usually invoked by persons on temporary partner visas or prospective marriage visas, who are in the process of applying for a permanent partner visa. The provisions allow these persons to remain in Australia and apply for permanent residence, even though, as a result of DFV and a relationship breakdown, they do not meet the ordinary requirements to obtain a permanent partner visa.

The provisions can also be invoked by persons on certain skilled stream visas in some circumstances. Victims of DFV seeking to invoke the provisions must substantiate their claims by proving their relationship was genuine until it ended and that DFV took place during the relationship in Australia. If the victim's claim of DFV has not been heard by a court, that person can provide the following as evidence that DFV took place during their relationship:

- a statutory declaration (form number 1410 for DFV claims first made on or after 24 November 2012, or form number 1040 for claims made on or after 15 October 2007); and
- two items of evidence from **professional experts**.

The *Migration Regulations 1994 - Specification of Evidentiary Requirements - IMMI 12/116* (IMMI 12/116) provides information on acceptable items of evidence from **professional experts**. Victims of DVF must present at least two of the types of evidence listed in IMMI 12/116 in support of their claim. They cannot present two items of evidence of the same type.

NSW Health workers categorised as **professional experts** include registered medical practitioners, nurses or psychologists and members or eligible members of the Australian Association of Social Workers. Professional experts within NSW Health may provide a statement in a statutory declaration or an official letter with relevant supporting documents in their professional capacity, including a medical report, hospital report or a discharge summary. Their evidence must include:

- details of the violence, identifying all individuals involved;
- evidence or reasons for any opinion or assessment;
- details about their professional relationship with the victim; and
- information regarding services and support offered or provided to the victim.

Professional experts within NSW Health should proactively follow up by asking about the safety of the victim - if they are safe to go home, if they need assistance to go home or a safe place as per the NSW Health policy on *Identifying and Responding to Domestic Violence* PD2006_084.

Professional experts within NSW Health should also identify if children are involved in the violence by asking victims directly. If so, questions should be asked about this - if children have been hurt or witnessed violence, where and who are the children with, and if victims are worried about the children's safety.

Professional experts within NSW Health are also required to follow mandatory reporting protocols if they suspect that a child is at risk of significant harm.

The NSW Mandatory Reporting Guide should be used as part of this assessment and reports to the Child Protection Helpline should be made where indicated.

REFERENCES

1. NSW Ministry of Health. 2006. ***Domestic Violence - Identifying and Responding***. [ONLINE] Available at: http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2006_084. [Accessed 14 March 2018].
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4. Minister for Immigration and Citizenship. 2012. ***Migration Regulations 1994 - Specification of Evidentiary Requirements - IMMI 12/116.*** [ONLINE] Available at: https://www.legislation.gov.au/Details/F2012L022377. [Accessed 05 April 2018].
5. Australian Medical Association. 2016. ***Supporting Patients Experiencing Family Violence***. [ONLINE] Available at: https://ama.com.au/article/ama-family-violence-resource. [Accessed 14 March 2018].
6. Childstory Reporter. 2016. ***Mandatory Reporter Guide***. [ONLINE] Available at: https://reporter.childstory.nsw.gov.au/s/mrg. [Accessed 14 March 2018].

NSW PLAN FOR HEALTHY CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES: 2019-2023 (PD2019_018)

PURPOSE

The NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023 is the strategic statewide policy for meeting the health needs of culturally and linguistically diverse consumers for the next five years. It aims to ensure people of culturally and linguistically diverse backgrounds have equitable access to health care services that are culturally responsive, safe and high quality. The Plan also affirms the commitment of NSW Health to the principles of the *Multicultural NSW Act 2000* in particular respecting and making provision for the culture and language of others. The Plan serves as the NSW Health multicultural plan under the NSW Multicultural Policies and Services Program.

MANDATORY REQUIREMENTS

NSW Health organisations are required to take action to work towards achieving the outcomes of the NSW Plan for Healthy Culturally and Linguistically Diverse communities: 2019-2023. These are:

1. Strategies in place to improve access and quality of care for people of culturally and linguistically diverse backgrounds
2. Support provided for people of culturally and linguistically diverse backgrounds to build their health literacy so they can be actively involved in decisions about their health
3. Health organisations are responsive to people's individual needs, language and culture
4. An understanding of the needs, experiences and identities of culturally and linguistically diverse communities in NSW.

Local health districts, specialty health networks, pillars, statewide specialist multicultural health services and statewide health services, should use the Plan to develop a local plan or include elements of the Plan in relevant strategic plans.

IMPLEMENTATION

NSW Health organisations should:

- Nominate a senior officer to sponsor implementation and reporting on the Plan
- Have a multicultural or diversity committee to oversee implementation
- Identify local needs and develop strategies in partnership with consumers
- Have a local-level plan of action to implement the Plan
- Engage and include consumers in policy, service and program planning, implementation and evaluation processes
- Include evaluation in multicultural health projects and program
- Monitor and report on progress towards achieving the outcomes of the Plan.

The full policy implementation plan with outcomes, strategic objectives, indicators, and responsibilities are listed in the Plan on pages 10 - 13, and actions to implement the plan are listed on page 14.

14. MIGRANT HEALTH 14.36

Under the NSW Multicultural Policies and Services Program (MPSP) reporting program, the Ministry of Health will:

- Provide policy support and guidance to NSW Health organisations in implementing the Plan for Healthy Culturally and Linguistically Diverse communities: 2019-2023.
- Monitor progress towards achieving the outcomes of the Plan including coordinating the NSW Health annual MPSP reporting process.
- Draft the consolidated NSW Health MPSP report for submission to Multicultural NSW.
- Provide MPSP policy advice to the Minister for Health, the senior executive of the Ministry of Health, local health districts, specialty health networks, pillar organisations, statewide health services and programs.

ATTACHMENTS

1. NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023. https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2019_018

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters

CHAPTER 15 - NURSING

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NSW Health Nurse Practitioners	PD2022_057
Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care	PD2020_032
Nursing & Midwifery Clinical Guidelines – Identifying and Responding to Drug & Alcohol Issues	GL2008_001
Nurse administered Thrombolysis for ST Elevation Myocardial Infarction (STEMI)	PD2022_055
Nurse Delegated Emergency Care (NDEC) Nurse Management Guidelines (NMG)	GL2017_009
RN Supply and Administration of STI Therapies in Publicly Funded Sexual Health Services	PD2020_024

Updated as at December 2022

NSW HEALTH NURSE PRACTITIONERS (PD2022_057)

PD2022_057 rescinded PD2020_034

POLICY STATEMENT

NSW Health organisations must have appropriate systems and processes in place for establishing, implementing, governing and sustaining nurse practitioner roles.

SUMMARY OF POLICY REQUIREMENTS

NSW Health organisations are to conduct a service needs analysis to identify, describe and inform a business case to support the implementation of nurse practitioner roles. Adequate recurrent funding for a nurse practitioner service must exist to support the position beyond existing nursing workforce requirements.

Recruitment for nurse practitioner positions is to follow the NSW Health Policy Directive Recruitment and Selection of Staff to the NSW Health Service (PD2017_040). Organisations are not obligated to create nurse practitioner positions in order to regrade an individual who has been endorsed, commenced relevant study or expressed an interest in becoming an endorsed nurse practitioner.

Suitable registered nurse applicants for nurse practitioner positions are to be clinically and professionally supported to undertake a Nursing and Midwifery Board of Australia (NMBA)approved nurse practitioner master's degree or supported to meet course entry requirements at time of employment.

Registered nurses supported to work towards endorsement as a nurse practitioner and transitional nurse practitioner clinical training is to be supported by a clinical learning and development plan. All clinical practice by transitional nurse practitioners, nurse practitioner students and registered nurses working towards nurse practitioner endorsement is to remain supervised by an appropriately senior practitioner.

NSW Health organisations are to ensure a Nurse Practitioner Governance Committee is established to authorise the scope of practice for nurse practitioners, transitional nurse practitioners and registered nurses working towards nurse practitioner endorsement. Individual scopes of practice must be periodically reviewed.

A nurse practitioner's scope of practice document is to define the area of practice, expertise, accountabilities and practice of nursing required to satisfy the authority to prescribe in NSW.

Nurse practitioners are to prescribe within their scope of practice, in line with relevant legislation and the NSW Health formulary, policies, and in accordance with Drug and Therapeutics Committee requirements.

Nurse practitioners may request diagnostic investigations relevant to their scope of practice, such as requesting pathology, medical imaging and other investigations.

Organisations are to periodically evaluate nurse practitioner services in terms of quality, safety, effectiveness, appropriateness, consumer participation, access and efficiency.

To download a copy of the NSW Health Nurse Practitioners: Policy and Procedures please go to: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_057

NURSING AND MIDWIFERY MANAGEMENT OF ALCOHOL AND DRUG USE IN THE DELIVERY OF HEALTH CARE (PD2020_032)

PD2020_032 rescinds PD2007_091

POLICY STATEMENT

Nurses and midwives in all NSW Health care settings are to ensure people with drug and alcohol related issues experience person-centred, safe and high-quality intervention and care.

SUMMARY OF POLICY REQUIREMENTS

All care and treatment delivered to people who are experiencing harm from alcohol and other drug use is to be person centred and non-discriminatory.

On admission to a health service all patients will undergo an initial screening to identify alcohol and/or drug use and risks as part of all nursing and midwifery care.

The use of drugs and alcohol is to be recorded for all patients so that there is a consistent approach to provision of care and referral of patients to specialist services.

As part of responding to alcohol and/or drug use risks, nurses and midwives are to deliver brief interventions in line with their scope of practice, consult and refer to a specialist treatment provider for comprehensive assessment, as appropriate.

Nurses and midwives need to maintain awareness that patients presenting with risk factors, associated with alcohol and other drug use, also may predispose any child to increased risks to their wellbeing. Where this is identified, appropriate and sensitive questioning must be undertaken in line with NSW Health Policy.

The drug and alcohol goals, and treatment plan must be considered and integrated into their overall holistic health care plan, in collaboration with the patient.

Nurses and Midwives must ensure a patient's drug and alcohol health care needs are integrated into their transfer of care planning process.

At each transition of care, clinical handover must occur to ensure patient safety.

To download the Nursing and midwifery management of alcohol and drug use in the delivery of health care policy and procedures please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_032

332(03/09/20)

NURSING AND MIDWIFERY CLINICAL GUIDELINES – IDENTIFYING & RESPONDING TO DRUG & ALCOHOL ISSUES (GL2008_001)

These guidelines provide nurses and midwives with support and a benchmark for quality drug and alcohol use assessment and care in daily practice. The Guidelines can be accessed at https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2008_001

64(2/08)

NURSE ADMINISTERED THROMBOLYSIS FOR ST ELEVATION MYOCARDIAL INFARCTION (STEMI) (PD2022_055)

PD2022_055 replaced PD2015_044

POLICY STATEMENT

The Nurse Administered Thrombolysis (NAT) protocol authorises an accredited registered nurse to administer specified doses of thrombolytic and antithrombotic medication when there is no medical officer or authorised nurse practitioner on site using standing orders for people presenting with ST elevation myocardial infarction (STEMI) who meet the Nurse Administered Thrombolysis criteria.

SUMMARY OF POLICY REQUIREMENTS

Nurse Administered Thrombosis (NAT) is one of the models included in the NSW State Cardiac Reperfusion Strategy (SCRS) which aims to improve the care of patients with an Acute Coronary Syndrome (ACS) and reduce the time to reperfusion for patients with ST elevation myocardial infarction (STEMI).

The Nurse Administered Thrombolysis protocol is only for the management of patients with ST elevation myocardial infarction confirmed by the electrocardiogram (ECG) Reading Service who meet all Nurse Administered Thrombolysis criteria.

The protocol is only to be used in facilities that have fully implemented the Nurse Administered Thrombolysis protocol and when there is no medical officer or authorised nurse practitioner on site at the time of presentation. The protocol is only to be used by registered nurses accredited in Nurse Administered Thrombolysis processes and procedures.

Facilities must implement appropriate governance, including procedures to ensure counter signature by the medical officer or authorised nurse practitioner on call within 24 hours, as per local procedures, identify and minimise the risks of adverse events and to approve the relevant protocols.

In accordance with the NSW Health Policy Directive Medication Handling (PD2022_032), Nurse Administered Thrombolysis standing orders must be in the form of a written instruction, signed and dated by the authorising senior medical officer or authorised nurse practitioner and approved by the local drug and therapeutics committee to enable the administration of Nurse Administered Thrombolysis medications without a patient specific written order.

Each standing order must be reviewed every two years and re-approved as appropriate.

Activation of the Nurse Administered Thrombolysis protocol occurs in parallel with notification of the local medical officer or authorised nurse practitioner on call. It is not the intention of a Nurse Administered Thrombolysis protocol to bypass or exclude the local medical officer or authorised nurse practitioner; rather it allows appropriate treatment to be commenced while awaiting their arrival. On arrival, the medical officer or authorised nurse practitioner assumes responsibility for the medical management of the patient, in collaboration with nursing staff.

Medication administration must follow the NSW Health Policy Directive Medication Handling (PD2022_032).

Registered nurses administering Nurse Administered Thrombolysis must have successfully completed the requisite education and accreditation packages which include:

- Nurse Administered Thrombolysis education and accreditation package
- Competency in basic cardiac rhythm and basic 12 lead ECG interpretation
- Advanced Life Support (ALS) certification including recognition of life-threatening arrhythmias, manual and/or automated defibrillation and the use of Advanced Life Support drugs
- Certification in peripheral intravenous (IV) cannulation.

To download the Nurse Administered Thrombolysis for ST Elevation Myocardial Infarction (STEMI) policy and procedures please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_055

344(18/11/22)

NURSE DELEGATED EMERGENCY CARE (NDEC) NURSE MANAGEMENT GUIDELINES (NMG) (GL2017_009)

PURPOSE

The Nurse Management Guidelines (NMGs) direct all clinical care in the Nurse Delegated Emergency Care (NDEC) model. NDEC is designed to provide timely, quality care for patients presenting to Emergency Departments (EDs) in rural and remote areas with low risk, low acuity conditions. Under this model the care of these patients is delegated by the facility's Medical Officer/s to specially trained and credentialed registered nurses (RNs).

The NMGs guides appropriately trained and credentialed RNs to undertake assessment, investigation, intervention and discharge of patients presenting to EDs with specific less-urgent conditions.

KEY PRINCIPLES

This Guideline should be used by NSW Health facilities and Local Health Districts that have implemented the NDEC model. The NDEC Nurse Management Guidelines must be used in Emergency Departments where the NDEC model operates in accordance with Section 1.5 of *PD2015_024 Standing Orders for the Supply or Administration of Medication under the NDEC Model* and with local modes of implementation.

USE OF THE GUIDELINE

This Guideline should be used by RNs accredited to practice NDEC, in accordance with the NDEC Education and Accreditation Framework. The Guideline must only be used in facilities where NDEC is approved and for patient presentations that meet the strict inclusion criteria. Local Health Districts should ensure relevant staff have ready access to these guidelines.

The full guideline can be accessed at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_009

312(15/05/17)

RN SUPPLY AND ADMINISTRATION OF STI THERAPIES IN PUBLICLY FUNDED SEXUAL HEALTH SERVICES (PD2020_024)

PD2020_024 rescinds PD2018_014

POLICY STATEMENT

NSW Health STI treatment protocol increases the likelihood that patients attending NSW Publicly Funded Sexual Health Services (PFSHS) diagnosed with common sexual health infections and their sexual partners will receive treatment in a timely manner, and treatment is available to all patients, regardless of their geographical location.

This Policy Directive outlines the mandatory requirements for implementation and utilisation of the state-wide Supply and Administration of Sexually Transmissible Infection (STI) Therapies under Protocol by Accredited Registered Nurses employed in NSW PFSHS.

SUMMARY OF POLICY REQUIREMENTS

STI treatment protocol authorises a Registered Nurse (RN) employed within a publicly funded sexual health service who has successfully completed an education and accreditation package to supply and/or administer specified medications to eligible patients and their sexual partners for the purpose of treatment of uncomplicated STIs.

Patients and sexual partners are assessed against inclusion criteria.

If inclusion criteria are **not met** then a medical review must be sought.

This protocol is only for:

- The management of patients with a confirmed STI diagnosis (positive laboratory test result or by an accepted diagnostic criteria) and who meet the criteria specified

  OR

- Sexual partners for presumptive treatment of a STI and who meet the criteria specified.

The protocol is only to be used by RNs accredited to supply and administer STI treatments under protocol and in conjunction with the *NSW Sexual Health Services Standard Operating Procedures Manual*

Facilities must implement appropriate governance, identify and minimise the risks of adverse events as outlined under Implementation. Medication administration and documentation must be in accordance to *NSW Health Medication Handling in NSW Public Health Facilities* (PD2013_043). Nurse medication protocols are to be approved by the relevant Drug and Therapeutics Committee to enable the nurse supply and administration of STI medications.

Each medication protocol must be reviewed every 24 months and re-approved as appropriate. Review must include sexual health experts such as Directors of Services, or Staff Specialists and Senior Nurses employed within Publicly Funded Sexual Health Services.

Registered Nurses administering and supplying STI medication under protocol must have successfully completed the requisite education and accreditation packages which include:

- Sexual Health Services STI Pharmacotherapy education and accreditation package; and
- Clinical competency assessment and accreditation for sexual health nurses as outlined in Section 7: Education Accreditation Clinical accreditation process of NSW Sexual Health Standard Operating Procedure.

To download the RN Supply and Administration of STI Therapies in Publicly Funded Sexual Health Services Policy and Procedures go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_024

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

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CHAPTER 16 – AGED CARE FACILITIES (NURSING HOMES)

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Reporting for Residential Aged Care Services	PD2022_054
Wellness and Reablement in Aged Care	GL2021_002

REPORTING FOR RESIDENTIAL AGED CARE SERVICES
(PD2022_054)

PD2022_054 rescinds PD2019_049

POLICY STATEMENT

NSW Health is the Approved Provider of aged care services funded by the Australian Government, including State Government Residential Aged Care Facilities, residential Transitional Aged Care Program services, and Multi-Purpose Services. Local Health Districts operate these aged care services, and the Australian Government has legal, regulatory and funding responsibility for them.

To help protect aged care residents, the Aged Care Act 1997 (Commonwealth) and the National Disability Insurance Scheme Act 2013 (Commonwealth) have compulsory reporting provisions through the Serious Incident Response Scheme (SIRS) and the National Disability Insurance Scheme (NDIS).

These Commonwealth incident management and reporting requirements are in addition to those required under the NSW Health Policy Directive Incident Management (PD2020_047).

SUMMARY OF POLICY REQUIREMENTS

NSW Health operated aged care services must report incidents in each system, when the reporting criteria are met for the Serious Incident Response Scheme (SIRS), the National Disability Insurance Scheme (NDIS) and NSW Health's Incident Management System. Serious Incident Response Scheme reportable incidents are:

- Unreasonable use of force
- Unlawful sexual contact or inappropriate sexual conduct
- Neglect
- Psychological or emotional abuse
- Unexpected death
- Stealing or financial coercion by a staff member
- Inappropriate use of restrictive practices
- Unexplained absence from care

Priority 1 Serious Incident Response Scheme reportable incident (Aged Care) must be reported to the Aged Care Quality and Safety Commission within 24 hours.

Priority 2 Serious Incident Response Scheme reportable incident (Aged Care) must be reported to the Aged Care Quality and Safety Commission within 30 days of becoming aware of the incident.

These incidents must be reported in the My Aged Care Service and Support Portal.

National Disability Insurance Scheme reportable incidents are:

- Death
- Serious injury
- Abuse or neglect
- Unlawful sexual or physical contact with, or assault of, a person with disability

- Sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity.
- Use of restrictive practice not in accordance with authorisation/ behaviour support plan

All National Disability Insurance Scheme reportable incidents are to be reported in the National Disability Insurance Scheme Quality and Safeguards Commission Portal within 24 hours except for:

- use of restrictive practice not in accordance with a required state or territory authorisation and/or
- not in accordance with a behaviour support plan which must be reported within 5 business days.

Reportable incidents must be reported to NSW Police within 24 hours when there are reasonable grounds of facts or circumstances that could be of a criminal nature.

To download a copy of the Reporting for Residential Aged Care Services policy and procedures go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_054

WELLNESS AND REABLEMENT IN AGED CARE (GL2021_002)

GUIDELINE SUMMARY

This Guideline outlines what wellness and reablement is, the contractual requirements, and roles and responsibilities of NSW Health organisations for implementing a wellness and reablement approach.

Wellness and reablement ensures older people in NSW live as active, purposeful, healthy, and independent lives as they can and, where possible, remain living in their own homes.

NSW Health is contracted by the Commonwealth Department of Health to provide a range of assessment and support services for older people wishing to live independently at home. NSW Health is contractually obliged to provide these services with a consistent wellness and reablement approach.

KEY PRINCIPLES

Wellness and reablement practice with older people within NSW Health is based on the following set of principles:

- supporting older people living at home to live as independently as possible for as long as possible.
- treating each older person as a unique individual with their own strengths, abilities, life experiences, preferences, choices, and needs.
- assessing an older person in a holistic, strength–based way, promoting wellness, considering dignity of risk and encouraging active participation in the development of appropriate support plans.
- ensuring an older person's aspirations and needs are best met when assessment, support planning, and service provision is a partnership between the older person, their informal support network, the assessor and service providers.

NSW Health is in a unique position to maximise use of wellness and reablement programs in and across the aged services it delivers. NSW Health embraces the wellness and reablement approach and ensures that assessments by Regional Assessment Services (RAS) and Aged Care Assessment Services (ACAT) and service provision from the Transitional Aged Care Program (TACP) and the Commonwealth Home Support Programme (CHSP) funded services are aligned.

Contracted Aged Care Services are provided throughout NSW Health (Local Health Districts and Specialty Health Networks). ACAT and RAS assess eligibility for aged care services, while the Transitional Aged Care Program and Commonwealth Home Support Programme provide care and support in the community. All aged care services provided by NSW Health are required to ensure wellness and reablement practices are implemented as a core part of the aged care services we deliver.

To view guideline GL2021_002 Wellness and Reablement in Aged Care go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_002

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters

CHAPTER 17 - OBSTETRICS

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PUBLIC HOMEBIRTH SERVICES IN NSW (GL2020_022)

GL2020_022 rescinds PD2006_045.

PURPOSE

This document guides NSW maternity services seeking to establish or sustain a public homebirth service (homebirth services).

KEY PRINCIPLES

NSW Health recognises that the place of birth is a decision for women, their partners and their families, and that some women may choose to birth at home with the care of professionals.

Homebirth services align with NSW Health's commitment to the provision of safe, sustainable, high quality, woman-centred maternity care.

Homebirth services should utilise consultation, escalation, referral and transfer processes in line with local guidelines and referral pathways developed in line with NSW Health Policy Directives/ Guidelines and all relevant legislative requirements.

Women should be advised of the health risks and health benefits of all aspects of maternity care, including those associated with their planned place of birth.

Clinical outcomes in all models of care including the homebirth service should be routinely reviewed to identify quality improvement opportunities irrespective of place of birth.

LOCAL HEALTH DISTRICT RESPONSIBILITIES

Local health districts (districts) should consider the needs of their communities when developing models of care. Those districts seeking to establish and or sustain a homebirth service should ensure the following.

- Consumer and other relevant stakeholder participation and involvement at all stages of implementation and ongoing evaluation of a homebirth service.
- Local guidelines for the provision of a homebirth service follow a robust and comprehensive risk assessment process.
- Strong clinical obstetric and midwifery leadership and commitment to establish, support, and maintain a well-functioning and sustainable homebirth service (see Section 2).
- An appropriately skilled and qualified workforce to provide care across the continuum of pregnancy, birth and postpartum care.
- Systems and processes are established to monitor and evaluate the service including workforce management and clinical service provision.

The Public Homebirth Services in NSW gudieline can be downlownded from
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_022

MANAGEMENT OF THREATENED PRETERM LABOUR (GL2022_006)

GL2022_006 rescinds GL2020_009

GUIDELINE SUMMARY

This Guideline applies to all NSW Health Organisations and/or maternity services where women may present with signs and/or symptoms of threatened preterm labour.

The screening for risk factors associated with prevention and the management of preterm birth are outside the scope of this document.

KEY PRINCIPLES

NSW Health organisations are responsible for the implementation of this Guideline within their services / facilities to ensure local protocols or operating procedures are in place and aligned and consistent with this Guideline.

A comprehensive clinical assessment must be reviewed by the most senior obstetric clinician available and is essential to differentiate threatened preterm labour from preterm labour. The clinician must assess maternal and fetal wellbeing and to develop a comprehensive management plan.

Interventions for threatened preterm labour may include the use of corticosteroids, tocolytics, magnesium sulphate and antibiotics.

The use of tocolytic agents is restricted to when there is benefit from delaying preterm birth. There is greater benefit in delaying birth under **34 weeks' gestation**.

Care at 23-25+6 weeks should be individualised and will depend on the risk to the woman from continuing the pregnancy and the management approach to care of the fetus after birth.

Women and their families must be provided with information and resources to guide shared decision making.

The Maternal Transfer Decision Making Tool is to be used to determine when an in-utero transfer is required and the subsequent process for effective transfer.

The Management of Threatened Preterm Labour: Guideline can be download from:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_006

REPORTING OF MATERNAL DEATHS TO THE CLINICAL EXCELLENCE COMMISSION (PD2021_006)

PD2021_006 rescinds PD2020_043

POLICY STATEMENT

All NSW Health services must report all maternal deaths to the Clinical Excellence Commission (CEC) in addition to other existing reporting obligations.

SUMMARY OF POLICY REQUIREMENTS

For all maternal deaths, the Maternity Unit Manager, Nurse Unit Manager, or Patient Safety Manager is to email CEC-PatientSafety@health.nsw.gov.au, with relevant information.

The death is also to be reported by completing the Admitted Patient Death Screening Tool in the CEC Death Review Reporting System.

Unexpected deaths of women who are either pregnant (any stage) or up to 42 days (6 weeks) postpartum are a reportable incident and must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047).

Hospitals must also have effective systems and procedures in place to report deaths to the Coroner in accordance with the Coroners Act 2009; a Reportable death is defined in NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054) .

The health facility will be asked to supply the CEC with the following information via a secure file sharing system:

- a copy of the relevant medical records, including medical certificate of cause of death (if applicable)
- post-mortem report (if applicable)
- any other relevant material requested by the Maternal and Perinatal Mortality Review Committee.

The Reporting of Maternal Deaths to the Clinical Excellence Commission Procedures can be download from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2021_006

THE MANAGEMENT AND INVESTIGATION OF A STILLBIRTH (PD2007_025)

PD2007_025 rescinds GL2005_013.

This Policy Directive should be read in conjunction with:

- PD2005_341 - Human Tissue - Use/Retention Including Organ Donation, Post-Mortem Examination and Coronial Matters
- PD2005_406 - Consent to Medical Treatment – Patient Information
- PD2007_094 - Client Registration Policy
- The Australian Health Ministers Advisory Council The National Code of Ethical Autopsy Practice 2002.
- PD2011_076 - Deaths - Review and Reporting of Perinatal Deaths

This Policy Directive is based on the *Clinical Practice Guideline for Perinatal Mortality Audit* produced by the Perinatal Society of Australia and New Zealand. The complete guideline can be found at http://www.stillbirthalliance.org.au/doc/Section_1_Version_2.2_April_2009.pdf

A stillbirth[1] is the complete expulsion or extraction from the mother of a product of conception of at least 20 weeks gestation or 400grams birth weight that did not, at any time after delivery, breathe or show any evidence of life such as a heartbeat (see Glossary Appendix 1).

In the case of a stillbirth where it is unclear whether the gestational age is less than 20 weeks at the time of delivery the fetus is to be weighed. If the weight is 400 grams or greater the fetus must be registered as a stillbirth.

1. General considerations

1.1 Every hospital must have a local policy for the management of the family, care of the stillborn baby and the investigation of the stillbirth.

[1] NSW Health NSW Mothers and Babies 2005 NSW Public Health Bulletin Volume 18 Number S-1 2007

1.2 The local policy must clearly articulate the processes for the distinct identification of the body of the stillborn baby and comply with PD2007_094 Client Registration Policy.

1.3 The local policy must include procedures for the transfer of the stillborn baby between and within maternity services and the mortuary. This must be documented in the baby's medical record.

2. Documentation

1.1 There must be full documentation of the clinical circumstances of the stillbirth.

1.2 Clinicians must undertake and document a comprehensive maternal and family history.

1.3 All clinical examinations of the mother, baby, placenta, membranes and cord must be documented.

2. Consent

2.1 Clinicians must comply with PD2005_406 Consent to Medical Treatment - Patient Information.

2.2 Consent for all investigations must be documented in the maternal record. This includes the histological examination of the placenta and membranes.

2.3 Consent for the post-mortem examination, which clearly outlines the extent of the investigation, must be recorded on an approved consent form.

2.4 Clinicians are also required to ascertain that the other parent has no objections and this must be documented in the maternal record.

3. Respect

3.1 The deceased baby must be treated with the same respect as a live baby.

3.2 The different cultural and religious practices and rituals associated with death must be respected.

3.3 Parents must be given time to make decisions and be informed about how much time can be spent with the baby in keeping with hospital policies and procedures.

4. Information

4.1 Parents must be given:

4.1.1 Written information using parent friendly language (for example to not use terms such as fetus).

4.1.2 Verbal and written information about birth registration.

4.1.3 The leaflet *Information for Parents about the Post-mortem Examination of a Stillborn Baby*. (Appendix 2). This leaflet is available in print and can be downloaded from the Department of Health website in English and several other languages.

5.1.4 Written information regarding available support services.

- Up-to-date information on genetic counseling services availability, locations, access and educational resources is available from:
  NSW Genetics Education Program
  PO Box 317
  St Leonards NSW 2065
  Ph (02) 9926 7324
  (02) 9906 7529
- Information and support is available from SIDS& Kids NSW
  Phone (02) 9818 8400
- 24 hour bereavement line 1800 651 186 or
  http://www.sidsandkids.org/bereavement-support/

5.1.5 Information about expectations for their grief. Mothers with mental illness or risk factors for psychological disturbance must have an appropriate mental health referral.

5.1.6 Expectations for a 6 week check up and that there may be other babies present.

6 Birth options

6.1 Caesarean section must only be considered in the presence of compelling maternal risk factors.

7 Creating memories

7.1 Parents must be informed that:

7.1.5 They can hold, undress and bath their baby.

7.1.6 Mementos are helpful for long-term grief outcome.

7.1.7 Baptism or blessing can be arranged through the hospital.

8 Investigation of stillbirths

8.1 The following Investigations must be undertaken where parental consent has been granted, for all stillbirths where there is no obvious cause. Consideration should be given to omitting screening tests when the cause of death is absolutely clear.

8.1.1 At diagnosis of a fetal death:

- Ultrasound scan to detect possible fetal abnormalities and to assess amniotic fluid volume.
- Amniocentesis (where available and warranted) for cytogenetic and infection investigations .
- A low vaginal and peri-anal swab, to culture for anaerobic and aerobic organisms.
- Maternal blood must be collected for:
  - Full blood examination
  - Serology for cytomegalovirus, toxoplasmosis parvovirus B19
  - Rubella and syphilis if not already undertaken in the pregnancy
  - Blood group determination and antibody screen if not already undertaken in this pregnancy

- Kleihauer - Betke test
- Renal function tests including uric acid
- Liver function tests
- Bile acids
- HbA_{1c}
- Anticardiolipin antibodies
- Lupus Anticoagulant; and
- Activated protein C (APC) resistance

8.1.2 Following birth

- External examination of the baby (by a Perinatal pathologist, neonatologist or a paediatrician where possible).
- Clinical photographs.
- Surface swabs (ear and throat) for microbiological cultures.
- Babygram or ultrasound (where an post-mortem is refused).
- Post-mortem examination.
- Blood samples from the cord or cardiac puncture for investigations of infection.
- Blood samples for chromosomal analysis.
- Detailed macroscopic examination of the placenta and cord.
- Placental microbiological cultures.
- Placental and amnion biopsy for chromosomal analysis.
- Placental histopathology.

8.2 Further investigation for thrombophilia must be undertaken 8-12 weeks after the birth where:

8.2.1 fetal death is associated with:

- fetal growth restriction;
- preeclampsia;
- maternal thrombosis and/or there is maternal family history of thrombosis.

8.2.2 the stillbirth remains unexplained following the standard investigations; or

8.2.3 tests for thrombophilia were positive at the time of the intrauterine fetal death (IUFD) as follows:

- Anticardiolipin antibodies; and Lupus anticoagulant repeated if positive at the time of the intrauterine fetal death or initial testing if not previously undertaken;
- APC resistance if it was not undertaken at birth;
- Factor V Leiden mutation if APC resistance was positive at birth;
- Fasting Homocysteine and if there is a positive test for MTHFR gene mutation;
- Protein C and S deficiency;
- Prothrombin gene mutation 20210A.

9 Post-mortem

9.1 Clinicians must discuss the value of a post-mortem examination with the parents in all cases of a perinatal death and seek consent for the procedure. Where possible, this must be a senior clinician who has established a rapport and understanding with the parents.

9.2 The clinician approaching for post-mortem consent must discuss:

9.2.1 the value of the post-mortem examination;
9.2.2 options for a full, limited or stepwise post-mortem examination;
9.2.3 the issue of retained tissues;
9.2.4 the possibility that the information gained may not benefit them but may be of benefit to others.

9.3 When consent has been obtained for specific organ/s to be retained for further examination, the parents must be offered the choice between delaying the funeral until the organs can be returned to the body or specifying their preferred method of organ disposal.

9.4 There must be no charge to a parent where the hospital requests the post-mortem.

9.5 The Guidelines on Autopsy Practice produced by the Royal College of Pathologists[2] should be used for guidance on minimum standards until guidelines for Australia and New Zealand are developed.

9.6 Guidelines for post-mortem reports produced by the Royal College of Pathologists must be used as a guide for reporting of perinatal post-mortem examinations.

9.7 A request for the General Practitioner to receive a copy of the report (including the PLR if available) must be explicit on the request form, as they are the main care provider on discharge.

9.8 The parents are not to be unduly rushed into making a decision for post-mortem, but should be advised that ideally a post-mortem should take place within 48 hours of birth.

10 Placenta, membrane and umbilical cord

10.1 The placenta, membranes and cord must be examined thoroughly following the birth and findings documented in the mother's notes.

10.2 Clinicians must discuss the value of pathological examination of the placenta, membranes and cord.

10.3 Where parental consent has been granted, the placenta, membrane and cord must be sent as soon as possible, fresh and unfixed, for pathological examination by the perinatal/paediatric pathologist, once samples have been taken for cytogenetics and microbiology.

10.4 Where parents are ambivalent about pathological examination, the placenta, membrane and cord should not be disposed of immediately in anticipation that they may change their minds.

11 Funeral arrangements

11.1 Parents must be advised that there is no urgency to organise a funeral and that they have continued access to baby prior to the funeral, depending on requested investigations such as post mortem.

[2] The Royal College of Pathologists. Guidelines on Autopsy Practice: report of a working group of the Royal College of Pathologists. In. London: Royal College of Pathologists; 2002

12 Health professionals

11.2 Clinical leaders must promote formal and informal educational opportunities for clinicians on: post-mortem examination procedures; the potential benefits of an post-mortem examination; compassionate counseling and obtaining parental consent; and address specific local barriers to the conduct of perinatal post-mortem examination.

11.3 Area Health Services should provide all clinicians with specific training in bereavement counselling.

11.4 Area Health Services should make debriefing/support services available to staff working with perinatal death.

Appendix 1

Glossary of Terms

AMNION
A thin but tough extraembryonic membrane of reptiles, birds and mammals that lines the chorion and contains the fetus and the amniotic fluid around it, in mammals it is derived from trophoblast by folding or splitting.

AMNIOTIC FLUID
The fluid that surrounds the developing fetus within the amniotic sac. This environment cushions the baby from injury and plays an important role in fetal development.

APC RESISTANCE
Activated protein C resistance.

AUTOPSY
A surgical procedure post-mortem, which involves the examination of body tissues (including internal organs), often to determine cause of death.

CHORION
Extraembryonic membrane surrounding the embryo of amniote vertebrates. The outer epithelial layer of the chorion is derived from the trophoblast.

CHROMOSOME ANALYSIS (KARYOTYPE)
A picture of the chromosomes of an individual arranged in a standard manner so that abnormalities of chromosome number or form can be identified.
Perinatal Society of Australia and New Zealand Perinatal Mortality Audi Guideline Section 1: Overview and summary of recommendations; Appendix 2.

CONFIDENTIAL ENQUIRY
Enquiry by peer groups, including experts in the field, into the cause of, and the factors surrounding, a death, where strict confidentiality is observed at all stages of the process. It is a form of clinical audit, with the important difference that the feedback or 'closing of the audit loop' is via reports on the general findings, and not direct feedback to those involved with the individual cases subjected to enquiry.

CESDI
Confidential Enquiry into Stillbirths and Deaths in Infancy.

CMV
Cytomegalovirus.

CONGENITAL ANOMALY
A physical malformation, chromosomal disorder or metabolic abnormality which is present at birth.

CYTOGENETICS
The study of the structure of chromosomes; cytogenetic tests are carried out to detect any chromosomal abnormalities associated with a disease; these help in the diagnosis and selection of optimal treatment.

DIC
Disseminated intravascular coagulation is an acquired disorder of clotting characterised by intravascular fibrin formation which occurs in the course of a variety of conditions including sepsis and pre-eclampsia.

DCT
Direct Coombs Test.

FETAL DEATH
See Stillbirth.

HAEMOGLOBIN A1C
The substance of red blood cells that carries oxygen to the cells and sometimes joins with glucose. Because the glucose stays attached for the life of the cell (about 4 months), a test to measure haemoglobin A1C shows what the person's average blood glucose level was for that period of time.

HISTOLOGY
The study of cells and tissue on the microscopic level.

HISTOPATHOLOGY
This is the science concerned with the study of microscopic changes in diseased tissues.

INTRAUTERINE FETAL DEATH (IUFD)
Death of a fetus in utero after 20 weeks gestation or at birth weighing at least 400gms. See STILLBIRTH.

IUFD
See INTRAUTERINE FETAL DEATH.

KARYOTYPE
The complete set of chromosomes of a cell or organism; used especially for the display prepared from photographs of mitotic chromosomes arranged in homologous pairs.

KLEIHAUER-BETKE
A blood test performed on the mother's blood to identify whether substantial bleeding has occurred from the fetus into the mother's circulation.

METHYLENETETRAHYDROFOLATE REDUCTASE (MTHFR) GENE
The MTHFR gene provides instructions for making an enzyme called methylenetetrahydrofolate reductase. This enzyme plays a role in processing amino acids (the building blocks of proteins).

MTHFR
Methylenetetrahydrofolate reductase.

PATHOLOGY
The branch of medicine concerned with disease, especially its structure and its functional effects on the body.

PCR
Polymerase Chain Reaction.

POST-MORTEM
After death. Hence a post-mortem examination may not include an autopsy.

PSANZ
Perinatal Society of Australia and New Zealand.

PSANZ-PDC
Perinatal Society of Australia and New Zealand - Perinatal Death Classification.

PSANZ-NDC
Perinatal Society of Australia and New Zealand - Neonatal Death Classification.

RANZCOG
Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

RCP
Royal College of Pathologists.

RCPA
Royal College of Pathologists of Australasia.

SADFA
Support After Fetal Diagnosis of Abnormality.

SANDS
Stillbirth And Neonatal Death Support Group.

SLE
Systemic lupus erythematosus.

STILLBIRTH (Fetal Death)
Death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight. The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Appendix 2

INFORMATION FOR PARENTS ABOUT THE POST-MORTEM EXAMINATION OF A STILLBORN BABY

When your baby is stillborn, expectations, hopes and dreams are shattered and lives are changed. Any parents have initial feelings of shock and confusion when told that their baby has died. Babies are not supposed to die. When they do, it can be devastating, overwhelming, and painful. It is a great sadness that your baby has died.

You may have a lot of questions and there will be decisions to make over the coming days and weeks. Help is available to you; your caregiver(s) will be able to advise you.

This leaflet has been prepared to help you make a decision about a post-mortem examination.

Deciding about a post-mortem can be very difficult. It is important that you make the decision that is right for you and your family. Consider how you and your family will feel in the future. In particular, think about whether a post-mortem would help you and your family to understand why your baby died. Hospital staff will respect and support whatever decision you make about a post-mortem examination.

A post mortem examination of a stillborn baby can only be undertaken with the parent/s consent.

After reading this information, you may find it helpful to discuss the examination with a doctor or midwife who has cared for you during your pregnancy or a counsellor or hospital social worker. You may also ask for more time to think about it and speak with your partner, family, friends or religious leaders.

What is a post-mortem?

The purpose of a post-mortem examination is to find any medical condition which may have contributed to or led to your baby's death.

A post-mortem, also known as an autopsy, is a medical examination of a body after death. A doctor undertakes the examination (usually a pathologist or a doctor undertaking specialised training in pathology, under the supervision of a pathologist). Pathologists are doctors who specialise in the study of disease. The post-mortem is carried out with utmost respect and care for the baby's body.

What information can a post-mortem provide?

A post-mortem examination can be a full or a limited post-mortem. These two options will be explained in further detail.

A full post-mortem may:

- Help you to find out more information about medical conditions that may have caused your baby's death.
- Provide information that may confirm or rule out a suspected or unsuspected medical condition. This may be important for you or other members of your family, particularly if the condition is likely to be inherited.

- Provide information to health professionals that may be important in the management of your future pregnancies.
- Indicate conditions that may affect other children within the family or future pregnancies.
- Contribute to the understanding of those who cared for you and provide knowledge that can be used to help other mothers and babies in the future.

A post-mortem examination does not always provide all the answers about a cause of death.

What is a limited post-mortem?

A limited post-mortem may involve either an external examination only; an external examination and some testing on small samples of tissue or blood; or an external examination with an internal examination limited to one particular area.

A limited post-mortem will not provide the same amount of information as a full post-mortem examination and there is always the possibility that something unexpected will be missed. However, a limited post-mortem can provide valuable information.

What happens to your baby at a post-mortem?

A doctor, who is usually a specialist pathologist, performs the post-mortem. The doctor will carefully review the medical record and then undertake a thorough examination of your baby. A full post-mortem examination includes a careful external examination, with measurements, as well as an examination of internal organs. X-rays and photographs may also be taken to further assist in making a diagnosis or to determine the cause/s of death.

A full post-mortem examination is undertaken as though the baby was having an operation. The Pathologist will usually make two openings, one across the back of the head, and another on the front of the body. This allows the pathologist to examine all the major organs and look for anything unusual or any clues to the cause of death. Small samples of tissues and fluids will usually be taken for microscopic examination and other tests, such as looking for an infection, or in special cases for genetic testing.

Sometimes it is necessary for the pathologist to retain an entire organ (usually the brain or heart) for further examination in order to test for signs of disease or injury that are not immediately apparent. The importance of retaining a particular organ may not be known until the post-mortem is under way. In some cases, a short delay in the funeral arrangements may be enough to have these organs returned to the body before it is released for burial or cremation. If this is not possible, you can decide whether you would like the baby's organs returned to you or a person nominated by you for separate burial or cremation or disposed of in a lawful manner by the public health organisation (usually by cremation). Your doctor will explain in further detail what these processes are.

What happens after the post-mortem?

Once the examination is complete, the baby is washed and the incisions are closed. In most cases, once the baby has been dressed, the effects of the post mortem are not very noticeable. Normally, after the post-mortem examination you and your family can usually see and hold your baby again. The appearance and colour of your baby's skin will change after death and the body will feel different to touch. These changes occur naturally after death and are not related to the post-mortem.

Will I have to pay for a post-mortem examination?

There are usually no costs associated with the post-mortem examination. However, it is important that you discuss any potential costs with your doctor or hospital representative before you give consent. If you and not the hospital request the post-mortem, these costs may be related to transport of your baby to a hospital that provides post-mortem examinations for babies. Financial assistance with the funeral costs associated with burial of your baby or of the retained organs may be available through the hospital or Area Health Service.

Why is consent needed for a post-mortem?

Written consent is required from you before a post-mortem of your stillborn baby is carried out. This is a legal requirement. You will be approached by a health professional and asked for your consent to the post-mortem examination. You are free to choose whether or not to give your consent for the post-mortem examination. Your consent must be given in writing.

Because a post-mortem examination may reveal potential genetic information relating to either biological parent, consent also includes a requirement to find out whether the other parent has no objections.

Alternatively, you may prefer someone else to make the decisions on your behalf, regarding consent for the post-mortem and for the use of tissue removed for the purposes of the post-mortem. There is a form you will be asked to complete if you wish to have someone else to make these decisions on your behalf. You must understand that in so doing you are allowing another person to make decisions about your baby in this regard.

What happens after consent is given for a post-mortem?

The post-mortem will be carried out as soon as possible after consent has been given. Occasionally, when certain conditions are suspected, samples need to be taken soon after death to enable the appropriate tests to be done. If this is the case your doctor will discuss this with you. If you wish to see your baby prior to the post-mortem, let your doctor or midwife know and arrangements will be made to delay the post-mortem. The post-mortem can be delayed for a short period, but it is recommended within 48 hours.

When will I know the results of the post-mortem?

A preliminary post-mortem report will be available within a few days of the examination but the results of some tests may not be available for twelve weeks, after which the final report will be prepared.

You should consider whether it is best for you to receive the post-mortem report directly from your primary carer, or to receive a copy through your family doctor, or another doctor who can discuss the report with you. It is suggested that you make a time with one of these doctors to discuss the report and any implications it may have for you or your family, as it may contain technical language.

Retaining and using organs and tissue for use for therapeutic, medical and scientific purposes

When your health professional approaches you to give consent for a post-mortem, you may also be asked to consider allowing the use of your baby's organs or tissue for other purposes (such as research, medical or therapeutic purposes) that are not part of the post-mortem examination.

If you consent for your baby's organs and/or tissue being retained for research, medical or therapeutic purposes, the organ or tissue will usually be retained for the period for which it is considered needed. The period of retention of retained organs or tissue for research may be outlined in the specific information on the research project or you can ask for more information.

You do not have to consent to the use of organs or tissue for therapeutic, medical or scientific purposes. A post-mortem can still be carried out, even if you do not consent to the use of tissue for these purposes. If you do give such consent, it applies only to the tissue that was removed for the purposes of the post-mortem examination. It does not mean that any extra organs or tissue will be removed.

Information and bereavement support

If you have any questions, your doctor, midwife, post-mortem coordinator or social worker will try to answer them for you. Health professionals can provide you with contact details of support groups to help you through this sad time.

SIDS and Kids NSW (incorporating SANDS) provide bereavement support services to families who have experienced the death of their baby, for support and information phone 02 9818 8400, toll free 1800 651 186 or information can be accessed via the website http://www.sidsandkids.org

Summary

- A post-mortem is an important medical examination to help find answers as to why your baby died and to exclude treatable or inherited conditions for future pregnancies.
- It may help to talk to your doctor, midwife, social worker or religious leader or other members of your family, if you have more questions about the post-mortem.
- If you do not want your baby to have a full post-mortem, talk to your doctor about other possible tests, which may give you more information about the cause of the death.
- A post-mortem cannot take place without your written consent.
- The hospital post-mortem will be carried out as soon as possible after consent. Usually this is within 48 hours after death.
- If you wish, you can see and hold your baby again after the post-mortem.
- Results of the post-mortem are usually sent to the doctor within 6-12 weeks

Contact numbers

Post-mortem Coordinator_____
Phone _____

Doctor _____
Phone _____

Social Worker _____
Phone _____

Chaplain_____
Phone _____

MATERNITY – MANAGEMENT OF PREGNANCY BEYOND 41 WEEKS GESTATION
(GL2014_015)

PURPOSE

The purpose of this document is to provide guidance for the clinical management and provision of evidence based information to women with low risk, singleton pregnancies that extend beyond 41^{+0} weeks gestation. It is important to assess each woman individually and base the management plan for pregnancy beyond 41^{+0} weeks on her specific circumstances and preferences.

KEY PRINCIPLES

Effective communication between health care professionals and women is essential. Information should be offered regarding the risks associated with prolonged pregnancies, and the options available. This will help women to make an informed choice, based on her individual preferences and circumstances for either a scheduled induction for a pregnancy beyond 41^{+0} weeks or expectant management.

Women should be informed that most women will go into labour spontaneously by 42^{+0} weeks gestation. The use of early gestational scans to calculate the estimated date of birth can lower the rate of pregnancy beyond 41^{+0} weeks in women. If pregnancy is prolonged, additional fetal surveillance and management plans should be discussed with the woman and clearly documented in the woman's antenatal record.

The information discussed should include:

- The risks and benefits of membrane sweeping during a vaginal examination, as described in Section 2.2.1 of this document.
- The risks and benefits of expectant management, as described in Section 3.1.1 of this document.
- The need for increased foetal surveillance from 41^{+0} weeks, as described in Section 3.2 of this document.
- The risks and benefits of induction of labour, as described in Section 3.3.1.

USE OF THE GUIDELINE

This guideline will describe clinical management of pregnancies beyond 41^{+0} weeks gestation for otherwise low risk women with singleton pregnancies. The terms postdates, post term and overdue will not be used in this document as these terms are often used interchangeably and can be misleading.

To download the Guideline go to http://www.health.nsw.gov.au/policies/gl/2014/GL2014_015.html

ASSISTED REPRODUCTIVE TECHNOLOGY - ETHICAL GUIDELINES (GL2006_011)

GL2006_011 rescinds GL2005_041.

NSW Health endorses the NHMRC Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2004). These guidelines cover activities associated with assisted reproductive technology in clinical practice and research, and were developed through extensive public, community and professional stakeholder consultation. They are primarily intended for assisted reproduction practitioners, researchers, infertility clinic administrators, HRECs, and state and national government officials. They replace the 1996 NHMRC Ethical guidelines on assisted reproductive technology.

Copies can be obtained through National Mailing and Marketing (02) 6269 1000 or http://www.nhmrc.gov.au/guidelines/publications/e78 . ISBN Print: 1864962712

GENETIC TESTING INCLUDING DNA DIAGNOSTIC TESTING, DNA TESTING FOR MUTATION CARRIERS AND DNA PREDICTIVE AND PRESYMPTOMATIC TESTING (PD2007_066)

Guidelines for Testing for Genetic Disorders (GL2005_012) has been replaced by two policy directives:

1. **Genetic Testing – including DNA Diagnostic Testing, DNA Testing for mutation carriers and DNA Predictive and Presymptomatic Testing (PD2007_066)**
2. **Prenatal Testing - including prenatal screening for Down syndrome and other chromosomal abnormalities (PD2007_067)**

GENETIC TESTING including DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing

This policy sets out NSW Department of Health requirements for testing for genetic disorders and particularly addresses counselling issues and laboratory requirements associated with genetic testing.

Genetic tests and procedures are available for individuals at high risk for certain genetic disorders and birth defects. Testing may benefit individuals and families in a number of ways but it may also create dilemmas which need sensitive management. Counselling is an essential element of genetic testing. Each test has distinct advantages, disadvantages and limitations and should only be used after the individual being tested has given full consideration to these issues. All testing should be carried out with the informed consent of the person being tested. Health professionals and potential test users need to become familiar with the context in which the tests are used.

See also:

- Prenatal testing - including prenatal screening for Down syndrome and other chromosomal abnormalities - PD2007_067

- Guidelines for predictive and diagnostic DNA testing for serious adult onset neurogenetic disorders with predictive implications for other family members and which are likely to reduce normal life expectancy - (PD2005_303) http://www.health.nsw.gov.au/policies/PD/2005/PD2005_303.html

1. General Information for testing for all genetic disorders

1.1 Professional experience

It is important that health professionals involved with the use of genetic tests and procedures have adequate knowledge and experience to achieve a high standard of service. Health professionals need to be aware of their own professional limitations and of the availability of others with specific expertise. It will sometimes be necessary to transfer responsibility to, or consult with clinical geneticists, cancer geneticists, fetal medicine specialists, obstetricians trained in prenatal diagnosis procedures, genetic counsellors or other appropriate specialists. (See Appendix 1 for Genetics Services contact details.)

1.2 Duty to inform

The outcome of genetic testing can have a significant impact not only on the individual being tested but also on other members of their families. Testing must only be undertaken when the individual has been fully informed about the purpose of the test or the procedure and the possible implications of the results.

1.3 Consent

The person being tested must be legally competent to give consent; must consent freely without coercion by professional staff, family members, employers, insurers or others; and must be adequately informed about all relevant issues including available future options. The person may withdraw consent at any time. (See 2.2 and Appendix 3 for template consent forms.)

1.4 Educational resources

A variety of resources is available to assist with patient education. (See Appendix 2 for details.)

1.5 Pre-test counselling

Testing should be accompanied by pre and post test counselling carried out by a health professional, knowledgeable about:

- the genetic disorder being tested;
- genetic risk assessment and pre-test counselling;
- the features or limitations of the laboratory test;
- interpretation of results and post-test counselling;
- implications of positive and negative results; and
- options available on the outcome of testing.

The way the health professional gives information should help a patient understand the testing process and purpose. The health professional should:

- communicate information and opinions in a form that the patient can understand;
- counsel without coercion; the patient is free to accept or reject the advice or the test;
- allow the patient sufficient time to make a decision, reflect on opinions, ask more questions and consult with the family, within the time constraints of the test;
- encourage the patients to make their own decisions.

1.6 Post-test counselling

Careful consideration should be given to the way results are conveyed. The health professional should take this opportunity to explain again the implications of the result. (See also Section 2.1.)

1.6.1 Normal result:

Where the sensitivity of a test is less than 100%, a low risk result will not indicate the absence of a genetic disorder. It is therefore important that health professionals ensure that people are fully informed about their residual risk.

1.6.2 Abnormal result:

Notification of an abnormal result may precipitate a crisis and the person may for some time be unable to absorb any information. Appropriate pre-test counselling will help to reduce post-test anxiety. Post-test counselling must be offered and follow up support may require several consultations. Counselling should be sensitive to the nature of decisions to be taken, should respect individual decisions and allow time to reach decisions. Appropriate follow-up when an abnormality is detected may require referral to genetic counselling services, other professional services or support networks.

When an abnormality is detected women should be offered appropriate follow-up, eg. referral to genetic counselling, family doctor and support networks such as the Association of Genetic Support of Australasia (AGSA).

1.7 Individuals and families from culturally and linguistically diverse backgrounds

Professional interpreter services should be used. The interpreter should not be a member of the family.

1.8 NSW Birth Defects Register

All abnormal results identified by prenatal testing and postnatal testing in the first year of life should be notified to the NSW Birth Defects Register of the NSW Health Department. For further information see http://www.health.nsw.gov.au/policies/pd/2012/PD2012_055.html

1.9 Quality assurance

Quality assurance should be undertaken to achieve optimum results and quality care. (See Section 2.3 and 2.4 for further details.)

1.10 Exception to pre-test counselling requirements

Pre-test counselling requirements are not usually applicable to certain routine haematology, biochemistry, biochemical genetic tests, although testing may lead to diagnosis of a genetic condition. Information should be made available prior to newborn screening and other population screening tests. Counselling should be offered if a result is abnormal.

2. Additional information for DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing

2.1 Clinical and counselling issues in DNA predictive testing

In addition to the general information for testing for all genetic disorders outlined in section 1, the following apply specifically to counselling about DNA predictive testing:

- An abnormal result will indicate the presence of a particular mutation, but the presence of a mutation may not necessarily define the presence or severity of disease;
- Implications for other members of the family including information which changes the risk of other family members who have not requested testing;
- Implications for future reproductive options;
- Availability of treatment;
- Clinical examination by an experienced specialist prior to a test result is encouraged, as knowledge of a normal recent examination in the event of an abnormal DNA test result will be reassuring. If signs of the disorder are present, appropriate further assistance can be obtained.

See also:
Guidelines for predictive and diagnostic DNA testing for serious adult onset neurogenetic disorders with predictive implications for other family members and which are likely to reduce normal life expectancy - (PD2005_303)
http://www.health.nsw.gov.au/policies/PD/2005/PD2005_303.html

2.2 Consent

Different types of genetic testing raise specific issues that need to be discussed as part of the consent process. Template consent forms (Appendix 3) provide direction on particular considerations to be addressed.

- Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Conditions.
- Consent Form for Specialised/DNA Diagnostic Testing/Storage.
- Consent Form for Collection, Testing and Storage of Human Tissue for Research.
- Consent Form for Analysis of Genes Associated with Cancer.
- Consent Form for Pre-symptomatic, Predictive and Diagnostic DNA Testing for Serious Adult Onset Neurogenetic Disorders with Predictive Implications for other Family Members.

2.3 Collection and transport of specimens

- Specimens should be collected under optimum conditions including type of specimen tube, conditions for sample storage during transport, etc.
- DNA predictive testing optimally requires 2 samples from separate blood draws at separate times, with each time recorded on the tube.
- Specimen tubes are to be labelled with the full name and date of birth of the person being tested. The person being tested should sign the specimen tube at the time of collection.
- A copy of the consent form should be forwarded to the testing laboratory with the specimen.
- Patient's suburb and postcode should be included on the test request form.
- The specimen must be accompanied by a signed referral form that specifies the test(s) to be performed.
- The transport of specimens is to occur at times agreed to by the testing laboratory.
- The time frame for receiving results should be estimated with advice from the testing laboratory.

2.4 Quality assurance

All laboratories providing human diagnostic test results (including both diagnostic and research laboratories) must comply with relevant requirements including:

- *Therapeutic Goods Act of 1989*, its regulations and subsequent amendments, particularly with regard to IVDs
- NATA/RCPA

All laboratories should participate in an appropriate quality assurance program (where available) and perform sufficient numbers of tests relevant to the area of investigation in order to maintain reliability and expertise.

Effective communication between the clinician and the testing laboratory regarding requirements is essential to achieving optimum specimen quality.

Appendix 1

General Clinical Genetics and Genetic Counselling Services

Metropolitan Centres

Camperdown	Royal Prince Alfred Hospital, Department of Molecular and Clinical Genetics, Missenden Road, Camperdown NSW 2050 Ph: (02) 9515 5080 Fax: (02) 9550 5389
Kogarah	St George Hospital, Kogarah NSW 2217 Ph: (02) 9113 3635 Fax: (02) 9113 3694
Liverpool	Liverpool Health Services, Clinical Genetics Department, Locked Bag 7103, Liverpool BC 1871 Ph: (02) 9828 4665 Fax: (02) 9828 4650
Newcastle	Newcastle Western Suburbs Hospital, Hunter Genetics, PO Box 84, Waratah NSW 2298 Ph: (02) 4985 3100 Fax: (02) 4985 3105
Penrith	Nepean Hospital Clinical Genetics Department, Penrith NSW 2750 Ph: (02) 4734 3362 Fax: (02) 4734 2561
Randwick	The Sydney Children's Hospital Department of Medical Genetics, High St, Randwick NSW 2031 Ph: (02) 9382 1704 Fax: (02) 9382 1711
St Leonards	Royal North Shore Hospital St Leonards NSW 2065 Ph: (02) 9926 6478 Fax: (02) 9926 7880
Westmead	The Children's Hospital Department of Clinical Genetics, Westmead NSW 2145 Ph: (02) 9845 3273 Fax: (02) 9845 3204

Regional Centres

Bathurst	Community Health Centre PO Box 1479 Bathurst NSW 2795 Ph: (02) 6339 5677 Fax: (02) 6339 5655
Broken Hill	Greater Western Area Health Service Community Health Centre, PO Box 457, Broken Hill NSW 2880 Ph: (02) 8080 1554 Fax: (02) 8080 1611
Coffs Harbour	Primary Health Service Coffs Harbour Health Campus Locked Mail Bag 812, Cnr High & Boambee Sts, Coffs Harbour NSW 2450 Ph: (02) 6656 7200 Fax: (02) 6656 7203
Forster	Forster Community Health Centre Breeze Parade, Forster NSW 2428 Ph: (02) 6555 6822 Fax: (02) 6554 8874
Gosford	Child And Family Health Gateway Centre, PO Box 361, Gosford NSW 2250 Ph: (02) 4328 7994 Fax: (02) 4328 7925
Goulburn	CIFTS, Locked Bag 15, Goulburn NSW 2580, Ph: (02) 4827 3950, Fax: (02) 4827 3958
Kempsey	C/- North Coast Area Health Service Community Health Centre, Morton Street, Port Macquarie NSW 2444 Ph: (02) 6588 2882 Fax: (02) 6588 2800
Mudgee	Macquarie Area Health Service PO Box 29, Mudgee NSW 2850 Ph: (02) 6378 6236 Fax: (02) 6372 7341
Muswellbrook	Community Health Centre Brentwood Street, Muswellbrook NSW 2333 Ph: (02) 6542 2050 Fax: (02) 6542 2005
North Coast	Lismore Base Hospital PO Box 419, Lismore NSW 2480 Ph: (02) 66250 111 Fax: (02) 66250 102
Port Macquarie	North Coast Area Health Service Community Health Centre, Morton Street, Port Macquarie NSW 2444 Ph: (02) 6588 2882 Fax: (02) 6588 2800
Tamworth	Community Health Centre 180 Peel Street, Tamworth NSW 2340 Ph: (02) 6767 8100 Fax: (02) 6766 3967
Taree	Community Health Centre 22 York Street, Taree, NSW 2430 Ph: (02) 6592 9703 Fax: (02) 6592 9607
Wagga Wagga	Wagga Wagga Base Hospital, Cnr Edward and Docker Sts, Wagga Wagga NSW 2650 Ph: (02) 6938 6666 Fax: (02) 6921 5632

Familial Cancer Services

Camperdown	Royal Prince Alfred Hospital, Department of Molecular and Clinical Genetics, Missenden Rd, Camperdown NSW 2050 Ph: (02) 9515 5080 Fax: (02) 9550 5389
Darlinghurst	St Vincent's Hospital, Family Cancer Clinic, Victoria Rd, Darlinghurst NSW 2011 Ph: (02) 8382 3395 Fax: (02) 8382 3386
Kogarah	St George Hospital, Hereditary Cancer Clinic, Cancer Care Centre, Gray St, Kogarah, NSW 2217 Ph: (02) 9350 3815 Fax: (02) 9350 3958
Westmead	Westmead Hospital, Familial Cancer Service, Department of Medicine, Westmead NSW 2145 Ph: (02) 9845 6947 Fax: (02) 9687 2331
Newcastle	Hunter Family Cancer Service, PO Box 84, Waratah NSW 2298 Ph: (02) 4985 3132 Fax: (02) 4985 3133
Penrith	Nepean Hospital, Clinical Genetics Department, Level 5 South Block, PO Box 63, Penrith NSW 2750 Tel: (02) 4734 3362 Fax: (02) 4734 2567
Randwick	Prince of Wales Hospital, Hereditary Cancer Clinic, High St, Randwick NSW 2031 Ph: (02) 9382 2551 Fax: (02) 9382 2588
St Leonards	Royal North Shore Hospital, Family Cancer Service, Level 2, Vindin House, St Leonards NSW 2065 Ph: (02) 9926 5665

Fetal Medicine Services in Public Hospitals Associated with Clinical Genetics Services

Camperdown	Royal Prince Alfred Hospital, Department of Molecular and Clinical Genetic, Building 65, Level 6 Missenden Road, Camperdown NSW 2050 Ph: (02) 9515 5080, Fax: (02) 9550 5389
Kogarah	St George Hospital, Women and Children's Health Gray Street, Kogarah NSW 2217 Ph: (02) 9350 3635,Fax: (02) 9350 3694
Liverpool	Liverpool Hospital, Fetal Medicine Unit, Locked Bag 7103 Liverpool BC NSW 1871 Ph: (02) 9828 5631, Fax: (02) 9828 5570
Newcastle	John Hunter Hospital, Maternal and Fetal Medicine, Locked Bag 1, Hunter Region Mail Centre Newcastle, NSW 2310 Ph: (02) 4921 4694, Fax: (02) 4921 3133
Penrith	Nepean Hospital, Perinatal Ultrasound, Level 3 South Block, Derby Street Penrith NSW 2751 Ph: (02) 4734 2578, Fax: (02) 4737 3206
Randwick	Royal Hospital for Women, Maternal/Fetal Medicine, Barker Street, Randwick, NSW 2031 Ph: (02) 9382 6098, Fax: (02) 9382 6706
St Leonards	Royal North Shore Hospital, Fetal Medicine Unit, Pacific Highway, St Leonards NSW 2065 Ph: (02) 9926 6478, Fax: (02) 9926 7880
Westmead	The Children's Hospital, Department of Clinical Genetics, Locked Bag 4001, Westmead NSW 2145 Ph: (02) 9845 3273, Fax: (02) 9845 3204

Genetics Education Services

Centre for Genetics Education	PO Box 317, St Leonards NSW 1590 Ph: (02) 9926 7324, Tax: (02) 9906 7529 Web: http://www.genetics.edu.au/

Association for Genetic Support of Australasia (AGSA)

AGSA	66 Albion Street, SURRY HILLS NSW 2010 Ph: (02) 9211 1462, Fax: (02) 9211 8077 Email: agsa@ozemail.com.au Web: http://www.agsa-geneticsupport.org.au

Medications in pregnancy and lactation service (NSW)

Mothersafe	Medications in Pregnancy and Lactation Service, Royal Hospital for Women High St, Randwick, NSW 2031 Ph: (02) 9382 6539 or 1800 647 848

Birth Defects Register (NSW)

NSW Birth Defects Register	Centre for Epidemiology and Research, NSW Health Department Locked Mail Bag 961, North Sydney NSW 2061 Ph: (02) 9424 5829 Fax: (02) 9391 9232

Genetics of Learning Disability Service (GOLD)

GOLD	Hunter Genetics, PO Box 84, WARATAH NSW 2298 Ph: (02) 4985 3131, Fax: (02) 4985 3133

Appendix 2

Resources

Centre for Genetics Education
PO Box 317
ST LEONARDS NSW 1590

Tel: 02 9926 7324
Fax: 02 9906 7529
http://www.genetics.edu.au/

AGSA
Association of Genetic Support of Australasia Inc.
66 Albion Street
SURRY HILLS NSW 2010

Tel: 02 9211 1462
Fax: 02 9211 8077
Email: agsa@ozemail.com.au
Web: http://www.agsa-geneticsupport.org.au

Appendix 3

Template consent forms

- Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Conditions
- Consent Form for Specialised/DNA Diagnostic Testing/Storage
- Consent Form for Collection, Testing and Storage of Human Tissue for Research
- Consent Form for analysis of Genes Associated with Cancer
- Consent Form for Pre-symptomatic, Predictive and Diagnostic DNA Testing for Serious Adult Onset Neurogenetic Disorders with Predictive Implications for other Family Members

Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Conditions

- Must be used for **non-Medical Benefits Schedule items**
- Before testing is commenced, the laboratory may require the following details (see ***Guidelines for Specialised DNA Testing for Genetic Disorders*** http://www.health.nsw.gov.au/health-public-affairs/publications/gentest/)

Send by courier/express post to:

Send samples at room temperature
Same day OR overnight

Patient ID MRN

Last name .....

First name .....

Address .....

..... Postcode .....

Date of birth ...../...../..... Sex M F
(dd/mm/yyyy)

Sample Date Drawn ...../...../.....
(dd/mm/yyyy)

Blood

☐ EDTA ..... mL (room temp)
☐ Lithium heparin..... mL (room temp)

Prenatal

☐ amniotic fluid ..... mL (room temp)
☐ cultured amniocytes xT25 Flask(s) (room temp)
☐ CVS sample ..... mg ☐ on ice
☐ cleaned
☐ uncleaned

Other

☐ DNA .....µg
Other, specify:

Test requested

PLEASE ATTACH FAMILY/PEDIGREE INFORMATION

Purpose of test
☐ Confirm clinical diagnosis
☐ Predictive/presymptomatic testing
☐ Carrier Status
☐ Prenatal Diagnosis - complete box below
☐ Determine feasibility of prenatal Dx
☐ Family study (no report for this individual)
☐ For research (no report for this individual)
☐ Bank DNA until further notice
☐ Other.....

Pregnancy Information (if applicable)

Is this individual or the partner of this individual currently pregnant

L.M.P. (dd/mm/yyyy) .....

Amnio (dd/mm/yyyy) .....

CVS (dd/mm/yyyy) .....

Family Information

Have samples from this family been sent to a DNA lab before? ☐ Yes ☐ No

If Yes, specify .....

Date of birth or age .....

Ethnic background .....

Genetic Counselling

Has the individual been offered counselling consistent with ***Specialised/DNA Testing for Genetic Disorders***? http://www.health.nsw.gov.au/health-public-affairs/publications/gentest/

☐ Yes ☐ No ☐ Refused

Consent to Testing

Has a ***Consent Form for Specialised/DNA Testing*** been completed?

☐ Yes ☐ No

Consent to payment

☐ **Public patient, or**
☐ **Privately referred non-inpatient**
Payment to be made by Area Health Service by arrangement

Authorised by.....

☐ **Private patient** - Payment to be made by patient

Consent to payment.....

Send Account to:

Name.....

Address.....

.....Postcode.....

Test requested by:

Name.....Initials.....

Address.....

..... Postcode.....

Telephone No.....

Signature.....Date.....

Specialty/Appointment.....

Copy of report to:

Name.....Initials.....

Address.....

.....Postcode.....

Telephone No.....

Consent Form for Specialised/DNA Diagnostic Testing/Storage

This form has been designed to ensure that your consent is on an informed basis. Please read and consider each section.

Genetic File No	MRN

Patient

Surname	Given Name(s)
Address	
	Postcode
Date of Birth	Telephone

Parent or Guardian
(Patient under age for or unable to consent)

Surname	Given Name(s)
Address	
	Postcode
Date of Birth	Telephone

PROVISION OF INFORMATION TO PATIENT — **To be completed by Health Professional**

I, _____ **have informed this patient/guardian as detailed**
Insert name of Health Professional and designation

below including the nature, likely results, and material risks of DNA diagnostic testing.

Interpreter present Yes/No

_____ _____ _____
Signature of Interpreter | Signature of Health Professional | Date

PATIENT CONSENT — **To be completed by Patient**

_____ **and I have discussed the consequences and procedures**
Insert name of Health Professional

involved in testing and storage of my tissue/blood/DNA. I have been told that:

- Testing may reveal non-paternity or non-maternity of a presumed natural parent
- Testing may not be informative for some families or family members
- Tissue/blood/DNA will be stored in good faith but may not remain in a suitable state for testing
- The collection of samples of blood/muscle/skin/_____from me/

_____
will be used for (tick where applicable):

- ☐ **direct testing**
- ☐ **testing in family studies** (indirect testing)
- ☐ storage of **cell lines** from the sample for _____ insert period of time
- ☐ **storage** of the tissue/blood/**DNA** for _____ insert period of time

Explanation of terms
1 direct testing: testing of the gene for the disorder to determine whether a mutation is present.
2 **indirect testing (family studies)**: the tracking through a family of a mutation in a gene using 'markers' to identify the mutation.
3 **cell lines**: cells from blood or other tissues kept alive in the laboratory.
4 **DNA (deoxyribonucleic acid)** The chemical compound which the genes are made of.

- The information gained from testing may be used to assist the health care of other family members Yes ☐ No ☐
  - ☐ other family members
  - ☐ only the following individual(s)
- I have been advised to inform other adult family members who may be at risk
- I request that the sample be stored and retested if testing is inconclusive and future testing may be more informative
- I understand the potential benefits and adverse consequences involved in testing and storage of this sample
- I have had the opportunity to ask questions and am satisfied with the explanation and the answers to my questions
- I understand that consent may be withdrawn

I request and consent to the above

_____ _____ _____
Signature of Patient/Guardian | Print name of Patient | Date

Consent Form for Collection, Testing and Storage of Human Tissue for Research

This form has been designed to ensure that your consent is on an informed basis. Please read and consider each section.

Genetic File No	MRN

Patient

Surname	Given Name(s)
Address	
	Postcode
Date of Birth	Telephone

Parent or Guardian
(Patient under age for or unable to consent)

Surname	Given Name(s)
Address	
	Postcode
Date of Birth	Telephone

PROVISION OF INFORMATION TO PATIENT — **To be completed by Health Professional**

I, _____ **have informed this patient as detailed below**
Insert name of Health Professional and designation

including the nature, likely results, and material risks of testing and storage of tissue/blood/DNA.

Interpreter present Yes/No

Signature of Interpreter _____ Signature of Health Professional _____ Date _____

PATIENT CONSENT — **To be completed by Patient**

_____ **and I have discussed the consequences and procedures**
Insert name of Health Professional

involved in testing and storage of my tissue/blood/DNA. I have been told that:

- ☐ The tissue/blood/DNA will be used in a research study entitled _____
- ☐ The study has been approved by the Institutional Ethics Committee of _____
- ☐ My tissue/blood/DNA (*cross out two)
  - ❖ will be destroyed at the completion of the project
  - ❖ will be stored for _____ years after completion of the project
  - ❖ may be stored indefinitely
- ☐ I will not necessarily receive a report on the outcome of the project
- ☐ I or my attending doctor will be advised if the project produces information which could be of value to me or my family
- ☐ Testing may reveal non-paternity or non-maternity of a presumed natural parent
- ☐ If tissue/blood/DNA is stored it may not remain in a suitable state for testing

DNA is an abbreviation for deoxyribonucleic acid, the name of the chemical compound of which genes and chromosomes are made

I have had the opportunity to ask questions and am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

After testing has been completed:

- ☐ **I consent to my de-identified DNA sample being used for future Institutional Ethics Committee approved research**

OR

- ☐ **My DNA sample may not be used for research without my written consent**

I request and consent to the above

Signature of Patient/Guardian _____ Print name of Patient _____ Date _____

(Name of Hospital)

Consent Form for analysis of Genes Associated with Cancer

This form has been designed to ensure that your consent is on an informed basis. Please read and consider each section.

Title	Family Names	MRN		
Given Name		VMO		
Address	Street	DOB	Sex	HIS
Suburb	Postcode	Admission Date		

PROVISION OF INFORMATION TO PATIENT **To be completed by Health Professional**

I, _____ have informed this patient
Insert name of Medical Practitioner/Health Professional and designation

as detailed below including the nature, likely results, and risks associated with gene testing.

_____ _____ _____
Signature of Medical Practitioner/Health Professional Signature of Interpreter (if present) Date

PATIENT CONSENT **To be completed by Patient/Guardian**

_____ **and I have discussed diagnostic testing for the**
Insert name of Health Professional

analysis of genes associated with cancer. He/she has told me that:

TESTING

- The collection of blood/..... will be used for testing of genes involved in:
  (tick the appropriate box)

☐ hereditary breast/ovarian cancer

☐ hereditary bowel cancer

☐ hereditary cancer predisposition (specify)

.....

- The sample will be stored by the laboratory according to regulations.
- The sample will not be used for any purpose other than that agreed upon in this consent.
- Testing is voluntary and it is possible to withdraw from the testing process at any stage.

RESULTS

A Mutation Screen-when a gene change <u>has not</u> been found in any other family member

- A **<u>positive</u>** test result means that I carry a gene change (mutation) that gives me an increased risk for cancer. Each of my children have a 50% chance of inheriting the same gene change.
- A **<u>negative</u>** result is uninformative. This may be because
  - We have not been able to find a gene change using current technology or
  - It is possible that changes in other genes may be responsible for the increased risk of cancer in the family.
  - A negative result **<u>does not</u>** exclude an inherited predisposition in the family.
- Results of **<u>unknown significance</u>** - Sometimes a gene change is found and we are not sure whether it has caused the increased risk of cancer in the family. This is because the exact effect of this change on the gene is, as yet unknown.
- Other relevant information:

.....

.....

Further testing may be performed in the future as our knowledge of cancer genetics improves.

B. Predictive Test-when a gene change has already been found in another family member

- A **positive** test result means that I carry the gene change that causes an increased risk of cancer in my family. Each of my children have a 50% chance of inheriting the same gene change.
- A **negative** result means that I have **not** inherited the gene change that has caused an increased risk of cancer in my family. As I do not carry this gene change, I cannot pass it on to my children.
- Other relevant information.....

.....

.....

The test result:

- cannot predict whether a cancer will occur.
- cannot predict the age of onset or type of cancer that may develop.
- of one individual can change the estimation of risk for other family members.
- may affect the ability to obtain some types of insurance.
- may reveal non-maternity or non-paternity of a presumed parent.

CONFIDENTIALITY

- The test result will be held by this centre and will be known by those involved in the testing process.
- My test result will be given to me first in person. Other arrangements please specify -

.....

.....

- In the event of my death, the test results may be made known to:

Name:.....Relationship.....Contact details.....

.....

Name:.....Relationship.....Contact details.....

.....

- The fact that I have had a genetic test will not be revealed to any other person or organisation without my written consent except in situations where disclosure is legally required.
- My test result may be revealed to my Doctor(s) Yes ☐ No ☐

specify .....

- The information gained from the testing may be used to assist the health care of other family members Yes ☐ No ☐
- Other relevant information

.....

AFTER TESTING IS COMPLETED:

☐ I consent to my de-identified DNA sample being used for future ethics approved research

☐ I do not consent to my DNA sample being used for research without my written consent

I request and consent to the test described above.

I understand the potential benefits, potential consequences and limitations involved in testing and the storage of this sample. I have had an opportunity to ask questions and I am satisfied with the explanations and answers to my questions. I understand that genetic counselling will be available for myself and my family.

Signature of person being tested	Print name of person being tested	Date
or		
Signature of guardian	Print name of guardian	Date
Signature of guardian	Print name of guardian	Date

Explanation of terms used in this consent form

- **Genes associated with cancer:** Specific genes in which changes (mutations) are associated with an increased risk of cancer.
- A **gene test** involves analysis of one or more of those genes to determine whether a mutation is present
- **Cancer predisposition gene mutation:** Changed DNA code which gives rise to an increased risk of certain cancers
- **DNA** (Deoxyribonucleic acid): The chemical compound of which the genes are made

Consent Form for Pre-symptomatic, Predictive and Diagnostic DNA Testing for Serious Adult Onset Neurogenetic Disorders with Predictive Implications for other Family Members

This form has been designed to ensure that your consent is on an informed basis. Please read and consider each section.

(Name of Hospital)

Title	Family Names	MRN		
Given Name		VMO		
Address	Street	DOB	Sex	HIS
Suburb	Postcode	Admission Date		

PROVISION OF INFORMATION TO PATIENT — **To be completed by Health Professional**

I, _____ have informed this patient as detailed below
Insert name of Health Professional and designation

the nature, likely results, and risks associated with gene testing for _____
name of disorder

Interpreter present Yes/No

_____ Signature of Interpreter

_____ Signature of Health Professional

_____ Date

PATIENT CONSENT — **To be completed by Patient/Guardian**

_____ **and I have discussed predictive testing**
Insert name of Health Professional

testing for the analysis of the gene fault (mutation) for _____
name of disorder

He/she has told me that:

- The collection of blood will be used to examine my DNA and tested for the gene involved in _____ name of disorder
- A **positive test result** indicates that I have inherited a faulty gene (mutation). This means that I am at high risk of developing/will develop _____ and my children and siblings have a _____ % chance
  name of disorder
  percentage
- A positive test result cannot accurately predict the age of onset of the disorder.
- A **negative test result** means that I have not inherited the faulty gene (mutation). I will not develop _____ and cannot pass the faulty gene involved on to my children
  name of disorder
- An intermediate result means that I may or may not develop _____
  name of disorder
- In some instances this may have implications for my siblings and children and their descendents

- Test results of one individual can change the estimation of risk for other family members and I have been advised to inform other adult family members who may be at risk.
- The test result may impact on obtaining some types of insurance or employment.
- Testing may reveal non-paternity or non-maternity of a presumed natural parent
- Genetic counselling will be available for myself and other family members during the testing process and after the test result has been given.

I have been told about storage of the test results and the DNA sample. I understand the following:

- The test result will be held by this centre and will only be known by those involved in the testing process.
- My own test result, the fact that I have had a test, and my DNA sample will not be revealed or made available to any other person or organisation outside of the testing process, except with my written consent (as detailed below), or in situations where disclosure is required by law.
- The test results will be given to me first.
- The DNA sample will remain the property of the laboratory. It will be stored in good faith, but its suitability for future use cannot be guaranteed. It will be disposed of at a time determined by standard laboratory practices or regulatory requirements.
- My identified DNA sample will not be used for any other purpose except in accordance with my written consent (as detailed below).

I request and consent to the test described above.

I understand the potential benefits of testing and storing this sample and I accept the risks involved. I have had the chance to ask questions and am satisfied with the explanations and the answers to my questions.

I understand that I may withdraw my consent for this test to be processed.

I consent to my test results being revealed at any time to the following people:

- ☐ Any family member
- ☐ Only to the following individuals (specify) _____
- ☐ My doctor(s) *(specify)* _____
- ☐ No other individual
- ☐ In the event of my death **test results** may be made known to: _____

After testing has been completed:

- ☐ **I consent to my de-identified DNA sample being used for future Institutional Ethics Committee approved research**

OR

- ☐ **My DNA sample may not be used for research without my written consent**

Signature of Patient/t/Guardian	Print name of Patient	Date

Explanation of terms used in this consent form

- A **gene test** involves analysis of one or more of those genes to determine whether a mutation is present
- **Mutation:** Change in the normal DNA code which may cause or increase risk for a condition
- **DNA** (Deoxyribonucleic acid): The chemical compound of which the genes are made

PRENATAL TESTING/SCREENING FOR DOWN SYNDROME & OTHER CHROMOSOMAL ABNORMALITIES (PD2007_067)

Guidelines for Testing for Genetic Disorders (GL2005_012) has been replaced by two policy directives:

1. **Prenatal Testing - including prenatal screening for Down syndrome and other chromosomal abnormalities (PD2007_067)**
2. **Genetic Testing - including DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing (PD2007_066)**

This policy directive addresses:

Prenatal screening tests - these tests may identify a baby as being at an increased risk of having a particular problem and include:

- First trimester screening for women presenting between 10 to 14 weeks of pregnancy using a combination of maternal age, ultrasound nuchal translucency measurement (NTS) and serum screening tests (free β-hCG and PAPP-A).
- Second trimester screening for women presenting between 15 to 18 weeks of pregnancy, using maternal age, maternal serum screening (free βhCG, AFP and unconjugated estriol).
- Ultrasound

Prenatal diagnostic tests - these tests may be used following an increased risk result on prenatal screening or independently:

- Ultrasound
- Chorionic villus sampling
- Amniocentesis
- Fetal blood sampling

This policy is directed to NSW Health clinical and care providers involved in prenatal care. It provides direction on access to and provision of prenatal screening and diagnostic tests so pregnant women are informed about screening options and are appropriately directed to services.

See also:

Genetic Testing - including DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing PD2007_066.

1. Introduction

In recent years, an increasing number of non-invasive biochemical screening tests and ultrasound techniques have been developed which can significantly increase the identification of pregnancies at risk for Down syndrome and other chromosomal abnormalities in women of all ages.

The use of prenatal screening tests has added to the complexity of prenatal care. These screening tests give a risk indication only and are not definitive tests. Use and interpretation are dependent on a number of factors including accurate gestational age, the stage of pregnancy, maternal age, and in the case of ultrasound, operator expertise. They are associated with varying levels of false positive and false negative results, depending on different combinations of tests offered. Women indicated to be at high risk on screening tests should be offered follow-up definitive testing by amniocentesis or chorionic villus sampling.

Each screening test has advantages, disadvantages and limitations. Offers of screening need to be accompanied by sufficient information and counselling, with professional interpreter services if necessary, to help women choose screening on an informed basis. This includes accurate information about the health and development issues for children with Down syndrome and the potential ramifications for women entering into the screening process.

NSW Health's policy of offering diagnostic testing by chorionic villus sampling and amniocentesis to women at increased risk for chromosome errors through family history or advanced maternal age (35 years and older at estimated date of confinement) remains unchanged (see Section 5).

2. Down syndrome and other chromosomal abnormalities

In NSW, the incidence of Down syndrome in pregnancy is approximately 2.5 per 1000. In 2004, the NSW Birth Defects Register[i] reported 98 births and 132 terminations of pregnancy for Down syndrome, ie a total of 230. The number of livebirths and stillbirths for all chromosomal abnormalities (including Down syndrome) in 2004 was 202 with 243 reported terminations, ie a total of 445.

The risk of having a baby with Down syndrome increases with advancing maternal age. Since 1990 confinements to women 35 years and over have risen from 10.4% to 20.7% in 2005, increasing the potential for more Down syndrome affected pregnancies in this age group.

Table 1 Risk by age of Down syndrome and other chromosomal abnormalities

maternal age at delivery	* **chance of having a live-born baby with Down syndrome**	** **chance of having a live-born baby with a chromosomal abnormality**
20-24 years	1 in 1411	1 in 506
25 years	1 in 1383	1 in 476
26 years	1 in 1187	1 in 476
27 years	1 in 1235	1 in 455
28 years	1 in 1147	1 in 435
29 years	1 in 1002	1 in 417
30 years	1 in 959	1 in 385
31 years	1 in 837	1 in 385
32 years	1 in 695	1 in 323
33 years	1 in 589	1 in 286
34 years	1 in 430	1 in 244
35 years	1 in 338	1 in 179
36 years	1 in 259	1 in 149
37 years	1 in 201	1 in 124
38 years	1 in 162	1 in 105
39 years	1 in 113	1 in 81
40 years	1 in 84	1 in 64
41 years	1 in 69	1 in 49
42 years	1 in 52	1 in 39
43 years	1 in 37	1 in 31
44 years	1 in 38	1 in 24
45 years	1 in 32	1 in 19

* Morris JK, Mutton DE, and Alberman E (2002). Revised estimates of the maternal age specific live birth prevalence of Down's syndrome. J Med Screen, 9, 2-6.

** Hook EB (1981) Rates of chromosomal abnormalities. Obs Gyn 58 282-285

Although the risk to an individual pregnancy increases with age, about half of the occurrences of Down syndrome and other chromosomal abnormalities are in babies of women under the age of 35 who comprise a much greater proportion (80%) of women giving birth.

Table 2 Chromosomal abnormalities among birth defect cases by maternal age, NSW 2002

Maternal age	No.	%
<25	32	7.4
25-29	42	9.7
30-34	79	18.2
35-39	87	20.0
40+	60	13.8
Not Stated	135	31.0
Total	435	100

Source: NSW Birth Defects Register, Centre for Epidemiology and Research, NSW Department of Health[1]
Note: Includes terminations of pregnancy, livebirths and stillbirths

3. Consent and provision of information on prenatal screening and testing

It is recognised that not all women will want to use prenatal screening or diagnostic tests.

Any test undertaken should be consented to on the basis of provision of full relevant information. It is important that women/couples considering prenatal screening or diagnostic testing make an informed choice appropriate to them and free from coercion. They should have access to written information on the tests, their implications and their risks (see resources listed in Appendix 2). The relative advantages, disadvantages and limitations of the available tests should be discussed with the woman or couple prior to testing as part of general counselling and support. Discussion should include:

- information on the conditions being screened for
- the timing of testing
- the importance of accurate gestation dates
- the risk to the woman of having an affected offspring
- test performance information based on the audit figures of the local providers of prenatal screening services
- that a screening test alone does not identify any birth defect but indicates a risk only
- interpretation of both **increased and low risk** screening results. Women must be informed about their residual risk.
- the impact of an **increased risk** result and the options available for definitive diagnosis, such as amniocentesis.
- the impact on a woman and her family of a false negative or false positive result
- the time frame for receiving results and making further decisions if necessary
- long term implications for the person and their family of having an affected baby and the health and development issues for children with the condition.

Women at increased risk should have access to consultation with an individual or centre able to provide both counselling and prenatal diagnosis procedures. (See Appendix 4 for contact details.) Full information about the risks of amniocentesis and chorionic villus sampling should be provided (See Section 5).

Appendix 1 provides general information for testing for all genetic disorders including:

- Professional experience
- Duty to inform
- Educational resources (listed in Appendix 2)
- Pre-test counselling
- Consent
- Individuals and families from culturally and linguistically diverse backgrounds
- Post-test counselling

4. Prenatal screening for Down syndrome and other chromosomal abnormalities

The following policy has been developed to inform health care providers about the tests available and their effectiveness, so that women can be helped to make informed decisions and be given appropriate care.

The policy is based on the data currently available on the performance of screening tests.[ii,iii,iv,v,vi] However, prenatal screening tests continue to evolve and providers need to ensure their information is up-to-date.

4.1 Women at increased risk

Women considered at increased risk for chromosome errors, ie those with an indicative previous history or who will be 35 years or older at estimated date of confinement; should be offered prenatal screening or diagnostic testing as an integral part of management. Offers of screening or testing should be accompanied by sufficient information and counselling to help women choose and consent to testing on an informed basis and to be aware of the potential ramifications of entering into the screening process (see Section 3).

First trimester screening tests for women presenting between 10 to 14 weeks of pregnancy:

- First trimester screening using combination of maternal age, ultrasound nuchal translucency measurement (NTS) and serum screening tests (free β-hCG and PAPP-A).
- A detection rate of up to 90% with up to 5% false positive results should be achieved.[vii]
- Women should be sure of their gestational age based on a known LMP and regular pre-conception menstrual cycle. In the event of any uncertainty about gestational age a pre-test ultrasound examination is optimal.
- Only accredited operators - Fetal Medicine Foundation (FMF) or Nuchal Translucency - Ultrasound, Education and Monitoring Project (NT-UEMP) should perform nuchal translucency (NT) screening (see Section 8).
- The first trimester combined screening risk provided to women is calculated automatically ‘at the gestation at screening’, not ‘at term’, since up to a third of pregnancies affected by Down syndrome spontaneously abort between 10-40 weeks gestation.

Second trimester screening tests for women presenting between 15 to 18 weeks of pregnancy:

- Second trimester triple screening using maternal age, maternal serum screening (free βhCG, AFP and unconjugated estriol).

- A detection rate of at least 60% with up to 5% false positive results should be achieved. About 40% of babies with Down syndrome will therefore be missed using this test.

Management of high-risk screening results

All women receiving a high-risk test result should be provided with adequate post-test counselling. The level of counselling support needed may vary with the type of result and the resources of the referring practitioner to deal with the issues surrounding an abnormal result. Abnormal screening test results should be dealt with as urgent clinical problems requiring early referral to an individual or centre able to provide both counselling and diagnostic procedures for prenatal diagnosis (see Appendix 3 for a list of services). Full information about the risks of amniocentesis and chorionic villus sampling should be provided (see Section 5). Referral to family doctor, the Association for Genetic Support of Australasia (AGSA) and support networks should be included.

Collection and transport of maternal serum specimens for 1st and 2nd trimester screening

A minimum of 3 mls of serum is required. The blood sample can be drawn at a collecting pathology service and sent immediately to the laboratory. It may be refrigerated for up to 24 hours or frozen if longer.

Laboratories offering maternal serum testing should provide request forms detailing the information that must be provided for accurate interpretation of the test result. This will include at least:

- Gestational age by dating scan.
- Patient's age - it is most important that this be clearly and correctly stated on the referral form.
- Patient's weight.
- Patient's height.
- Whether the patient is an insulin dependent diabetic.
- Previous history of Down syndrome and other chromosomal abnormalities.
- Patient's suburb and postcode.
- A signed referral form that specifies the test(s) to be performed.

4.2 Women not in the increased risk category (above)

Women not in the increased risk category, ie no previous history and under the age of 35 years at estimated date of confinement should be informed about screening tests and given appropriate risk information by their doctor or midwife (see Section 2, Table 1 - Risk by age of Down syndrome and other chromosomal abnormalities risks) and informed of the availability and potential cost of screening tests.

For further information contact:

Information on prenatal screening for all women is available from:
Centre for Genetics Education
PO Box 317
ST LEONARDS NSW 1590
Tel: 02 9926 7324
Fax: 02 9906 7529
Website: http://www.genetics.edu.au/

Prenatal Testing - Special tests for your baby during pregnancy
http://www.genetics.edu.au/Publications-and-Resources/PublicationsBrochuresandPamphlets/PrenatalTestingSpecialTestsforYourBabyDuringPregnancy.pdf

A note on second trimester ultrasound at 18 - 20 weeks gestation

For all women, ultrasound assessment of markers of chromosomal abnormality in the second trimester is not recommended as a primary screening test for Down syndrome (see section 7).

5. <u>Prenatal diagnosis</u> using amniocentesis, chorionic villus sampling and fetal blood sampling to determine the fetal karyotype.

These are invasive tests which pose a risk of miscarriage (of less than 1%) in addition to the "background risk" of miscarriage due to natural causes. It is important to discuss this. After the age of 35 the risk of Down syndrome rises rapidly so the risk of a Down syndrome affected pregnancy becomes greater than the risk of miscarriage associated with amniocentesis and chorionic villus sampling (CVS) procedures.

Prenatal diagnostic services should be made available to:

- Women of 35 years and over at date of confinement.
- Women who have a screening test for Down syndrome which suggests increased risk.
- Women who have had a child with a neural tube defect.
- Women determined to be at high risk for a neural tube defect in light of first or second trimester screening.
- Other women who have a high risk of a fetus with a genetic or chromosomal disorder which may be detectable by prenatal diagnosis.

Additional clinical and counselling issues

It is recommended that where practical patients are counselled face to face at least one day before the procedure with the opportunity to clarify information and options. This may not be possible in some situations. Telephone counselling through the local genetics service may provide an alternative. Counselling should address:

- criteria for access to procedures and choice between CVS and amniocentesis;
- a clear and simple explanation of the probability of an affected fetus;
- stage of pregnancy when the procedure should be undertaken;
- explanation of the process of the procedure:
  - amniocentesis
  - trans-abdominal CVS
  - trans-vaginal CVS
  - fetal blood sampling
- the risk of pregnancy complications including a risk of miscarriage (of less than 1%) in addition to the "background risk" of miscarriage due to natural causes;
- waiting time for results and how they will be conveyed;
- the possibility that the procedure may not be successful;
- the possibility that laboratory testing of specimens obtained may fail;
- the laboratory analysis may not accurately reflect the fetal status and in rare cases this can lead to incorrect interpretation of results;
- options to be considered if the result is abnormal;
- acknowledgement of the individual nature of decisions about continuing or terminating the pregnancy;
- methods of termination of pregnancy;

- a normal result on amniocentesis, chorionic villus sampling or fetal blood sampling means that within the diagnostic limitations of the test, the fetus is not affected for the disorder being tested. It does not exclude the possibility that the child may have birth defects and/or mental retardation due to other causes. It is important that health professionals ensure that people are fully informed about their residual risk;
- the implications of a multiple pregnancy;
- the possibility of unexpected results which are difficult to interpret eg a chromosome marker;
- costs involved and how they are to be met.

NB Abnormal results should be reported to the NSW Birth Defects Register (see Appendix 1-1.8).

Consent

A template consent form is attached at Appendix 3.

Collection and transport of specimens:

- Specimens should be collected under optimum conditions including type of specimen tube and conditions for sample storage during transport.
- Specimen tubes are to be labelled with the **full name** and **date of birth** of the person being tested. It would be preferable if the patient could sign the tube containing their specimen.
- Patient's suburb and postcode should be included on the test request form.
- The specimen must be accompanied by a signed referral form that specifies the test(s) to be performed.
- The transport of specimens is to occur at times agreed to by the testing laboratory.
- The time frame for receiving results should be estimated with advice from the testing laboratory.
- ***DNA testing*** - A copy of the completed consent form should be forwarded to the testing laboratory with the specimen.

Quality Assurance

- Effective communication between the clinician and the testing laboratory regarding requirements is essential to achieving optimum specimen quality**.**
- Laboratories should be NATA accredited or should participate in an appropriate quality assurance program performing sufficient numbers of tests relevant to the area of investigation.
- Where prenatal testing is to be performed on DNA from chorionic villus tissue on cells, it would be advisable to also test the sample and parental DNA samples to rule out maternal contamination.

6. Serum alpha fetoprotein testing for neural tube defects

Neural Tube Defects

Neural tube defects (NTD) include anencephaly, spina bifida and encephalocele and occur in about 1 in 800 births. The incidence is increased among women who:

- have a neural tube defect;
- have had a previous child or pregnancy with NTD;
- have a close family history of NTD;
- have insulin-dependent diabetes;
- are taking specific anticonvulsant medications;
- are obese.

These women should be offered genetic counselling.

Note on Folate
Approximately 70% of cases of neural tube defects can be prevented by increased folate intake at least one month before and continuing for the first three months of pregnancy. See Appendix 2 for further information on pamphlets.

Serum Alpha Fetoprotein (AFP) Testing

AFP testing is a voluntary and optional prenatal test which gives a risk assessment for **neural tube defects. It is not a diagnostic test.** An elevated level of serum AFP signifies an increased risk for neural tube defects. Elevated AFP is also associated with other causes such as multiple gestation or threatened miscarriage and indicates the need for follow up procedures such as ultrasound or an amniocentesis.

Timing
The optimal time for AFP testing is between 15 and 18 weeks of gestation.

Sensitivity and specificity
The high risk cut off point is normally set at 2.5 MOM so that for every 10 pregnancies identified at high risk, one will have spina bifida.

Collection and transport of specimens

A minimum of 3 mls of serum is required. The blood sample can be drawn at a collecting pathology service and sent immediately to the laboratory. It may be refrigerated for up to 24 hours or frozen if longer.

Laboratories offering serum alpha fetoprotein testing should provide request forms detailing the information that must be provided for accurate interpretation of the test result. This will include at least:

- Gestational age by dating scan.
- Patient's age - it is most important that this be clearly and correctly stated on the referral form.
- Patient's weight.
- Patient's height.
- Whether the patient is an insulin dependent diabetic.
- Whether the patient is taking anticonvulsant medication.
- Multiple pregnancy (if known).
- Previous history of neural tube defects.
- Patient's suburb and postcode.
- A signed referral form that specifies the test(s) to be performed.

7. Prenatal screening and diagnosis by fetal imaging

Ultrasound has become a routine part of prenatal care and may be done at any stage during the pregnancy. It may be used as either a screening or a diagnostic test.

Parents often view the ultrasound as an opportunity to bond with the fetus and may not have given consideration to the prospect of an adverse result. When an abnormality is detected, care should be taken to provide counselling and emotional support to minimise the impact of the result on the woman and her family.

It is recommended that providers of fetal imaging services develop and implement protocols for managing counselling issues associated with the detection of abnormalities. Important elements would include:

- counselling by obstetricians, ultrasound staff, referring doctor and other health professionals prior to routine ultrasound, concerning possible outcomes and management strategies;
- training of ultrasound technologists in management strategies in the event of an abnormality being detected;
- ensuring abnormal results are conveyed in a supportive, informative and timely manner to reduce unnecessary anxiety associated with the diagnosis;
- ensuring appropriate tertiary referral for women when an abnormality is detected ,eg. referral to genetic counselling and fetal medicine units, and follow-up by family doctor and support networks such as the Association of Genetic Support of Australasia (AGSA).

NB Abnormal results should be reported to the NSW Birth Defects Register (see Appendix 1-1.8).

Second trimester ultrasound at 18 – 20 weeks gestation

For all women, ultrasound assessment of markers of chromosomal abnormality in the second trimester is not recommended as a primary screening test for Down syndrome. However, if women have not had the opportunity to have a prior screening test, the second trimester ultrasound may be used to indicate an increased or decreased risk for Down syndrome based on the presence or absence of markers of aneuploidy. This scan has poor sensitivity and specificity for aneuploidy.

8. Professional experience, audit, quality assurance and monitoring

Users of services should be provided with accurate and current information on the numbers of pregnancies screened, the detection rate, and the screen positive rate. Ideally, providers should contribute data to a central body to facilitate pooling of data and allow for external scrutiny of results.

Women's understanding of and satisfaction with the screening methods, counselling and associated procedures ideally should be assessed so that appropriate information and education can be offered.

Standards for laboratories providing Down Syndrome Screening services

Laboratories should have internal audit and external QA through UK National External Quality Assessment Schemes (UK NEQAS) as well as accreditation with the National Association of Testing Authorities (NATA).

Ultrasound

All procedures should be performed by experienced operators who have appropriate training. Nuchal translucency screening should only be performed by trained operators, using a risk-assessment program that incorporates NT, crown-rump length (CRL) and maternal age. Accreditation should be either through the Fetal Medicine Foundation UK or through the Nuchal Translucency - Ultrasound, Education and Monitoring Project (NT-UEMP) administered through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

All ultrasound providers have to be audited at least six monthly by the NT-UEMP.

Providers of prenatal diagnosis by amniocentesis, chorionic villus sampling or fetal blood sampling

Amniocentesis, chorionic villus sampling and fetal blood sampling should be performed in a prenatal diagnosis service where the operator(s) have sufficient training and annual experience of the procedure to keep the complication rate as low as possible. There is evidence that fetal loss rate is multifactorial eg maternal age, gestation and operator experience.

Providers should have an established relationship with a fetal medicine unit, and have ready access to appropriate genetic counselling in the fields of cytogenetics, molecular genetics and biochemical genetics. This association does not necessarily imply that an individual practitioner is geographically located at a hospital containing a fetal medicine unit.

Providers should participate in quality assurance activities and contribute to the statistics of a fetal medicine unit with regard to sampling success rate, proportion of abnormalities detected, fetal loss rate and other complications. They should participate in clinical audit procedures of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Providers should have demonstrated adequate training and experience in prenatal diagnostic procedures. A minimum level of experience for amniocentesis would be at least 100 procedures in training and 50 per year. A minimum for chorionic villus sampling is at least 100 procedures in training and 50 per year. Fetal blood samplings should only be performed in fetal medicine units.

Minimum qualifications would be FRANZCOG, FRANZCR, DDU or equivalent, with appropriate invasive prenatal diagnosis training.

Appendix 1

General information for testing for all genetic disorders

1.1 Professional Experience

It is important that health professionals involved with the use of genetic tests and procedures have adequate knowledge and experience to achieve a high standard of service. Health professionals need to be aware of their own professional limitations and of the availability of others with specific expertise. It will sometimes be necessary to transfer responsibility to, or consult with clinical geneticists, fetal medicine specialists, obstetricians trained in prenatal diagnosis procedures, genetic counsellors or other appropriate specialists.

1.2 Duty to Inform

The outcome of genetic testing can have a significant impact not only on the individual being tested but also on other members of their families. Testing should only be undertaken when the individual has been fully informed about the purpose of the test or the procedure and the possible implications of the results.

1.3 Consent

The person being tested must be legally competent to give consent; must consent freely without coercion by professional staff, family members, employers, insurers or others; and must be adequately informed about all relevant issues including available future options.

The person may withdraw consent at any time.

1.4 Educational Resources

A variety of resources is available to assist with patient education (see Appendix 2 for details).

1.5 Pre-test counselling

Testing should be accompanied by pre and post test counselling carried out by a health professional, knowledgeable about:

- the genetic disorder being tested
- genetic risk assessment and pre-test counselling
- the features or limitations of the laboratory test
- interpretation of results and post-test counselling
- implications of positive and negative results, and
- options available on the outcome of testing.

The way the health professional gives information should help a patient understand the testing process and purpose. The health professional should:

- communicate information and opinions in a form that the patient can understand;
- counsel without coercion; the patient is free to accept or reject the advice or the test;
- allow the patient sufficient time to make a decision, reflect on opinions, ask more questions and consult with the family, within the time constraints of the test;
- encourage the patients to make their own decisions.

1.6 Post-test counselling

Careful consideration should be given to the way results are conveyed. The health professional should take this opportunity to explain again the implications of the result.

1.6.1 Normal Result:

Where the sensitivity of a test is less than 100%, a low risk result will not indicate the absence of a genetic disorder. It is therefore important that health professionals ensure that people are fully informed about their residual risk.

1.6.2 Abnormal Result:

Notification of an abnormal result may precipitate a crisis and the person may for some time be unable to absorb any information. Appropriate pre-test counselling will help to reduce post-test anxiety. Post-test counselling must be offered and follow up support may require several consultations. Counselling should be sensitive to the nature of decisions to be taken, should respect individual decisions and allow time to reach decisions. Appropriate follow-up when an abnormality is detected may require referral to genetic counselling services, other professional services or support networks.

When an abnormality is detected women should be offered appropriate follow-up eg. referral to genetic counselling, family doctor and support networks such as the Association of Genetic Support of Australasia (AGSA).

1.7 Individuals and families from culturally and linguistically diverse backgrounds

Professional interpreter services should be used. The interpreter should not be a member of the family.

1.8 NSW Birth Defects Register

All abnormal results identified by prenatal testing and postnatal testing in the first year of life should be notified to the NSW Birth Defects Register of the NSW Health Department. For further information see http://www.health.nsw.gov.au/policies/pd/2012/PD2012_055.html

1.9 Quality Assurance

Quality assurance should be undertaken to achieve optimum results and quality care.

1.10 Exception to pre-test counselling requirements

Pre-test counselling requirements are not usually applicable to certain routine haematology, biochemistry, biochemical genetic tests, although testing may lead to diagnosis of a genetic condition. Information should be made available prior to newborn screening and other population screening tests. Counselling should be offered if a result is abnormal.

Appendix 2

Resources

1. Centre for Genetics Education

PO Box 317
ST LEONARDS NSW 1590

Tel: 02 9926 7324
Fax: 02 9906 7529
http://www.genetics.edu.au/

The following publications are available:

- Prenatal Testing: Special tests for your baby during pregnancy
- Screening Tests for Your Baby in Early Pregnancy (Consumer and Professional versions available)
- The Maternal Serum Test
- Genetic Services and counselling: Why knowing about your genes is important to your future
- Ultrasound - Obstetric care for pregnant women
- Prenatal Diagnosis and Counselling - Importance of checking your baby's health before birth
- The Importance of Your Family Health Information (Consumer and Professional versions available)
- When your baby has a problem: How to manage the weeks ahead
- Diagnosis Of Abnormality In An Unborn Baby, The Impact, Options and Afterwards
- Folate pamphlet
- Tests to protect your baby - newborn screening
- The Genetics Resource Book

2. Multicultural Resources Available from Multicultural Health Communication Services

http://www.mhcs.health.nsw.gov.au/

The following publications available in a variety of languages other than English

- Prenatal Testing - Special tests for your baby during pregnancy
  http://www.mhcs.health.nsw.gov.au/publication_details/7750.asp

- Ultrasound Examination Preparation
  http://www.mhcs.health.nsw.gov.au/publication_details/864.asp

- How can Genetic Counselling Help?
  http://www.mhcs.health.nsw.gov.au/publication_details/3070.asp

- Bringing up children with Down Syndrome
  http://www.mhcs.health.nsw.gov.au/publication_details/3370.asp

- Questions Women ask about Abortion
  http://www.mhcs.health.nsw.gov.au

3. The NSW Department of Health

- Having a baby - free to all women at their first antenatal booking appointment at a public hospital. Also available on the NSW Health website at http://www.health.nsw.gov.au

4. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) http://www.ranzcog.edu.au

- Amniocentesis and Chorionic Villus Sampling (CVS) - a Guide on Prenatal Diagnostic Procedures
- Antenatal Care and Routine Tests During Pregnancy - a Guide for Women
- Prenatal Screening Tests for Down Syndrome and Other Conditions
- Why Aren't All Babies Perfect?

5. AGSA
Association of Genetic Support of Australasia Inc.
66 Albion Street
SURRY HILLS NSW 2010
Tel: 02 9211 1462
Fax: 02 9211 8077
Email: agsa@ozemail.com.au
Web: http://www.agsa-geneticsupport.org.au

6. The Down Syndrome Association of NSW
PO Box 2356
North Parramatta NSW 1750
Tel: 02 9683 4333
Fax: 02 9683 4020
http://www.downsyndromensw.org.au/

Consent Form for Prenatal Diagnosis

Appendix 3

This form has been designed to ensure that your consent is on an informed basis. Please read and consider each section

(Name of Hospital)

Genetic File No.	MRN

Surname	Given Name(s)
Address	
	Postcode
Date of Birth	Telephone

PART A

PART A of this form must be completed by the health professional for all patients requesting prenatal diagnosis whether they have the procedure or not

PROVISION OF INFORMATION TO PATIENT **To be completed by Health Professional**

I, _____ **have informed this patient as detailed below**
Insert name of Health Professional and designation

including the nature, likely results, and risks of the prenatal diagnosis procedure.

- The procedure involves a risk of causing pregnancy complications including miscarriage
- There is a possibility that the procedure may not be successful
- There is a possibility that laboratory testing of specimens obtained may fail
- The laboratory analysis may not accurately reflect the fetal status and in some instances this can lead to incorrect interpretation of the results
- A normal result from this test means that, within the diagnostic limitations of the test, the fetus is not affected for the disorder being tested. It does not exclude other abnormalities
- No assurance has been given that any particular doctor will perform this procedure

Interpreter present Yes/No

_____ _____ _____
Signature of Interpreter | Signature of Health Professional | Date

PART B

PATIENT CONSENT **To be completed by Patient**

_____ **and I have discussed the consequences and**
Insert name of Proceduralist

procedures involved in prenatal diagnosis.

☐ I understand that undergoing the procedure carries risks.

☐ I have had the opportunity to ask questions.

☐ I am satisfied with the explanation and the answers to my questions.

☐ I understand that I may withdraw my consent.

I request and consent to _____ **and accept the risks involved**
Insert name of Procedure

in the procedure.

_____ _____ _____
Signature of Patient | Print name of Patient | Date

Appendix 4

Fetal Medicine Services in Public Hospitals Associated with Clinical Genetics Services

Camperdown	Royal Prince Alfred Hospital, Department of Molecular and Clinical Genetics, Building 65, Level 6 Missenden Road, Camperdown NSW 2050 Ph: (02) 9515 5080, Fax: (02) 9550 5389
Kogarah	St George Hospital, Women and Children's Health Gray Street, Kogarah NSW 2217 Ph: (02) 9350 3635, Fax: (02) 9350 3694
Liverpool	Liverpool Hospital, Fetal Medicine Unit, Locked Bag 7103 Liverpool BC NSW 1871 Ph: (02) 9828 5631, Fax: (02) 9828 5570
Newcastle	John Hunter Hospital, Maternal and Fetal Medicine, Locked Bag 1, Hunter Region Mail Centre Newcastle, NSW 2310 Ph: (02) 4921 4694, Fax: (02) 4921 3133
Penrith	Nepean Hospital, Perinatal Ultrasound, Level 3 South Block, Derby Street Penrith NSW 2751 Ph: (02) 4734 2578, Fax: (02) 4737 3206
Randwick	Royal Hospital for Women, Maternal/Fetal Medicine, Barker Street, Randwick, NSW 2031 Ph: (02) 9382 6098, Fax: (02) 9382 6706
St Leonards	Royal North Shore Hospital, Fetal Medicine Unit, Pacific Highway, St Leonards NSW 2065 Ph: (02) 9926 6478, Fax: (02) 9926 7880
Westmead	The Children's Hospital, Department of Clinical Genetics, Locked Bag 4001, Westmead NSW 2145 Ph: (02) 9845 3273, Fax: (02) 9845 3204

General Clinical Genetics and Genetic Counselling Services

Metropolitan Centres

Camperdown	Royal Prince Alfred Hospital, Department of Molecular and Clinical Genetics, Missenden Road, Camperdown NSW 2050 Ph: (02) 9515 5080 Fax: (02) 9550 5389
Kogarah	St George Hospital, Kogarah NSW 2217 Ph: (02) 9113 3635 Fax: (02) 9113 3694
Liverpool	Liverpool Health Services, Clinical Genetics Department, Locked Bag 7103, Liverpool BC 1871 Ph: (02) 9828 4665 Fax: (02) 9828 4650
Newcastle	Newcastle Western Suburbs Hospital, Hunter Genetics, PO Box 84, Waratah NSW 2298 Ph: (02) 4985 3100 Fax: (02) 4985 3105
Penrith	Nepean Hospital Clinical Genetics Department, Penrith NSW 2750 Ph: (02) 4734 3362 Fax: (02) 4734 2561
Randwick	The Sydney Children's Hospital Department of Medical Genetics, High St, Randwick NSW 2031 Ph: (02) 9382 1704 Fax: (02) 9382 1711
St Leonards	Royal North Shore Hospital St Leonards NSW 2065 Ph: (02) 9926 6478 Fax: (02) 9926 7880
Westmead	The Children's Hospital Department of Clinical Genetics, Westmead NSW 2145 Ph: (02) 9845 3273 Fax: (02) 9845 3204

Regional Centres

Bathurst	Community Health Centre PO Box 1479 Bathurst NSW 2795 Ph: (02) 6339 5677 Fax: (02) 6339 5655
Broken Hill	Greater Western Area Health Service Community Health Centre, PO Box 457, Broken Hill NSW 2880 Ph: (02) 8080 1554 Fax: (02) 8080 1611
Coffs Harbour	Primary Health Service Coffs Harbour Health Campus Locked Mail Bag 812, Cnr High & Boambee Sts, Coffs Harbour NSW 2450 Ph: (02) 6656 7200 Fax: (02) 6656 7203
Forster	Forster Community Health Centre Breeze Pde, Forster NSW 2428 Ph: (02) 6555 6822 Fax: (02) 6554 8874
Gosford	Child And Family Health Gateway Centre, PO Box 361, Gosford NSW 2250 Ph: (02) 4328 7994 Fax: (02) 4328 7925
Goulburn	CIFTS, Locked Bag 15, Goulburn NSW 2580, Ph: (02) 4827 3950, Fax: (02) 4827 3958
Kempsey	C/- North Coast Area Health Service Community Health Centre, Morton Street, Port Macquarie NSW 2444 Ph: (02) 6588 2882 Fax: (02) 6588 2800
Mudgee	Macquarie Area Health Service PO Box 29, Mudgee NSW 2850 Ph: (02) 6378 6236 Fax: (02) 6372 7341
Muswellbrook	Community Health Centre Brentwood Street, Muswellbrook NSW 2333 Ph: (02) 6542 2050 Fax: (02) 6542 2005
North Coast	Lismore Base Hospital PO Box 419, Lismore NSW 2480 Ph: (02) 66250 111 Fax: (02) 66250 102
Port Macquarie	North Coast Area Health Service Community Health Centre, Morton Street, Port Macquarie NSW 2444 Ph: (02) 6588 2882 Fax: (02) 6588 2800
Tamworth	Community Health Centre 180 Peel Street,Tamworth NSW 2340 Ph: (02) 6767 8100 Fax: (02) 6766 3967
Taree	Community Health Centre 22 York Street, Taree, NSW 2430 Ph: (02) 6592 9703 Fax: (02) 6592 9607
Wagga Wagga	Wagga Wagga Base Hospital, Cnr Edward and Docker Sts, Wagga Wagga NSW 2650 Ph: (02) 6938 6666 Fax: (02) 6921 5632

Familial Cancer Services

Camperdown	Royal Prince Alfred Hospital, Department of Molecular and Clinical Genetics, Missenden Rd, Camperdown NSW 2050 Ph: (02) 9515 5080 Fax: (02) 9550 5389
Darlinghurst	St Vincent's Hospital, Family Cancer Clinic, Victoria Rd, Darlinghurst NSW 2011 Ph: (02) 8382 3395 Fax: (02) 8382 3386
Kogarah	St George Hospital, Hereditary Cancer Clinic, Cancer Care Centre, Gray St, Kogarah, NSW 2217 Ph: (02) 9350 3815 Fax: (02) 9350 3958
Westmead	Westmead Hospital, Familial Cancer Service, Department of Medicine, Westmead NSW 2145 Ph: (02) 9845 6947 Fax: (02) 9687 2331
Newcastle	Hunter Family Cancer Service, PO Box 84, Waratah NSW 2298 Ph: (02) 4985 3132 Fax: (02) 4985 3133
Penrith	Nepean Hospital, Clinical Genetics Department, Level 5 South Block, PO Box 63, Penrith NSW 2750 Tel: (02) 4734 3362 Fax: (02) 4734 2567
Randwick	Prince of Wales Hospital, Hereditary Cancer Clinic, High St, Randwick NSW 2031 Ph: (02) 9382 2551 Fax: (02) 9382 2588
St Leonards	Royal North Shore Hospital, Family Cancer Service, Level 2, Vindin House, St Leonards NSW 2065 Ph: (02) 9926 5665

Genetics Education Services

Centre for Genetics Education	PO Box 317, St Leonards NSW 1590 Ph: (02) 9926 7324, Fax: (02) 9906 7529 Web: http://www.genetics.com.au

Association for Genetic Support of Australasia (AGSA)

AGSA	66 Albion Street, SURRY HILLS NSW 2010 Ph: (02) 9211 1462, Fax: (02) 9211 8077 Email: agsa@ozemail.com.au Web: http://www.agsa-geneticsupport.org.au

Medications in pregnancy and lactation service (NSW)

Mothersafe	Medications in Pregnancy and Lactation Service, Royal Hospital for Women High St, Randwick, NSW 2031 Ph: (02) 9382 6539 or 1800 647 848

Birth Defects Register (NSW)

NSW Birth Defects Register	Centre for Epidemiology and Research, NSW Health Department, Locked Mail Bag 961, North Sydney NSW 2061 Ph: (02) 9424 5829 Fax: (02) 9391 9232

Genetics of Learning Disability Service (GOLD)

GOLD	Hunter Genetics, PO Box 84, WARATAH NSW 2298 Ph: (02) 4985 3131, Fax: (02) 4985 3133

References

[1] *New South Wales Mothers and Babies 2005*, NSW Public Health Bulletin Supplement, Vol 18, Number S-1. February 2007.

[1] *'Best Practice' Guidelines on antenatal screening for Down syndrome and other fetal aneuploidy* prepared by the Joint Human Genetics Society of Australasia and Royal Australian and New Zealand College of Obstetricians and Gynaecologists

[1] *First and second trimester antenatal screening for Down's syndrome: the results of the Serum, Urine and Ultrasound Screening Study (SURUSS)*, Wald NJ, Rodeck C, Hackshaw AK, Walters J, Chitty L, Makinson A, Health Technology Assessment NHS R&D HTA Programme, Vol 7, No 11, 2003.

[1] *Nuchal Translucency Measurement in the First Trimester of Pregnancy for Screening of Trisomy 21 and other Autosomal Trisomies*, Medical Services Advisory Committee, Department of Health and Ageing May 2002

[1] *Joint estimation of Down syndrome risk and ascertainment rates: a meta-analysis of nine published data sets*. Prenatal Diagnosis 1998;18(1):9-20) Bray I, Wright DE, Davies C, Hook EB

[1] *Maternal serum biochemistry at 11-13+6 weeks in relation to the presence or absence of the fetal nasal bone on ultrasonography in chromosomally abnormal fetuses: an updated analysis of integrated ultrasound and biochemical screening*. Prenatal Diagnosis 2005; 25:977-983, Cicero S, Spencer K, Avgidou K, Faiola S, Nicolaides K.

GENETIC TESTING - GUIDELINES FOR PRIORITISING GENETIC TESTS (GL2007_013)

Introduction

Many genetic tests provided by NSW public hospital laboratories are non-Medical Benefits Schedule items funded through NSW Health. The charging policy for these tests is addressed in Policy Directive PD2005_335. Further, the Policy Directive requires testing to be assessed and prioritised according to clinical necessity.

The attached guidelines have been developed to assist clinicians/health services to prioritise genetic test requests based on clinical need, equity of access and within available funding levels.

Background

Policy Directive PD2005_335 *Charging Policy for Clinically Required Specialised Genetics Tests which are non-Medicare Benefits Schedule Items*, http://www.health.nsw.gov.au/policies/pd/2005/PD2005_335.html states that:

"Area Health Services are to meet the cost of testing from within their global budget allocation for clinically/medically required specialised genetic testing for non-Medicare Benefits Schedule items for:

- *admitted public patients;*
- *non-admitted public patients; and,*
- *privately referred non-inpatients referred to a public sector specialist clinic.*

Except where indicated, arrangements are to be consistent with "Principles for Funding of NSW Public Health Sector Pathology Services" PD2005_533 http://www.health.nsw.gov.au/policies/pd/2005/PD2005_533.html

***Specialised tests for genetic disorders** refers to tests which are non Medicare Benefits Schedule items performed by public hospital laboratories and funded by the NSW Health System. The costs of tests are generally in the range of $100 to $2000 per test, and more in rare instances. These tests are used to:*

- *diagnose a genetic disorder, including a prenatal diagnosis;*
- *determine if a person is a mutation carrier for a disorder; or*
- *detect an inherited predisposition to a genetic disorder.*

Local arrangements are to be negotiated concerning clinical responsibility for authorising testing as well as budget responsibilities for approving test requests. This would most appropriately rest with the head of a clinical genetics unit or delegated staff member. Referral to public sector genetics services will provide the patient with clinical geneticist expertise not generally available in the private sector. It will not guarantee testing, as it will need to be assessed and prioritised according to clinical necessity."

Guidelines for prioritising genetic tests

To assist health services/clinicians prioritise genetic tests within available funding levels, the Genetic Services Advisory Committee (GSAC), NSW Department of Health, in association with Heads of Clinical Genetics Units has developed a priority system as a guide to appropriate genetic testing based on clinical need and equitable access. The charging of genetic tests is to be in accordance with the policy outlined in the above-mentioned policy directives.

High Priority

1. Prenatal Testing

- Where the confirmation of a clinical diagnosis by molecular testing will assist parents who may use the information in making reproductive choices.
- Where the confirmation of the clinical diagnosis will enable treatment options to be instituted which might be early in the newborn period.
- Where gonadal mosaicism is recognised to occur frequently (eg Osteogenesis Imperfecta with a risk of 3 - 4%)

2. Diagnostic Testing

- When confirmation of a clinical diagnosis will restore reproductive confidence in the family.
- When confirmation of a clinical diagnosis will lead to changes in management of an affected person.
- Where a diagnostic test can lead to predictive testing of other at-risk family members.
- To confirm a clinical diagnosis where it is relevant to screening for disease complications.
- To confirm a clinical diagnosis where it is relevant for funding purposes eg extra aid at school.

3. Carrier Testing

- Where the patient has had genetic counselling and is aware of a high likelihood of being a carrier based on family history or ethnicity and the patient has accepted the advantages and limitations of carrier testing.
- When there are prenatal diagnosis implications for a family because of a known family history.
- Where one partner is a known carrier of a recessive condition and carrier testing of the other partner may lead to the possibility of prenatal diagnosis and accurate reproductive counselling.

4. Presymptomatic and Predictive Testing

- Where there is a known family history of a disorder and mutation is known.
- Where there is definitive testing available and there is a family history of the disorder, ie Huntington disease.

Low Priority

1. Prenatal Testing

- Where confirmation of a clinical diagnosis by molecular testing will not alter the reproductive choices or obstetric or perinatal care for the patient.
- Where there is only a low theoretical risk of gonadal mosaicism.
- Where there is a recessive condition and there is no need for carrier testing for the new partner who is at a low risk of being a carrier.

2. Diagnostic Testing

- Where the clinical diagnosis is confirmed by other means and genetic testing will not alter the patient’s management or options.
- Where the test has been requested by the parents or health professionals and the geneticist thinks a diagnosis is unlikely or the test is not clinically indicated.

- Where confirmation of the clinical diagnosis by genetic testing will not influence whether prenatal testing is undertaken and or the type of test.
- Where the genetic test will not lead to confirmation or predictive testing of other family members eg no at risk relatives.
- Where confirmation of the clinical diagnosis will not alter screening of potential disease complications.

3. Carrier Testing

- Where the disorder is rare and there is no family history.
- Where the testing will not alter the lifestyle or health options for a person.

4. Presymptomatic and Predictive Testing

- Where there is no family history of the disorder.
- Where the only people to have predictive testing would be children for adult onset disorders.

GUIDELINES FOR PREDICTIVE AND DIAGNOSTIC DNA TESTING FOR SERIOUS ADULT ONSET NEUROGENETIC DISORDERS WITH PREDICTIVE IMPLICATIONS FOR OTHER FAMILY MEMBERS AND WHICH ARE LIKELY TO REDUCE NORMAL LIFE EXPECTANCY (PD2005_303)

1. INTRODUCTION

Predictive and diagnostic testing using DNA (or sometimes other analytes) is available for a number of adult onset genetic diseases, many of which result in presently incurable illness, dementia and premature death.

Predictive testing refers to testing in an individual who currently does not have symptoms or signs of disease, but who may be at risk due to their family history, and who requests more information about their risk.

Serious adult onset neurogenetic disorders likely to reduce normal life expectancy include Huntington disease, motor neurone disease, spinocerebellar ataxia and pre-senile dementias.

2. PREDICTIVE TESTING

DNA predictive testing for serious adult onset neurogenetic disorders carried out by NSW Health public hospital laboratories shall only be undertaken when requested by certified clinical geneticists.

2.1 Rationale

This requirement is to ensure that patients receive care according to best practice guidelines (Appendix 1). Taking a predictive DNA test is a major life decision and the results are irreversible. Predictive testing raises a number of complex issues outlined below and it is essential that prior to undertaking testing, the patient is fully informed about the implications of testing and is prepared for the results.

Clinical geneticists requesting predictive testing are required to have expertise in the disorder being tested, the complexities of predictive testing, interpretation of results and their implications and follow-up management strategies. Genetics Service staff work in close liaison with referring practitioners to ensure continuity of care.

2.2 Offering predictive testing

Predictive testing is best offered through a team which in addition to a clinical geneticist includes a neurologist, psychiatrist, genetic social worker/genetic counsellor, psychologist and laboratory scientists. A list of genetics services is included as Appendix 2.

The diagnosis in the affected relative should be verified. A baseline neurological consultation should be offered for any person undergoing predictive testing.

2.3 Laboratory requirements

Laboratories will only commence testing on receipt of all information required:

- Information as indicated in the attached request form (Appendix 3).
- A photocopy of the completed consent form (Appendix 4). Completion of the consent form provides the opportunity to address relevant issues in predictive testing.

Laboratories are to keep a list of certified clinical geneticists.

2.4 Results and their implications

A positive test result will indicate that the individual is at high risk of being affected by the disease, although the actual risk varies from disorder to disorder. For example, for Huntington disease a positive test result means that the person will almost definitely develop the condition if they live long enough. The test result may not accurately predict age of onset or severity of the condition. In the case of a positive result, the person should be offered follow-up with the neurologist. Some results are indeterminate or in the intermediate range and require very specialised interpretation. Such results may raise complex psychosocial issues for the individual being tested and their family, and on-going support is often necessary. A positive result may have implications for future reproductive decisions and possible adverse consequences for employment and insurance. The individual should be informed that routine check-ups with an appropriate specialist may be an alternative to a predictive genetic test.

There may be implications for other family members because genetic disorders are inherited. For example, for Huntington disease, a positive predictive test result means that the individual's children and siblings have a 50% chance of inheriting the mutation. Privacy and confidentiality issues need consideration, particularly the need to balance the right to privacy and confidentiality of the person being tested, with their responsibility to inform other family members, who potentially may suffer harm if their risk status is not disclosed to them.

3. DIAGNOSTIC TESTING

Neurologists and specialists requesting DNA diagnostic testing for adult onset neurogenetic disorders undertaken by NSW Health Public Hospital Laboratories are reminded that a positive result in diagnostic testing in clinically affected patients will have the same implications for family members as those outlined under predictive testing above. In the case of a positive diagnostic test result it is strongly recommended, that the patient's family members are offered counselling support and the opportunity for follow-up discussion of their risk with a clinical geneticist (Appendix 2), according to the above guidelines for predictive testing (Appendix 1).

4. CHARGING POLICY

Most of these specialised DNA tests are non Medicare Benefits Schedule Items funded by the NSW Health system. Public or privately referred non-inpatients accessing **predictive** testing services through a public sector clinical genetics service (Appendix 2), or **diagnostic** testing through a public sector specialist clinic will be treated as public patients without charge. Private patients will be responsible for their own test costs.

Appendix 1

1 BEST PRACTICE GUIDELINES FOR PREDICTIVE AND PRESYMPTOMATIC DNA TESTING

1.1 Genetic Testing, (PD2007_066)
http://www.health.nsw.gov.au/policies/pd/2007/PD2007_066.html

1.2 Genetics http://www.genetics.edu.au/

1.3 Guidelines for predictive testing for genetic disorders; Human Genetics Society of Australasia, available at http://hgsa.com.au

1.4 Predictive testing in children and adolescents, Human Genetics Society of Australasia, available at http://hgsa.com.au

1.5 Accreditation Standards for Nucleic Acid Detection Techniques (Section 1.2)
http://www.health.gov.au/internet/main/publishing.nsf/Content/health-npaac-docs-nad.htm

1.6 Ethical Code Governing the Provision of Genetics Services
State Health Publication No (SWS) 980068, ISBN: 0 7313 4036 1
http://www.health.nsw.gov.au/publications/Pages/genetic-services-ethics.aspx

2 DISORDER SPECIFIC GUIDELINES

2.1 **Huntington Disease**
Guidelines for the molecular genetics predictive test in Huntington disease, Journal of Medical Genetics (1994;31:555-559) and Neurology (1994;44:1533-1536).
http://www.huntington-assoc.com/

Appendix 2

Clinical and Genetic Counselling Service Locations

Clinical and Counselling Services

CAMPERDOWN
Department of Molecular and Clinical Genetics
Royal Prince Alfred Hospital
CAMPERDOWN NSW 2050
Tel: 02 9515 5080
Fax: 02 9515 7595

LIVERPOOL
Department of Clinical Genetics
Health Services Building
Cnr Campbell and Goulburn Sts
LIVERPOOL NSW 2170
Tel: 02 9828 4665
Fax: 02 9828 4650

PENRITH
Nepean Hospital
PENRITH NSW 2750
Tel: 4734 3362
Fax: 4734 2567

RANDWICK
Department of Medical Genetics
Sydney Children's Hospital
RANDWICK NSW 2031
Tel: 02 9382 1708
Fax: 02 9382 1711

WESTMEAD
Department of Clinical Genetics
The New Children's Hospital
WESTMEAD NSW 2145
Tel: 02 9845 3273
Fax: 02 9845 3204

NEWCASTLE
Hunter Genetics
Cnr Turton & Tinonee Sts
WARATAH NSW 2298
Tel: 4985 3100
Fax: 4985 3105

Genetic Counselling Services in conjunction with visiting clinical genetics services

KOGARAH
Women's and Children's Health
2nd Floor Prichard Wing
St George Hospital
Gray Street
KOGARAH NSW 2217
Tel: 02 9350 2315
Fax: 02 9350 3901T

ST LEONARDS
Fetal Medicine Unit
Royal North Shore Hospital
ST LEONARDS NSW 2065
Tel: 02 9926 6478
Fax: 02 9906 1872

BATHURST
Community Health Centre
158 William Street
BATHURST NSW 2795
Tel: 6331 5533
Fax 6332 2039

BROKEN HILL
Community Health Centre
BROKEN HILL NSW 2880
Tel: 08 8080 1556
Fax: 08 8080 1611

CANBERRA
The Antenatal Clinic
The Canberra Hospital
PO Box 11
CANBERRA ACT 2605
Tel: 6244 4042
Fax: 6244 3422

COFFS HARBOUR
Coffs Harbour Health Campus
Pacific Highway
COFFS HARBOUR 2450
Tel: 6656 7806
Fax: 6656 7817

GOSFORD
Central Coast Health
Public Health Unit
PO Box 361
GOSFORD NSW 2250
Tel: 4337 0207
Fax: 4337 0217

GOULBURN
Child Development Unit
Cnr Albert and Clifford Streets
GOULBURN NSW 2580
Tel: 4827 3951
Fax: 4827 3958

LISMORE
37 Oliver Avenue
GOONELLABAH NSW 2480
Tel: 6625 0111
Fax: 6625 0102

MUDGEE/DUBBO
Mudgee Community Health Centre
MUDGEE NSW 2850
Tel: 6372 6455
Fax: 6372 7341

MUSWELLBROOK
Community Health Centre
Brentwood Street
MUSWELLBROOK NSW 2332
Tel: 6542 2083
Fax: 6542 2005

PORT MACQUARIE
Hastings Macleay Community Health
Morton Street
PORT MACQUARIE 2444
Tel: 6588 2882
Fax: 6588 2800

TAMWORTH
Community Health Centre
180 Peel Street
TAMWORTH NSW 2340
Tel: 6766 2555
Fax: 6766 3967

TAREE/FORSTER
Community Health Centre
64 Putney Street
TAREE NSW 2430
Tel: 6592 9315
Fax: 6592 9607

WAGGA WAGGA
Wagga Base Hospital
WAGGA WAGGA NSW 2650
Tel: 6938 6393
Fax: 6921 5632

WOLLONGONG
Maternal and Paediatric Services
Wollongong Hospital
Crown Street
WOLLONGONG NSW 2500
Tel: 4222 5216
Fax: 4222 5477

Mothersafe

Statewide Medications in Pregnancy and Lactation Advisory Service

Royal Hospital for Women
RANDWICK NSW 2031
Tel: 02 9382 6539 (Sydney calls)
Tel: 1800 647 848 (Other calls)

AGSA

Association of Genetic Support of Australasia Inc.
66 Albion Street
SURRY HILLS NSW 2010
Tel: 02 9211 1462
Fax: 02 9211 8077
Email: agsa@ozemail.com.au
Web:www.agsa-geneticsupport.org.au

Prenatal Diagnosis & Counselling

Specialised services:

CAMPERDOWN
Fetal Medicine Unit
King George V Hospital
CAMPERDOWN NSW 2050
Tel: 02 9515 8258
Fax: 02 9515 6579

LIVERPOOL
Fetal Medicine Unit
Liverpool Hospital
Elizabeth Drive
LIVERPOOL NSW 2170
Tel: 02 9828 4145
Fax: 02 9828 4146

RANDWICK
Prenatal Diagnosis
Royal Hospital for Women
RANDWICK NSW 2031
Tel: 9382 6098
Fax: 9382 6706

PENRITH
Fetal Medicine Unit
Nepean Hospital
PENRITH NSW 2750
Tel: 02 4724 3163
Fax: 02 4724 3206

ST LEONARDS
Fetal Medicine Unit
Royal North Shore Hospital
ST LEONARDS NSW 2065
Tel: 02 9926 7280
Fax: 02 9906 1872

WESTMEAD
Fetal Medicine Unit
Westmead Centre
WESTMEAD NSW 2145
Tel: 02 9845 6802
Fax: 02 9845 7793

NEWCASTLE
Prenatal Diagnosis Unit
John Hunter Hospital
NEWCASTLE NSW 2310
Tel: 4921 4694
Fax: 4921 3133

Cancer Genetics

Specialised services:

DARLINGHURST
Family Cancer Clinic
Department of Medical Oncology
St Vincent's Hospital
Victoria Street
DARLINGHURST NSW 2010
Tel: 02 8382 3395
Fax: 02 8382 3386

KOGARAH
Cancer Care Centre
St George Hospital
Belgrave Street
KOGARAH NSW 2217
Tel: 02 9350 3815
Fax: 02 9350 3958

LIVERPOOL
Liverpool Hospital
Elizabeth Drive
LIVERPOOL NSW 2170
Tel: 02 9828 4665
Fax: 02 9828 4650

RANDWICK
Hereditary Cancer Clinic
Prince of Wales Hospital
RANDWICK NSW 2031
Tel: 02 9382 2587
Fax: 02 9382 2588

WESTMEAD
Familial Cancer Services
Westmead Hospital
WESTMEAD NSW 2145
Tel: 02 9845 5079
Fax 02 9687 2331

NEWCASTLE
Hunter Genetics
Cnr Turton & Tinonee Sts
WARATAH NSW 2298
Tel: 4985 3100
Fax: 4985 3105

Further Information:

on services in other areas and newly developed services:

NSW Genetic Education Program
PO Box 317,
ST LEONARDS NSW 2065
Tel: 02 9926 7324
Fax: 02 9906 7529
Web: www.genetics.com.au

Appendix 3

Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Disorders

- Must be used for **non-Medical Benefits Schedule items**
- Before testing is commenced, the laboratory may require the following details (see ***Guidelines for Specialised DNA Testing for Genetic Disorders*** www.health.nsw.gov.au/health-public-affairs/publications/gentest/)

Send by courier/express post to:

Send samples at room temperature
Same day OR overnight

Patient ID MRN

Last name .....

First name .....

Address .....

..... Postcode .....

Date of birth ...../...../..... (dd/mm/yyyy) Sex M F

Sample Date Drawn ...../...../..... (dd/mm/yyyy)

Blood

☐ EDTA ..... mL (room temp)

☐ Lithium heparin..... mL (room temp)

Prenatal

☐ amniotic fluid ..... mL (room temp)

☐ cultured amniocytes xT25 Flask(s) (room temp)

☐ CVS sample ..... mg ☐ on ice

☐ cleaned
☐ uncleaned

Other

☐ DNA .....µg

Other, specify:

Test requested

PLEASE ATTACH FAMILY/PEDIGREE INFORMATION

Genetic Counselling

Has the individual been offered counselling consistent with ***Specialised/DNA Testing for Genetic Disorders***?
www.health.nsw.gov.au/health-public-affairs/publications/gentest/

☐ Yes ☐ No ☐ Refused

Consent to Testing

Has a ***Consent Form for Specialised/DNA Testing*** been completed?

☐ Yes ☐ No

Payment of test cost

☐ **Public patient -** Payment to be made by Area Health Service by arrangement (see over)

☐ **Privately referred non-inpatient -** Payment to be made by Area Health Service by arrangement (see over)

Name of Area Health Service .....

☐ **Private patient -** Payment to be made by patient.

Has the patient been advised about the cost of the test and agreed to meet the cost? ☐ Yes ☐ No

Purpose of test

☐ Confirm clinical diagnosis
☐ Predictive/presymptomatic testing
☐ Carrier Status
☐ Prenatal Diagnosis - complete box below
☐ Determine feasibility of prenatal Dx
☐ Family study (no report for this individual)
☐ For research (no report for this individual)
☐ Bank DNA until further notice
☐ Other.....

Comments

Pregnancy Information (if applicable)

Is this individual or the partner of this individual currently pregnant

L.M.P. (dd/mm/yyyy) .....

Amnio (dd/mm/yyyy) .....

CVS (dd/mm/yyyy) .....

Test requested by:

Name ..... Initials .....

Address .....

..... Postcode .....

Telephone No .....

Signature..... Date .....

Specialty /Appointment.....

Family Information

Have samples from this family been sent to a DNA lab before? ☐ Yes ☐ No

If Yes, specify .....

Date of birth or age .....

Ethnic background .....

Copy of report to:

Name Initials .....

Address .....

..... Postcode .....

Telephone No .....

Appendix 4

(Name of Hospital)

Consent form for predictive and diagnostic DNA testing for serious adult onset neurogenetic disorders with predictive implications for other family members

This form has been designed to ensure that your consent is on an informed basis. Please read and consider each section.

Title Family Names		MRN		
Given Name		VMO		
Address Street		DOB	Sex	HIS
Suburb	Postcode	Admission Date		

PROVISION OF INFORMATION TO PATIENT — **To be completed by Health Professional**

I, _____ have informed this patient as detailed below
Insert name of Health Professional and designation

the nature, likely results, and risks associated with gene testing for _____
name of disorder

Interpreter present Yes/No

_____ Signature of Interpreter

_____ Signature of Health Professional

_____ Date

PATIENT CONSENT — **To be completed by Patient/Guardian**

_____ **and I have discussed predictive testing**
Insert name of Health Professional

testing for the analysis of the gene fault (mutation) for _____
name of disorder

He/she has told me that:

- The collection of blood will be used to examine my DNA and tested for the gene involved in _____
  name of disorder
- A **positive test result** indicates that I have inherited a faulty gene (mutation). This means that I am at high risk of developing _____ and my children and siblings have a _____ %chance of inheriting the mutation
  name of disorder percentage
- A positive test result cannot accurately predict the age of onset of the disorder.
- A **negative test result** means that I have not inherited the faulty gene (mutation). I will not develop _____ and cannot pass it on to my children
  name of disorder
- An intermediate result means that I may or may not develop _____
  name of disorder
- In some instances this may have implications for my siblings and children and their descendents

- Test results of one individual can change the estimation of risk for other family members and I have been advised to inform other adult family members who may be at risk.
- The test result may affect the ability to obtain some types of insurance or employment.
- Testing may reveal non-paternity or non-maternity of a presumed natural parent
- Genetic counselling will be available for myself and other family members during the testing process and after the test result has been given.

I have been told about storage of the test results and the DNA sample. I understand the following:

- The test result will be held by this centre and will only be known by those involved in the testing process.
- My own test result, the fact that I have had a test, and my DNA sample will not be revealed or made available to any other person or organisation outside of the testing process, except with my written consent (as detailed below), or in situations where disclosure is required by law.
- The test results will be given to me first.
- The DNA sample will remain the property of the laboratory. It will be stored in good faith, but its suitability for future use cannot be guaranteed. It will be disposed of at a time determined by standard laboratory practices or regulatory requirements.
- My identified DNA sample will not be used for any other purpose except in accordance with my written consent (as detailed below).

I request and consent to the test described above.

I understand the potential benefits of testing and storing this sample and I accept the risks involved. I have had the chance to ask questions and am satisfied with the explanations and the answers to my questions.

I understand that I may withdraw my consent for this test to be processed.

I consent to my test results being revealed at any time to the following people:

- ☐ Any family member
- ☐ Only to the following individuals (specify) _____
- ☐ My doctor(s) *(specify)* _____
- ☐ No other individual
- ☐ In the event of my death **test results** may be made known to: _____

After testing has been completed:

- ☐ **I consent to my de-identified DNA sample being used for future Institutional Ethics Committee approved research**

OR

- ☐ **My DNA sample may not be used for research without my written consent**

_____ _____ _____

Signature of Patient/t/Guardian | Print name of Patient | Date

Explanation of terms used in this consent form

- A **gene test** involves analysis of one or more of those genes to determine whether a mutation is present
- **Mutation:** Change in the normal DNA code which may cause disease
- **DNA** (Deoxyribonucleic acid): The chemical compound of which the genes are made

MATERNITY - MANAGEMENT OF HYPERTENSIVE DISORDERS OF PREGNANCY
(PD2011_064)

PD2011_064 rescinds PD2011_020.

PURPOSE

This policy provides direction to NSW maternity services, Emergency Departments, Ambulance Service of NSW and retrieval services regarding the management of hypertensive disorders of pregnancy. The NSW Maternal and Perinatal Committee and the NSW Maternal and Perinatal Health Priority Taskforce have endorsed *The Guidelines for the Management of Hypertensive Disorders of Pregnancy 2008* issued by the *Society of Obstetric Medicine of Australia and New Zealand* and it is now issued as NSW Health policy.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations providing maternity services and/or emergency department services must have clinical practice guidelines and protocols for the management of hypertensive disorders of pregnancy based on this policy directive.

Ambulance Service of NSW and all other retrieval services must also have protocols for the management of hypertensive disorders of pregnancy based on this policy directive.

IMPLEMENTATION

The Chief Executives of Local Health Districts and the Ambulance Service of NSW are ultimately responsible for the implementation of this policy directive within their respective facilities.

1. BACKGROUND

1.1 About This Document

Hypertension disorders of pregnancy are common affecting approximately 6% of pregnancies.[3] Hypertensive disorders of pregnancy are associated with increased maternal and perinatal morbidity and mortality. Previous guidance regarding the detection, investigation and management of hypertension, the use of intravenous hydralazine in severe hypertension, and the use of magnesium sulphate for eclamptic seizure prophylaxis was provided in separate policy documents. The primary reference for all three documents was a consensus statement from the Australasian Society for the Study of Hypertension in Pregnancy. This document has since been replaced by the *Guidelines for the Management of Hypertensive disorders of Pregnancy 2008* compiled by the *Society of Obstetric Medicine of Australia and New Zealand.*[4] These guidelines form the basis of this policy directive.

1.2 Key Definitions

Hypertension in pregnancy is defined as:
1. Systolic blood pressure greater than or equal to 140 mmHg and/or
2. Diastolic blood pressure greater than or equal to 90 mmHg (Korotkoff 5)

These measurements should be confirmed by repeated readings over several hours.

[3] Centre for Epidemiology and Research, NSW Department of Health. NSW Mothers and Babies Report 2010. NSW Public Health Bulletin 2007; 18(S-1).

[4] http://www.health.nsw.gov.au/hsnsw/Publications/mothers-and-babies-2010.pdf

Severe hypertension in pregnancy is defined as:
1. Systolic blood pressure greater than or equal to 170 mmHg and/or
2. Diastolic blood pressure greater than or equal to 110 mmHg.

White Coat Hypertension is defined as:
Hypertension in a clinical setting with normal blood pressure away from this setting when assessed by 24 hour ambulatory blood pressure monitoring or home blood pressure monitoring using an appropriately validated device.

Pre-eclampsia is defined as**:**

Hypertension that arises after 20 weeks gestation and is accompanied by one or more of the following:
- Renal involvement:
  - Significant proteinuria - dipstick proteinuria subsequently confirmed by spot urine protein/creatinine ratio ≥ 30mg/mmol. In view of the close correlation between spot urine protein/creatinine ratio and 24 hour urine excretion, the latter is rarely required.[21]
  - Serum or plasma creatinine > 90 μmol/L
  - Oliguria
- Haematological involvement
  - Thrombocytopenia
  - Haemolysis
  - Disseminated intravascular coagulation
- Liver involvement
  - Raised serum transaminases
  - Severe epigastric or right upper quadrant pain.
- Neurological involvement
  - Convulsions (eclampsia)
  - Hyperreflexia with sustained clonus
  - Severe headache
  - Persistent visual disturbances (photopsia, scotomata, cortical blindness, retinal vasospasm)
  - Stroke
- Pulmonary oedema
- Fetal growth restriction
- Placental abruption

Gestational hypertension is defined as:
The new onset of hypertension after 20 weeks gestation without any maternal or fetal features of pre-eclampsia, followed by return of blood pressure to normal within 3 months post-partum.

Chronic or essential hypertension is defined as:
A blood pressure > 140 mmHg systolic and/or > 90mm diastolic confirmed before pregnancy or before 20 completed weeks gestation without a known cause.

Pre-eclampsia superimposed on chronic hypertension is diagnosed when:
One or more of the systemic features of pre-eclampsia develop after 20 weeks gestation in a woman with chronic hypertension.

2. DEFINITION OF HYPERTENSION IN PREGNANCY

Normal pregnancy is characterized by a fall in blood pressure, detectable in the first trimester and usually reaching a nadir in the second trimester. Blood pressure rises towards pre-conception levels towards the end of the third trimester.

Hypertension in pregnancy is defined as:
1. Systolic blood pressure greater than or equal to 140 mmHg and/or;
2. Diastolic blood pressure greater than or equal to 90 mmHg (Korotkoff 5).

These measurements should be confirmed by repeated readings over several hours.

Elevations of both systolic and diastolic blood pressures have been associated with adverse fetal outcome and therefore both are important.(1) There are several reasons to support the blood pressure readings above as diagnostic of hypertension in pregnancy:
- Perinatal mortality rises with diastolic blood pressures above 90 mmHg;(2)
- Readings above this level were beyond two standard deviations of mean blood pressure in a New Zealand cohort of normal pregnant women(3); and
- The chosen levels are consistent with international guidelines and correspond with the current diagnosis of hypertension outside of pregnancy.

Detecting a rise in blood pressure from 'booking' or preconception blood pressure (> 30/15 mmHg), rather than relying on an absolute value, has in the past been considered useful in diagnosing pre-eclampsia in women who do not reach blood pressures of 140 or 90 mmHg. Available evidence however, does not support the notion that these women have an increased risk of adverse outcomes.(4,5) Nevertheless such a rise may be significant in some women, particularly in the presence of hyperuricaemia and proteinuria. Further data are required and in the meantime, closer monitoring of pregnant women with an increment in blood pressure of ≥30 mmHg systolic and/or 15 mmHg diastolic is appropriate.

Severe hypertension in pregnancy is defined as a systolic blood pressure greater than or equal to 170 mmHg and/or diastolic blood pressure greater than or equal to 110 mmHg. This represents a level of blood pressure above which cerebral autoregulation is overcome in normotensive individuals. It is generally acknowledged that severe hypertension should be lowered promptly, albeit carefully, to prevent cerebral haemorrhage and hypertensive encephalopathy.(6) This degree of hypertension therefore requires urgent assessment and management. It is important to acknowledge that systolic as well as diastolic hypertension increases the risk of cerebral haemorrhage. Certain experts have recommended lowering the cut-off for the definition of severe systolic hypertension to 160mm Hg. For now, in the absence of definitive data, the above definition should be retained as a clinically useful cut-off value to initiate urgent treatment (see Management of pre-eclampsia and gestational hypertension).

White Coat Hypertension is defined as hypertension in a clinical setting with normal blood pressure away from this setting when assessed by 24 hour ambulatory blood pressure monitoring or home blood pressure monitoring using an appropriately validated device. Women with this condition present early in pregnancy with apparent chronic hypertension, but their outcomes are better than those of women with true chronic hypertension. They may generally be managed without medication by using repeated ambulatory or home blood pressure monitoring. A small proportion will go on to develop pre-eclampsia.(7)

3. RECORDING BLOOD PRESSURE IN PREGNANCY

The woman should be seated comfortably with her legs resting on a flat surface. In labour, the blood pressure may be measured in the left arm in lateral recumbency. The supine posture should be avoided because of the supine hypotension syndrome. Measurement of blood pressure should be undertaken in both arms at the initial visit to exclude rare vascular abnormalities such as aortic coarctation, subclavian stenosis and aortic dissection. Generally the variation in blood pressure between the upper limbs should be less than 10 mmHg.

The systolic blood pressure is accepted as the first sound heard (K1) and the diastolic blood pressure the disappearance of sounds completely (K5).[8-10] Where K5 is absent, K4 (muffling) should be accepted. Correct cuff size is important for accurate blood pressure recording. A large cuff with an inflatable bladder covering 80% of the arm circumference should be used if the upper arm circumference is greater than 33 cm. This helps to minimise over-diagnosis of hypertension during pregnancy[11].

3.1 Measurement Devices

Mercury sphygmomanometers remain the gold standard for measurement of blood pressure in pregnancy however occupational health concerns are limiting their availability. Automated blood pressure recorders have provided major advantages for treatment and diagnosis of hypertension in the general community and they have been advocated for use in pregnant women.[12] Few studies have compared these self-initiated devices with mercury sphygmomanometry in pregnant women. While such automated devices may give similar mean blood pressure values to those obtained with mercury sphygmomanometry, there is wide intra-individual error and their accuracy may be further compromised in pre-eclamptic women.[13,14] Aneroid sphygmomanometers are also prone to error. Each unit should maintain a mercury sphygmomanometer for validation of automated and aneroid devices. All devices should be calibrated on a regular basis (ideally monthly), as recommended by the British Hypertension Society.

3.2 Twenty Four Hour Ambulatory Blood Pressure Monitoring (ABPM)

Normal blood pressure values recorded by ABPM have been established for different stages of pregnancy.[15,16] ABPM is useful in the evaluation of early (< 20 wks gestation) hypertension where approximately one third of these women will be shown to have “white coat” or “office” hypertension.[7] About half of these women will not require antihypertensive medication in pregnancy, while the other half develops true (ABPM confirmed) hypertension. ABPM is less useful in screening for white coat hypertension in the second half of pregnancy.[17] Twenty four hour ABPM has also been shown to predict those women at risk of developing hypertension later in pregnancy but its sensitivity and specificity for this purpose is low.[18]

4. CLASSIFICATION OF HYPERTENSIVE DISORDERS IN PREGNANCY

This classification of the hypertensive disorders in pregnancy reflects the pathophysiology of the constituent conditions as well as the risks and potential outcomes for both mother and baby. The following clinical classification modifies only slightly that proposed in the ASSHP consensus statement of 2000. It has subsequently been adopted by the International Society for the Study of Hypertension in Pregnancy (ISSHP).[19] In endorsing this classification the ISSHP committee examined the classifications proposed by the ASSHP, the National High Blood Pressure Education Programme (NHBPEP) in the United States[20] as well as earlier published criteria.

4.1 Pre-eclampsia

Pre-eclampsia is a multi-system disorder unique to human pregnancy characterised by hypertension and involvement of one or more other organ systems and/or the fetus. Raised blood pressure is commonly but not always the first manifestation. Proteinuria is the most commonly recognised additional feature after hypertension but should not be considered mandatory to make the clinical diagnosis. As this classification is based on clinical data, it is possible that women with another condition will sometimes be classified incorrectly as having pre-eclampsia during pregnancy. This is not usually a clinical problem as the diagnosis of pre-eclampsia should lead to increased observation and vigilance which is appropriate for conditions which may mimic pre-eclampsia. A diagnosis of pre-eclampsia can be made when hypertension arises after 20 weeks gestation and is accompanied by one or more of the following:

- Renal involvement:
  - Significant proteinuria - dipstick proteinuria subsequently confirmed by spot urine protein/creatinine ratio
  - ≥ 30mg/mmol. In view of the close correlation between spot urine protein/creatinine ratio and 24 hour urine excretion, the latter is rarely required.[21]
  - Serum or plasma creatinine > 90 μmol/L
  - Oliguria
- Haematological involvement
  - Thrombocytopenia
  - Haemolysis
  - Disseminated intravascular coagulation
- Liver involvement
  - Raised serum transaminases
  - Severe epigastric or right upper quadrant pain.
- Neurological involvement
  - Convulsions (eclampsia)
  - Hyperreflexia with sustained clonus
  - Severe headache
  - Persistent visual disturbances (photopsia, scotomata, cortical blindness, retinal vasospasm)
  - Stroke
- Pulmonary oedema
- Fetal growth restriction
- Placental abruption

Notes:

1. Oedema is not included in the diagnostic features of pre-eclampsia. It is a common feature of normal pregnancy and severe pre-eclampsia may be present in the absence of any oedema. Nevertheless rapid development of generalised oedema should alert the clinician to screen for pre-eclampsia.
2. Other rare disorders may present with some of the features of pre-eclampsia.[22] Disorders such as acute fatty liver of pregnancy, haemolytic uremic syndrome, thrombotic thrombocytopenic purpura, exacerbation of systemic lupus erythematosus or cholecystitis may need to be excluded.
3. Rarely pre-eclampsia presents before 20 weeks gestation[23], usually in the presence of a predisposing factor such as hydatidiform mole, multiple pregnancy, fetal triploidy, severe renal disease or antiphospholipid antibody syndrome.
4. Dipstick testing for proteinuria is a screening test with very high false positive and negative rates. The use of automated dipstick readers can significantly improve detection of proteinuria.[24] Although ideally all women with hypertension should have a urine protein/creatinine ratio performed; in practice, dipstick readings of ‘nil’ or ‘trace’ are unlikely to be significant. The presence of urinary tract infection should also be excluded.

5. Hyperuricaemia is a common but not diagnostic feature of pre-eclampsia; the degree of hyperuricaemia may correlate with fetal risk [25,26] although some studies have questioned this.[27-29] A rapidly rising plasma uric acid over a few days in the setting of hypertension usually indicates worsening pre-eclampsia, often in the presence of other markers of deterioration.
6. Serum transaminase levels are reduced in pregnancy (by approximately 20%) and the upper limits of normal should be based on local reference ranges.
7. The HELLP syndrome (Haemolysis, Elevated Liver enzymes and a Low Platelet count) represents a particular presentation of severe pre-eclampsia and separating it as a distinct disorder is not helpful.
8. Microangiopathic haemolysis although infrequent may cause a sudden fall in haemoglobin and the appearance of fragmented red blood cells on the blood film. It is accompanied by a rise in bilirubin and lactate dehydrogenase, as well as thrombocytopenia and elevated liver enzymes, sometimes with the appearance of red or black urine. This diagnosis should be considered after a fall in haemoglobin when there has been insufficient revealed bleeding to account for the anaemia. Despite this, anaemia is more often due to obstetric bleeding in these cases, including occult intra-abdominal haemorrhage.
9. Pre-eclampsia is a frequent cause of migrainous symptoms in pregnancy, the commonest cause in pregnancy of cerebral haemorrhage, and the only cause of eclampsia. Other rare neurological complications include cerebral haemorrhage, cerebral oedema, cortical and sinus vein thrombosis, retinal detachment and central serous retinopathy.

The above classification is a clinical one. Although it is recognised that women with pre-eclampsia may not show proteinuria,[30] for research purposes a more homogeneous group will be represented by women with both hypertension and proteinuria as this is less open to clinical interpretation and error.

The ISSHP research definition of pre-eclampsia[19] is as follows:
- De novo hypertension after 20 weeks gestation, returning to normal postpartum; and
- properly documented proteinuria.

4.2 Gestational Hypertension

Gestational hypertension is characterised by the new onset of hypertension after 20 weeks gestation without any maternal or fetal features of pre-eclampsia, followed by return of blood pressure to normal within 3 months post-partum. At first presentation this diagnosis will include some women (up to 25%) who are in the process of developing pre-eclampsia but have not yet developed proteinuria or other manifestations. Some women initially diagnosed in this category will manifest persistent blood pressure elevation beyond 12 weeks post-partum and eventually be classified as having chronic hypertension.

Gestational hypertension near term is associated with little increase in the risk of adverse pregnancy outcomes.[31] The earlier the gestation at presentation and the more severe the hypertension, the higher is the likelihood that the woman with gestational hypertension will progress to develop pre-eclampsia[32] or an adverse pregnancy outcome.[33] Severe hypertension (≥ 170/110mmHg) is associated with increased risk of adverse outcomes in pregnancy.[33]

4.3 Chronic Hypertension

Essential hypertension is defined by a blood pressure > 140 mmHg systolic and/or > 90mm diastolic confirmed before pregnancy or before 20 completed weeks gestation without a known cause. It may also be diagnosed in women presenting early in pregnancy taking antihypertensive medications where no secondary cause for hypertension has been determined. Some women with apparent essential hypertension may have white coat hypertension (raised blood pressure in the presence of a clinical attendant but normal blood pressure otherwise as assessed by ambulatory or home blood pressure monitoring). These women appear to have a lower risk of superimposed pre-eclampsia than women with true essential hypertension but are still at an increased risk compared with normotensive women.[7]

Important *secondary* causes of chronic hypertension in pregnancy include:

- Chronic kidney disease e.g. glomerulonephritis, reflux nephropathy, and adult polycystic kidney disease.
- Renal artery stenosis.
- Systemic disease with renal involvement e.g. diabetes mellitus, systemic lupus erythematosus.
- Endocrine disorders e.g. phaeochromocytoma, Cushing's syndrome and primary hyperaldosteronism.
- Coarctation of the aorta.

In the absence of any of the above conditions it is likely that a woman with high blood pressure in the first half of pregnancy has essential hypertension. It is not possible to investigate these disorders fully during pregnancy, and complete appraisal may need to be deferred until after delivery.

4.4 Pre-eclampsia Superimposed on Chronic Hypertension

Pre-existing hypertension is a strong risk factor for the development of pre-eclampsia.[34] Superimposed pre-eclampsia is diagnosed when one or more of the systemic features of pre-eclampsia develop after 20 weeks gestation in a woman with chronic hypertension. In women with pre-existing proteinuria, the diagnosis of superimposed pre-eclampsia is often difficult as pre-existing proteinuria normally increases during pregnancy. In such women substantial increases in proteinuria and hypertension should raise suspicion of pre-eclampsia but the diagnosis is not secure without the development of other systemic features or fetal growth restriction.

5. INVESTIGATION OF NEW ONSET HYPERTENSION IN PREGNANCY

Any woman presenting with new hypertension after 20 weeks gestation should be assessed for signs and symptoms of pre-eclampsia. Initially, assessment and management in a day assessment unit may be appropriate. However, if features of pre-eclampsia are detected, admission to hospital is indicated. The presence of severe hypertension, headache, epigastric pain or nausea and vomiting are ominous signs which should lead to urgent admission and management,[35,36] as should any concern about fetal wellbeing.

The following investigations should be performed in all patients:

- Urine dipstick testing for proteinuria, with quantitation by laboratory methods if >'1+' (30mg/dL)
- Full blood count
- Urea, creatinine, electrolytes
- Liver function tests
- Ultrasound assessment of fetal growth, amniotic fluid volume and umbilical artery Doppler flow

Notes:

1. Blood test abnormalities should be interpreted using pregnancy-specific ranges, some of which are gestation dependent.
2. If features of pre-eclampsia are present, additional investigations should include:
   - Urinalysis and microscopy on a carefully collected mid-stream urine sample.
   - If there is thrombocytopenia or a falling haemoglobin, investigations for disseminated intravascular coagulation (coagulation studies, blood film, LDH, fibrinogen).
3. Patients with severe early onset pre-eclampsia warrant investigation for associated conditions e.g. systemic lupus erythematosus, underlying renal disease, antiphospholipid syndrome or thrombophilias. The timing of these investigations will be guided by the clinical features.
4. Although a very rare disorder, undiagnosed phaeochromocytoma in pregnancy is potentially fatal and may present as pre-eclampsia.[37,38] Measurement of fasting plasma free metanephrines/normetanephrines or 24 hour urinary catecholamines should be undertaken in the presence of very labile or severe hypertension.
   Subsequent management will be based on the results of ongoing blood pressure measurement and these investigations (Tables 1 and 5).

Amongst women referred for assessment of new onset hypertension, a number will have normal blood pressure and investigations. These women are considered to have transient or labile hypertension. Repeat assessment should be arranged within 3-7 days as many will subsequently develop pre-eclampsia.

Table 1: Ongoing investigation of women with hypertension in pregnancy

	Modality	**Frequency**
Chronic Hypertension	Urinalysis for protein Preeclampsia bloods	Each visit If sudden increase in BP or new proteinuria
Gestational Hypertension	Urinalysis for protein Preeclampsia bloods	1 - 2 x per week Weekly
Preeclampsia	Urinalysis for protein Preeclampsia bloods	At time of diagnosis: If non-proteinuric, repeat daily Twice weekly or more frequent if unstable

6. MANAGEMENT OF PRE-ECLAMPSIA AND GESTATIONAL HYPERTENSION

Pre-eclampsia is a progressive disorder that will inevitably worsen if pregnancy continues. Current therapy does not ameliorate the placental pathology nor alter the pathophysiology or natural history of pre-eclampsia. Delivery is the definitive management and is followed by resolution, generally over a few days but sometimes much longer. At mature gestational age, delivery should not be delayed. Even so, it is important to control severe hypertension and other maternal derangements before subjecting the woman to the stresses of delivery.

Prolongation of pregnancy in the presence of pre-eclampsia carries no benefit for the mother but is desirable at early gestations to improve the fetal prognosis as in general, fetal outcome is proportional to gestational age at delivery. In cases of preterm pre-eclampsia before 34 weeks, delivery should be delayed for at least 24-48 hours if maternal and fetal status permit, to allow fetal benefit from antenatal corticosteroids administered for lung maturation. A number of trials[39-42] have shown that 25-30% of women managed expectantly with pre-eclampsia will develop severe morbidity including HELLP syndrome, abruption, pulmonary oedema and eclampsia and that the mean duration of prolongation is less than 12 days. Continuation also carries fetal risk and some stillbirths will occur despite careful monitoring.[43] These trials have excluded women with the “HELLP” variant of pre-eclampsia and with other evidence of severe morbidity.

The management of women with pre-eclampsia between gestational ages of 24-32 weeks should be restricted to those centres with appropriate experience and expertise. Clear “endpoints” for delivery should be defined for each patient (Table 2), such that the decision to terminate the pregnancy is based on agreed criteria. In many cases, the timing of delivery will be based upon a number of factors, maternal and/or fetal rather than a single absolute indication for delivery.

A team approach, involving obstetrician, midwife, neonatologist, anaesthetist and physician provides the best chance of achieving a successful outcome for mother and baby. Regular and ongoing reassessment of both the maternal and fetal condition is required. Careful daily assessment for clinical symptoms and signs should be complemented by regular blood and urine tests as indicated (Table 1 and 5).

Table 2: Indications for delivery in women with pre-eclampsia or gestational hypertension

Maternal	Fetal
Gestational age ≥ 37 weeks	Severe fetal growth restriction
Inability to control hypertension	Non-reassuring fetal status
Deteriorating platelet count	
Deteriorating liver function	
Deteriorating renal function	
Placental abruption	
Persistent neurological symptoms Eclampsia	
Persistent epigastric pain, nausea or vomiting with abnormal liver function tests	
Acute pulmonary edema	

The only controlled studies of bed rest for pre-eclampsia have shown no significant maternal or fetal benefit.(44) However, admission to hospital allows close supervision of both mother and fetus as progress of the disorder is unpredictable. Outpatient monitoring may be appropriate in milder cases after a period of initial observation.

6.1 Hypertension

6.1.1 Acute Treatment of Severe Hypertension

Antihypertensive treatment should be commenced in all women with a systolic blood pressure ≥ 170 mm Hg or a diastolic blood pressure ≥ 110 mm Hg because of the risk of intracerebral haemorrhage and eclampsia.(45) Whilst there is no controlled trial to determine how long severe hypertension may be left untreated, it is recommended that treatment be administered promptly aiming for a gradual and sustained lowering of blood pressure.

Drugs for the treatment of very high blood pressure in pregnancy have been the subject of a Cochrane review which concluded that no good evidence exists that any short acting antihypertensive is better than another.(46) Several rapidly acting agents are available to control severe hypertension (Table 3).

There is concern that a precipitous fall in blood pressure after antihypertensive treatment, particularly intravenous hydralazine, may impair placental perfusion resulting in fetal distress. This can be prevented by co-administration of a small bolus of fluid e.g. normal saline 250ml at the time of administration of antihypertensive therapy.(52) Continuous CTG monitoring should be considered in these situations, particularly when there is evidence of existing fetal compromise. However, fetal distress as a result of such treatment is rare.

Table 3: Acute blood pressure lowering for severe hypertension (47-51)

	Dose	Route	Onset of action
Labetalol	20-50 mg	IV bolus over 2 minutes	5 mins, repeat after 15-30 mins
Nifedipine	10-20 mg	Oral	30-45 mins, repeat after 45 mins
Hydralazine[5]	5-10 mg	IV bolus	20 mins, repeat after 30 mins
Diazoxide	15-45 mg, max 300mg	IV rapid bolus	3-5 mins, repeat after 5 mins

[5] See appendix 1 for principles and method of administration of intravenous hydralazine for severe hypertension in pregnancy

Persistent or refractory severe hypertension may require repeated doses of these agents or even an intravenous infusion of labetalol 20-160 mg/hr or hydralazine 5-10 mg/hr, titrated to the blood pressure response. The concurrent administration of longer acting oral agents (see Table 4) will achieve a more sustained blood pressure lowering effect. Infusions of sodium nitroprusside or glyceryl trinitrate are also effective but are recommended rarely, e.g. when other treatments have failed and delivery is imminent. Sodium nitroprusside may cause fetal cyanide and thiocyanate toxicity and transient fetal bradycardia. Such infusions may be considered with intra-arterial blood pressure monitoring in a high dependency care environment if the usual medications have failed to control the blood pressure, but only so as to effect safe operative delivery and not for prolonged use.

The most important consideration in choice of antihypertensive agent is that the unit has experience and familiarity with that agent. It is recommended that protocols for the management of severe hypertension should be readily accessible in all obstetric units.

6.1.2 Ongoing Treatment for Hypertension

Treatment of hypertension in pregnancy does not cure pre-eclampsia but is intended to prevent cerebral haemorrhage and eclampsia and perhaps delay progression of proteinuria. Uncontrolled hypertension is a frequent trigger for delivery and control of hypertension may allow prolongation of pregnancy. There is controversy regarding the need to treat mild to moderate hypertension in women with pre-eclampsia. In favour of treatment is the fact that blood pressure may be extremely labile in pre-eclampsia and treatment at lower blood pressure levels will prevent or attenuate acute and severe rises in blood pressure. In addition, it is possible that pharmacologic arteriolar vasodilatation may help improve organ perfusion. Arguments against treatment include that there is little risk to the mother in having relatively mild hypertension for a short time (usually only a few days or at the most weeks), that fetal perfusion is dependent upon adequate maternal blood pressure and that lowering blood pressure suppresses an important sign of the severity or progression of pre-eclampsia.

There is as yet no controlled trial of the treatment of mild to moderate hypertension in pregnancy, although a pilot trial of such a study has been completed.[53] One small Australian placebo-controlled randomised study examined the role of antihypertensive therapy in the management of mild hypertension.[54] Placebo-treated women were delivered significantly earlier, mainly as a result of severe hypertension or premonitory signs of eclampsia, and there was more neonatal morbidity secondary to prematurity.

In the absence of compelling evidence, treatment of mild to moderate hypertension in the range 140-160/90-100 mm Hg should be considered an option and will reflect local practice. Above these levels, treatment should be considered mandatory.

In terms of lowering blood pressure in pre-eclampsia, a number of drugs have demonstrated safety and efficacy (Table 4). First line drugs include methyldopa, labetalol and oxprenolol.[55-57] Second line agents are hydralazine, nifedipine and prazosin.[58-61] Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers are contraindicated in pregnancy. Their use in the third trimester has been associated with fetal death and neonatal renal failure. All of the drugs in Table 4 along with enalapril, captopril and quinapril are considered compatible with breastfeeding.[62]

It is important to control severe hypertension at any gestation and post partum. Induction of labour or Caesarean section does not control hypertension even though delivery begins the process of resolution of pre-eclampsia. Thus, antihypertensive medication will usually be required even when delivery has been arranged.

6.1.3 Summary

The intention in treating mild to moderate hypertension is to prevent episodes of severe hypertension and allow safe prolongation of the pregnancy for fetal benefit. It is reasonable to consider antihypertensive treatment when systolic blood pressure reaches 140-160 mmHg systolic and/or 90-100 mmHg diastolic on more than one occasion. If the blood pressure exceeds these levels, antihypertensive therapy should be commenced in all women. In view of this uncertainty, each Unit should develop protocols for the management of hypertension and regularly monitor and audit their outcomes.

Table 4. Guidelines for selecting antihypertensive drug treatment in pregnancy

Drug	Dose	Action	Contraindication	Practice points
Methyl dopa	250-75mg tds	Central	Depression	Slow onset of action over 24 hour. Dry mouth, sedation, depression, blurred vision.
Clonidine	75-300 µg tds			Withdrawal effect with clonidine
Labetalol	100-400mg tds	β blocker with mild alpha vasodilator effect	Asthma, chronic airways limitation	Bradycardia, bronchospasm, headache, nausea, scalp tingling which usually resolves within 24-48 hours (labetalol only)
Oxprenolol	20-160mg tds	β blocker with ISA	Heart block	
Nifedipine	20mg bd– 60mg SR bd	Ca channel antagonist	Aortic stenosis	Severe headache associated with flushing, tachycardia
				Peripheral edema, consipation
Prazosin	0.5 - 5mg tds	α blocker		Flushing, headache, nausea, lupus-like syndrome
Hydralazine	25-50 mg tds	Vasodilator		Flushing, headache, nausea, lupus-like syndrome

6.2 Treatment of Other Manifestations

6.2.1 Thromboprophylaxis

Pre-eclampsia is a risk factor for thrombosis, particularly in the presence of additional risk factors such as obesity, age above 35 years, previous thrombotic event, family history of thrombosis, nephrotic range proteinuria or likely inpatient stay more than a few days.[63] When women are admitted for observation in hospital they will usually be relatively immobile and graduated compression stockings should be considered, with or without prophylactic low molecular weight heparin (LMWH). Postnatal thromboprophylaxis should be administered to women with pre-eclampsia except where there is a surgical contraindication. Units should have clear protocols to deal with the timing of LMWH administration in regard to the insertion and withdrawal of epidural and spinal cannulae.[64]

6.2.2 Intravenous Fluids

Although maternal plasma volume is often reduced in women with pre-eclampsia[65] there is no maternal or fetal benefit to maintenance fluid therapy.[66] Administration of fluid at a rate greater than normal requirements should only be considered for:

1. Women with severe pre-eclampsia immediately prior to parenteral hydralazine, regional anaesthesia or immediate delivery.
2. Initial management in women with oliguria where there is a suspected or confirmed deficit in intravascular volume.

As vascular permeability is increased in women with pre-eclampsia[67] administration of large volumes of intravenous fluid before or after delivery may cause pulmonary oedema and worsen peripheral oedema. This tendency is further aggravated by hypoalbuminaemia. Appropriate blood product replacement is necessary when there has been haemorrhage, as in cases of placental abruption.

Post-partum oliguria is a regular accompaniment of pre-eclampsia and care must be taken to avoid its over-treatment. Persistent oliguria beyond 24 hours post-partum with rising plasma creatinine suggests the possibility of post partum renal failure. There is no evidence that fluid manipulation is able to prevent this rare complication.

Monitoring in a high dependency care unit is ideal for these cases because of the risk of pulmonary oedema as mentioned above. Invasive monitoring should only be considered when there is developing renal failure or pulmonary oedema. In view of the reduced plasma volume in most women with pre-eclampsia, diuretics should not be used in the absence of pulmonary oedema.

6.2.3 Eclampsia

Eclampsia complicates 1 in 200-300 cases of pre-eclampsia in Australia. There are no reliable clinical markers to predict eclampsia and conversely, the presence of neurological symptoms and/or signs is rarely associated with seizures.[68] Seizures may occur antenatally, intra-partum or postnatally, usually within 24 hours of delivery but occasionally later. Hypertension and proteinuria may be absent prior to the seizure and not all women will have warning symptoms such as headache, visual disturbances or epigastric pain.[69]

The further from delivery that the seizure occurs, the more carefully should other diagnoses be considered. Cerebral venous thrombosis in particular may occur in the first few days of the puerperium. It should be remembered that eclampsia is not the commonest cause of seizures in pregnancy and the differential diagnosis includes epilepsy and other medical problems that must be considered carefully, particularly when typical features of severe pre-eclampsia are lacking.

Management of eclampsia
Comprehensive protocols for the management of eclampsia (and severe hypertension) should be available in all appropriate areas. There are four main aspects to care of the woman who sustains eclampsia.

1. Resuscitation:
Resuscitation requires institution of intravenous access, oxygen by mask, assuring a patent airway and removing regurgitated stomach contents from the mouth/pharynx. These seizures are usually self-limiting. Intravenous diazepam (2mg/minute to maximum of 10mg) or clonazepam (1-2mg over 2-5 minutes) may be given whilst the magnesium sulphate is being prepared if the seizure is prolonged.

2. Prevention of further seizures
Following appropriate resuscitation, treatment should be commenced with magnesium sulphate heptahydrate (4g over 10-15 minutes) followed by an infusion (1-2g/hr).[6] In the event of a further seizure, a further 2-4g of magnesium sulphate heptahydrate is given IV over 10 minutes. Magnesium sulphate is usually given as an intravenous loading dose although the intramuscular route is equally

[6] See Appendix 2 for magnesium sulphate infusion notes and example infusion protocols

effective. Monitoring should include blood pressure, respiratory rate, urine output, oxygen saturation and deep tendon reflexes. Magnesium sulphate heptahydrate by infusion should continue for 24 hours after the last fit.[70,71] Magnesium sulphate is excreted renally and extreme caution should be used in women with oliguria or renal impairment. Serum magnesium concentration should be closely monitored in this situation. Magnesium is not universally successful and the recurrence rate of seizures despite appropriate magnesium therapy is 10-15%.[72]

3. Control of hypertension

Control of severe hypertension to levels below 160/100 mmHg by parenteral therapy is essential as the threshold for further seizures is lowered after eclampsia, likely in association with vasogenic brain oedema. In addition, the danger of cerebral haemorrhage is real.

4. Delivery

Arrangements for delivery should be decided once the woman's condition is stable. In the meantime, close fetal monitoring should be maintained. There is no role, with currently available treatment, for continuation of pregnancy once eclampsia has occurred, even though many women may appear to be stable after control of the situation has been achieved.

Prevention of eclampsia in the woman with pre-eclampsia

The drug of choice for the prevention of eclampsia is magnesium sulphate given as described above.[71] Although there is good evidence for the efficacy of this therapy, the case for its routine administration in women with pre-eclampsia in countries with low maternal and perinatal mortality rates is less than compelling. In some Units, the presence of symptoms or signs such as persistent headache, hyperreflexia with clonus, epigastric pain or severe hypertension are considered indications for prophylaxis with magnesium sulphate. It is appropriate for individual Units to determine their own protocols and monitor outcomes.

Hepatic and Haematological manifestations

Epigastric or right upper quadrant pain in a woman with pre-eclampsia often represents hepatic involvement. The pain responds poorly to analgesia but both the pain and associated increases in liver enzymes (AST, ALT) may subside (albeit temporarily) after blood pressure lowering, particularly with vasodilators. If the cause of epigastric or right upper quadrant pain is not clear, close ongoing assessment is required, with careful review of all indicators of maternal and fetal wellbeing (as above) and appropriate imaging of the liver and gallbladder.

Thrombocytopenia is the commonest hematologic abnormality seen in pre-eclampsia; the lower limit of the normal platelet count in pregnancy is approximately 140x109/L but the risk of spontaneous bleeding is not significantly increased until the count falls below 50 x 109/L. Even so, there are concerns with central neuraxial anaesthetic and analgesic techniques at higher levels (50-75 x 109 /L), and surgical bleeding may be increased even with moderate thrombocytopenia.

Platelet transfusion is the only rapidly effective treatment for severe thrombocytopenia and this may be necessary at the time of Caesarean delivery or in the case of postpartum haemorrhage, wound or vulval hematoma or other bleeding as sometimes occurs in these cases. Fresh frozen plasma may be required for management of coagulopathy indicated by active bleeding and a prolonged APTT and INR. In this setting, fibrinogen levels should also be measured and cryoprecipitate administered if levels are low.

Steroid therapy (other than for fetal lung maturation) is not indicated for the management of thrombocytopenia or hepatic dysfunction in women with pre-eclampsia.[73] These abnormalities recover spontaneously postpartum within a few days of delivery, without specific treatment.[74-77] If abnormalities worsen or show no improvement after 72 hours post partum, differential diagnoses such as thrombotic thrombocytopenic purpura or antiphospholipid syndrome should be considered, and appropriate therapy instituted.

7. FETAL SURVEILLANCE

Adverse perinatal outcome is increased in women with all subcategories of hypertensive disease in pregnancy as compared to normotensive women.[78] The increase in adverse outcomes is greatest in those with early gestation at onset of disease, severe hypertension and/or chronic hypertension with superimposed pre-eclampsia.[78-80] Although fetal surveillance is commonly recommended and performed in women with hypertensive disease in pregnancy[6,81] there is no established consensus on how this should be performed.[82,83] Frequency, intensity, and modality of fetal evaluation will depend on individual pregnancy (maternal and fetal) characteristics. Individual obstetric units should devise their own protocols for monitoring the fetus in pregnancies complicated by hypertension. In compiling such protocols, the following issues should be considered.

1. Accurate dating of pregnancy is important for women with chronic hypertension or those at high risk of pre-eclampsia.
2. Symphysis-fundal height measurement is a poor screening tool for detection of fetal growth restriction (FGR).[84] Therefore, ultrasound should be performed by an experienced operator to assess fetal size, amniotic fluid volume and umbilical artery Doppler flows in such women. Assessing growth trends by serial ultrasound is recommended if pregnancy continues.
    1. Umbilical artery Doppler flow is the only fetal surveillance modality that has been shown by systematic review to reduce the need for fetal interventions, improve neonatal outcome and predict adverse perinatal outcome.[85,86] Severe early onset FGR should be monitored at institutions experienced in advanced fetal Doppler waveform analysis. Absent or reversed end diastolic flow is unlikely to occur within 7-10 days after a normal umbilical artery Doppler waveform analysis. Umbilical artery Doppler flow studies have limited value after 36 weeks gestation.
    2. Although numerous observational studies have suggested improved outcome in the high-risk pregnancy monitored using protocols that included Biophysical Profile, cardiotocography, and combinations of both[87-89], none of these has shown significant benefit in systematic reviews.[90,91]
    3. No fetal testing can predict an acute obstetric event such as placental abruption or cord accident.
    4. Fetal Surveillance via a Day Assessment Unit is associated with good perinatal outcome in women with various obstetric complications, including women with well controlled hypertension.[92]
    5. An appropriately grown fetus in the third trimester in women with well-controlled chronic hypertension without superimposed pre-eclampsia generally is associated with a good perinatal outcome. Fetal monitoring using methods other than continued surveillance of fetal growth and amniotic fluid volume in the third trimester is unlikely to be more successful in preventing perinatal mortality/morbidity.

Table 5 demonstrates commonly used international and national protocols for fetal surveillance in women with hypertensive disease in pregnancy where immediate delivery is deferred. None of these protocols has been tested in prospective randomised trials, thus they are based only on the opinion and experience of the authors. As pre-eclampsia is an ever changing and unpredictable disease, for those women where expectant management is employed, the frequency and modality of fetal surveillance should be adjusted based on the current maternal and/or fetal condition. Each obstetric unit should develop an agreed institutional approach to fetal surveillance and/or fetal medicine referral.

Table 5. Protocol for fetal surveillance in women with hypertension in pregnancy

Hypertension	Modality	Frequency
Chronic Hypertension	Early dating ultrasound Ultrasound for fetal growth/AFV/Doppler	First trimester 3rd trimester: 4 - weekly
Gestational Hypertension	Ultrasound for fetal growth/AFV/Doppler	At time of diagnosis and 3 - 4 weekly
Preeclampsia	Ultrasound for fetal growth/AFV/Doppler Cardiotocography	At time of diagnosis and 2 - 3 weekly Twice weekly
Preeclampsia with FGR	Cardiotocography Doppler/AFV/Fetal growth	Twice weekly On admission and 2 weekly

7.1 Antenatal Corticosteroid Administration

Contrary to popular belief, accelerated fetal lung maturation does not occur in pre-eclampsia.[93] A systematic review has shown that a single course of antenatal corticosteroid given to women expected to deliver preterm reduces the risk of neonatal death, respiratory distress syndrome, cerebrovascular haemorrhage, necrotizing enterocolitis, respiratory support, and intensive care admission.[94] This systematic review showed that infants born to pregnancies complicated by hypertension syndromes treated with corticosteroids had significantly reduced risk of neonatal death, RDS, and cerebrovascular haemorrhage. There is insufficient evidence to support antenatal corticosteroids for those pregnancies that have reached 34 weeks gestation.[94] A recent randomized trial demonstrated a small benefit of antenatal corticosteroids to mothers undergoing a term (37 to 39 weeks gestation) elective Caesarean section.[95] In women with hypertensive disorders of pregnancy undergoing planned Caesarean section after 34 weeks gestation, urgent delivery should not be delayed for the benefits of corticosteroid therapy.

The administration of further courses of corticosteroid in women who remain undelivered and still at risk of preterm birth after an initial course of corticosteroids remains controversial. Until further studies are completed and published, repeated doses of corticosteroids should not be prescribed routinely. If they are considered necessary, the protocol described by Crowther et al[96,97] should be employed.[98]

8. RESOLUTION OF PRE-ECLAMPSIA

After delivery, all clinical and laboratory derangements of pre-eclampsia recover, but there is often a delay of several days, and sometimes longer, in return to normality. On the first day or two after delivery, liver enzyme elevations and thrombocytopenia will often worsen before they reverse. Hypertension may persist for days, weeks or even up to three months and will require monitoring and slow withdrawal of antihypertensive therapy. Resolution is still assured if the diagnosis was pre-eclampsia and there is no other underlying medical disorder. The woman and her family are often overwhelmed and distressed from their experience and appropriate counselling post partum should include psychological and family support.

All women who develop pre-eclampsia and gestational hypertension are at risk of these disorders in future pregnancies and should receive appropriate counselling before embarking upon another pregnancy.

9. MANAGEMENT OF CHRONIC HYPERTENSION IN PREGNANCY

Hypertension affects up to 20% of the Australian adult population, the prevalence increasing with age.[99] Many women of child-bearing age are hypertensive, and of the 10 to 12% of pregnancies affected by elevated blood pressure levels, at least one in five is related to chronic hypertension.[100,101] The diagnosis can be difficult in women whose blood pressure before pregnancy or early in the first trimester is unknown. Very rarely pre-eclampsia can present before 20 weeks' gestation and the physiological fall in blood pressure in the second trimester can obscure pre-existing chronic hypertension.

Women with chronic hypertension have an increased risk of accelerated hypertension in the third trimester, superimposed pre-eclampsia, fetal growth restriction, placental abruption, premature delivery and stillbirth. These events are seen more often in women who develop pre-eclampsia and are not correlated with actual blood pressure levels.[55,68,102-107] The exception to this appears to be uncontrolled hypertension in the first trimester when later fetal and maternal morbidity and mortality are markedly increased.[108] Other indicators of poor prognosis include a failure of blood pressure to normalize in the second trimester, the presence of secondary hypertension, a history of longstanding severe hypertension, and concurrent cardiovascular and/or renal disease.

The woman with chronic hypertension, whether essential or secondary, should be observed frequently during pregnancy by an obstetrician and by a physician familiar with the management of hypertension in pregnancy.

9.1 Investigation

A detailed history, physical examination and appropriate laboratory and cardiac testing are essential in seeking a possible cause for hypertension and to ascertain end-organ damage if present.

Investigation of hypertension presenting prior to 20 weeks gestation:

- All patients:
  - Urinalysis for protein, blood and glucose. If proteinuria is evident on dip-stick analysis, a spot urine protein:creatinine ratio.
  - Microscopy of centrifuged urinary sediment for white and red blood cells (including red cell morphology) and for casts.
  - Mid-stream urine culture.
  - Measurement of serum electrolytes, creatinine, uric acid and blood glucose.
  - Full blood examination.
  - ECG.
- Selected patients:
  - Renal Ultrasound should be considered, particularly if the hypertension is severe.
  - Fasting free plasma metanephrines or 24-hour urine collection for estimation of catecholamine excretion if there is concern regarding a possible phaeochromocytoma. At least two consecutive collections are advised.

9.2 Clinical and laboratory monitoring

Because women with chronic hypertension are at high risk of developing pre-eclampsia, close monitoring for its maternal and fetal manifestations is necessary. In addition to standard antenatal care, the following additional monitoring is indicated:

- Monitoring for signs of superimposed pre-eclampsia after 20 weeks gestation.
- Assessment for proteinuria at every visit.
- Laboratory assessment (as above) if worsening hypertension or proteinuria.
- Assessment of fetal growth and wellbeing (Table 5).

Admission to hospital or to a day assessment unit is recommended for women with worsening hypertension or proteinuria at any stage of pregnancy. This enables assessment of maternal and fetal welfare and facilitates discussion amongst all involved in the woman's care. When necessary, pharmacological treatment may be commenced under close supervision.

9.3 Antihypertensive therapy

The continued administration or initiation of antihypertensive therapy in women with chronic hypertension in pregnancy (except for the acute treatment of severe hypertension) remains controversial. Most women manifest a physiological fall in blood pressure in the first half of pregnancy that may allow withdrawal or a reduction of antihypertensive medication. Although treatment of chronic hypertension is associated with a significant reduction in severe hypertension, it has not been shown to alter the risk of superimposed pre-eclampsia, preterm delivery, placental abruption or perinatal death.[109-111]

There is insufficient evidence upon which to base a definite recommendation for the levels of blood pressure at which antihypertensive drug treatment should commence. We recommend that such treatment should definitely be started when the blood pressure consistently reaches or exceeds 160 mmHg systolic and/or 100 mmHg diastolic.

Treatment at BP levels between 140 and 160 mmHg systolic and/or 90 - 100 mmHg diastolic is also common practice, with good documented outcomes. It is therefore reasonable to treat with antihypertensive medications at these levels, but not below these levels. In the third trimester of pregnancy an increase in the requirement for antihypertensive therapy should be anticipated. The drugs used for treatment of chronic hypertension are the same as those recommended for pre-eclampsia and gestational hypertension (Table 4).

Atenolol and other highly selective beta blocker drugs are not recommended for prolonged use in pregnancy as they have been associated with fetal growth restriction.[57,112-113] The use of ACE-inhibitors and angiotensin receptor blockers is contraindicated in pregnancy. They have been associated with an increased risk of fetal, particularly cardiovascular, malformations in early pregnancy in one study and are known to cause adverse sequelae for the fetus in late pregnancy.[114] Diuretics, although not teratogenic, may restrict the natural plasma volume expansion of pregnancy and are not recommended for the treatment of hypertension.

9.4 Post partum management of women with chronic hypertension

In many women with chronic hypertension or superimposed pre-eclampsia, blood pressure is unstable for 1-2 weeks after delivery and may be difficult to control. It may be particularly high on the third to the sixth day after delivery and it is often necessary to increase or commence antihypertensive medication at that time. All of the agents mentioned earlier are compatible with breast feeding, as are the ACE inhibitors enalapril, captopril and quinapril.

9.5 Chronic hypertension with superimposed pre-eclampsia

As already mentioned, the main risk of chronic hypertension in pregnancy is the development of superimposed pre-eclampsia in the second half of pregnancy which occurs in about 20% of women. This is of considerable concern as the risks to both mother and fetus are greater than those of chronic hypertension alone. Management of superimposed pre-eclampsia should be as outlined above for pre-eclampsia unless specific diagnostic issues, such as some secondary causes of hypertension, are present.

10. ANAESTHETIC CONSIDERATIONS IN HYPERTENSIVE DISORDERS OF PREGNANCY

Whenever possible an anaesthetist should be informed about a woman with severe pre-eclampsia well prior to labour or operative delivery, because appropriate anaesthetic management is associated with reduction in both fetal and maternal morbidity.[115] Relevant issues include anaesthetic risk assessment, blood pressure control, fluid management, eclampsia prophylaxis, and planning of analgesia or anaesthesia.[116-119]

10.1 Fluid management

Fluid management is a challenging area in pre-eclampsia and there is no clear evidence regarding optimal type or volume of fluid.[119,120] Fluid therapy aims to maintain organ perfusion in the setting of vasoconstriction, endothelial dysfunction and in some parturients severe left ventricular diastolic dysfunction. Intravenous fluid should be administered incrementally in small volumes (e.g. crystalloid 250 mL) with monitoring of maternal haemodynamics, urine output and fetal heart rate, because overhydration contributes to maternal mortality from pulmonary oedema and adult respiratory distress syndrome.[121] Particular caution is necessary in women with oliguria, renal impairment or pulmonary oedema, in whom the left ventricle may adapt less well to volume load.[122] Fluid loading is not mandatory prior to regional analgesia during labour when low-dose local anaesthetic and opioid methods are used.[123] Prior to regional anaesthesia intravenous crystalloid loading is ineffective in preventing hypotension but colloid is effective.[124] Treatment or prevention of hypotension with drugs such as phenylephrine or metaraminol is effective and appears safe in pre-eclamptic women.[125,126]

10.2 Anaesthetic technique

10.2.1 Vaginal delivery

For labour and delivery, epidural analgesia is a useful adjunct to antihypertensive therapy for blood pressure control and improves renal and uteroplacental blood flow. When relatively contraindicated (e.g. severe thrombocytopenia, coagulopathy or sepsis), fentanyl or remifentanil patient-controlled intravenous analgesia is preferred. Although ephedrine usually does not cause rebound hypertension[127] occasionally vasopressors and epidural adrenaline (epinephrine) cause worrisome blood pressure elevation. Other drugs that are best avoided in severe pre-eclampsia include ergometrine[128], ketamine (hypertension); and the non-steroidal anti-inflammatory drugs and COX-2 specific inhibitors (impaired renal function and hypertension). Oxytocin should be given slowly in small doses to minimise its significant hemodynamic effects.[101]

10.2.2 Caesarean section

Unhurried preoperative preparation reduces the risk of anaesthesia in women with pre-eclampsia.[128] Regional anaesthesia is preferred to general anaesthesia (GA) for caesarean section (CS), especially as airway problems including laryngeal oedema may be increased.[129-131] However, well-conducted GA is also suitable[132,133] and may be indicated in the presence of severe fetal compromise; pulmonary oedema; hemodynamic instability; intraspinal haematoma risk (e.g. placental abruption; severe thrombocytopenia); or after eclampsia where altered consciousness or neurological deficit persists.

Emergency CS confers increased maternal morbidity, so early anaesthetic notification by the obstetrician and in-utero resuscitation provide additional time for assessment, planning and establishment of regional anaesthesia. When a well-functioning epidural catheter is in situ, GA is achieved only marginally more rapidly than conversion to epidural anaesthesia.[134,135] Prophylaxis against pulmonary aspiration is recommended using clear antacid and ranitidine, with or without metoclopramide. Skilled anaesthetic assistance is mandatory, as is left lateral tilt on a pelvic displacement wedge or table tilt to minimise aortocaval compression.

Attenuation of pressor responses at general anaesthesia for caesarean section
Laryngoscopy and tracheal intubation present a particularly dangerous time for the pre-eclamptic woman, especially if the intracranial pressure is elevated or the blood pressure is inadequately controlled.[128] The transient but severe hypertension that usually accompanies intubation can cause myocardial ischemia, cerebral haemorrhage or pulmonary oedema, all being important causes of maternal death.[121,128] Attenuation of this pressor response is best achieved with additional induction drugs such as remifentanil 1 mcg/kg[136,137] or magnesium sulphate 40 mg/kg or 30 mg/kg with alfentanil 7.5 mcg/kg.[138] Neuromuscular block must always be monitored closely after intravenous magnesium administration.[139] Lignocaine (lidocaine) 1.5 mg/kg is less effective[137] and fentanyl 2.5-10 mcg/kg or alfentanil 10 mcg/kg of slower onset.[140] Other drug options are beta-blockers (e.g. esmolol)[141], hydralazine, glyceryl trinitrate, sodium nitroprusside and diazoxide.

Regional anaesthesia for caesarean section and pre-eclampsia
All the regional anaesthetic techniques (spinal, epidural or combined spinal-epidural) appear safe provided meticulous attention is paid to fluid management, preventing aortocaval compression and dealing with hypotension.[116,119] Spinal anaesthesia with usual doses is now a recommended technique.[119,142,143] Cardiac output is well maintained and it is associated with less hypotension and lower vasopressor requirements than among healthy parturients.[144] Combined spinal-epidural anaesthesia appears to offer further advantages in specific cases.[119]

Low dose aspirin therapy is not a contraindication to regional techniques, which in the absence of bleeding are considered safe when the platelet count is > 75 x 109/L.[145] Platelet counts of < 50 x 109/L are generally considered a contraindication. Within the range 50-75 x 109/L an individual assessment (considering patient risks; coagulation tests and thermoelastography or platelet function if available) and risk reduction strategies (experienced operator; single-shot spinal anaesthesia or flexible tip epidural catheter) are encouraged.

10.3 Critical Care

10.3.1 Admission to an Intensive Therapy Unit

Anaesthetists form an important part of the critical care team. Women who develop organ failure require intensive monitoring and medical management, either within a high dependency or intensive care setting. Indications for admission to an intensive therapy unit include severe pulmonary oedema or sepsis; intractable hypertension; anuria or renal failure; repeated convulsions; massive blood loss with disseminated intravascular coagulation; neurological impairment requiring ventilation (e.g. intracerebral haemorrhage or infarction; cerebral oedema); and critical intra-abdominal pathology (e.g. acute fatty liver; liver or arterial aneurysm rupture; adrenal haemorrhage).

10.3.2 Invasive monitoring

Direct intra-arterial blood pressure monitoring is often useful, including during anaesthesia and operative delivery. However, establishing an arterial line should not delay treatment for acute severe hypertension. Central venous pressure correlates poorly with pulmonary capillary wedge pressure and although it may provide trend monitoring it is infrequently used to complement clinical indicators of intravascular volume.[146] Some recommend pulmonary artery catheters for assessment of left ventricular preload[147] but they can cause serious complications and are not of proven outcome benefit in pre-eclampsia. The increasing use of echocardiography and pulse contour or pulse power algorithms for cardiac output monitoring appears promising.[119]

11. PRECONCEPTION MANAGEMENT AND PROPHYLAXIS FOR WOMEN AT RISK OF PRE-ECLAMPSIA

11.1 Recurrence and prevention of pre-eclampsia

It is likely that development of pre-eclampsia requires a combination of underlying susceptibility and a triggering event. Many susceptibility factors for pre-eclampsia have been identified (see Table 6) but to date no accurate predictive tool, using either clinical or laboratory markers, has been developed.[148] Such a tool applied early in pregnancy would allow intervention that might modify outcomes.

A number of other factors are also associated with an increased risk of pre-eclampsia including chronic hypertension, pre-existing renal disease, autoimmune disease, > 10 years since previous pregnancy, short sexual relationship prior to conception, other thrombophilias e.g. Factor V Leiden and possibly periodontal disease.[148]

Table 6: Risk factors associated with pre-eclampsia[149]

Risk Factor	Relative risk [95%CI]
Previous history of preeclampsia	7.19 [5.85, 8.83]
Antiphospholipid antibodies	9.72 [4.34, 21.75]
Pre-existing diabetes	3.56 [2.54, 4.99]
Multiple pregnancy	2.91 [2.04, 4.21]
Nulliparity	2.91 [1.28, 6.61]
Family history of pre-eclampsia	2.90 [1.70, 4.93]
Elevated BMI > 25	2.47 [1.66, 3.67]
Maternal Age ≥ 40	1.96 [1.34, 2.87]
Diastolic BP ≥ 80 mmHg at booking	1.38 [1.01, 1.87]

11.2 Recurrence of pre-eclampsia

Studies of the risk of recurrent pre-eclampsia in women with a history of a hypertensive pregnancy disorder in a prior pregnancy show variable results. A number of factors appear to influence this risk including severity and gestation at onset of the initial episode and the presence of additional maternal risk factors such as chronic hypertension or diabetes. Recurrence rates vary from 6% to 55% with the greatest risk in women with early onset pre-eclampsia and chronic hypertension.[150] Data from one Australian centre suggest that women with pre-eclampsia have an overall 14% risk of pre-eclampsia and the same risk of developing gestational hypertension in their next pregnancy.[151]

11.3 Preventing pre-eclampsia

A number of agents have been studied for their ability to reduce the risk of pre-eclampsia and improve maternal and fetal outcomes. These include antiplatelet agents, vitamins, calcium and heparin.

Antiplatelet agents

Prophylactic therapy with antiplatelet agents has been the subject of a large number of studies and various statistical reassessments. They demonstrate that the use of aspirin in doses between 50-150mg daily is associated with a reduction in the recurrence rate of pre-eclampsia, delivery prior to 34 weeks as well as preterm birth and perinatal death. There was a reduction in the rate of small-for-gestational age (SGA) infants but this failed to reach statistical significance. Risk reduction was greater if the antiplatelet agent was started before 20 weeks and if doses > 75mg were taken. Of importance, there was no difference in the rate of bleeding complications such as antepartum and postpartum haemorrhage or placental abruption between treatment and placebo groups.

In translating these results into clinical practice, the underlying risk of pre-eclampsia in the population being treated must be taken into consideration. If the baseline risk is 8%, treating 114 women will prevent one case of pre-eclampsia. In a population with a 20% risk of pre-eclampsia, the number needed to treat to prevent one case of pre-eclampsia is 50. In view of this potential benefit, and the relative absence of maternal or neonatal complications, low dose aspirin is indicated for the secondary prevention of pre-eclampsia in women at increased risk. In most cases, aspirin may be ceased at 37 weeks gestation although continuation beyond this period is not unsafe.(152)

Calcium supplements

The use of calcium supplementation has been demonstrated to reduce the risk of pre-eclampsia, particularly in high risk women and those with low dietary calcium intake. However there was no significant effect on fetal and neonatal outcomes including preterm birth, low birth weight, fetal growth restriction, stillbirth or death before discharge from hospital. Calcium supplementation (1.5g/day) should therefore be offered to women at increased risk of pre-eclampsia, particularly in those women with a low dietary calcium intake.(153)

Other therapies

Randomised, placebo controlled trials of antioxidants Vitamins C and E failed to demonstrate any significant effect on the incidence of pre-eclampsia. Of concern, a number of adverse effects were seen including an increased risk of stillbirth and of birthweight < 2.5kg but there were fewer fetal deaths due to immaturity. Prophylactic antioxidant therapy with vitamins C and E is therefore not recommended.(154,155)

To date, there are no large randomised trials assessing the effect of heparin with or without aspirin in prevention of pre-eclampsia.(156) As discussed above, women with thrombophilias have an increased incidence of pre-eclampsia and there has been enthusiasm for prophylactic treatment with anticoagulants, particularly low molecular weight heparin, with or without aspirin. Other than in the specific case of antiphospholipid antibody syndrome, there is no randomised study to support this practice.(157)

Recent observational studies have suggested that supplementation with multivitamins containing folic acid during pregnancy is associated with a reduced risk of pre-eclampsia. Folic acid may reduce the risk of pre-eclampsia by improving placental and systemic endothelial function or by lowering blood homocysteine levels. Randomized, controlled trials are still required to address this potential therapy.(158,159)

Preconception counselling for women with chronic hypertension

Ideally, the woman with pre-existing hypertension and/or renal disease should be seen, investigated and a diagnosis established prior to a planned pregnancy. This also allows discussion of the potential risks and estimation of the prognosis. Women with significant prenatal renal dysfunction (serum creatinine $\geq$ 130 μmol/L) should have the risks of perinatal morbidity/mortality and of deterioration of their underlying renal disease fully explained at this time.(160) Antihypertensive drugs contra-indicated in pregnancy such as angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers and diuretics may be ceased and more appropriate therapy instituted. In women with mild-moderate chronic hypertension, the physiological fall in blood pressure that occurs in the first half of pregnancy may allow the discontinuation of antihypertensive therapy, at least temporarily.

12. AUDITING OUTCOMES IN WOMEN WITH HYPERTENSIVE DISORDERS OF PREGNANCY

The preceding guidelines aim to optimise the outcome of pregnancies complicated by pre-eclampsia and other hypertensive disorders of pregnancy. To quantify these outcomes, it is appropriate for all hospitals managing such patients to monitor and review their outcome data. Rigorous data collection is required to ensure the reliability of reported results. Strict diagnostic criteria for the diagnosis of pre-eclampsia/eclampsia, gestational hypertension and chronic hypertensive disorders should be utilised as defined in this document.

13. LONG-TERM CONSEQUENCES OF HYPERTENSIVE DISORDERS OF PREGNANCY

Women who have been diagnosed with either pre-eclampsia or gestational hypertension are at increased risk of subsequent cardiovascular morbidity including hypertension and coronary heart disease. A recent systematic review and meta-analysis[162] determined that the relative risks for hypertension were 3.70 after 14 years follow-up, for ischemic heart disease 2.16 after 12 years, for stroke 1.81 after 10 years, and for venous thromboembolism 1.87 after 5 years. Overall mortality after pre-eclampsia was increased 1.5 fold after 14 years.

These associations are likely to reflect a common cause for pre-eclampsia and cardiovascular disease, or an effect of pre-eclampsia on vascular disease development, or both. It is reasonable to counsel patients who develop hypertension in pregnancy that they will benefit from avoiding smoking, maintaining a healthy weight, exercising regularly and eating a healthy diet. It is recommended that all women with previous pre-eclampsia or hypertension in pregnancy have an annual blood pressure check and regular (5 yearly or more frequent if indicated) assessment of other cardiovascular risk factors including serum lipids and blood glucose.

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APPENDIX 1: PRINCIPLES AND METHOD OF ADMINISTRATION OF INTRAVENOUS HYDRALAZINE FOR SEVERE HYPERTENSION IN PREGNANCY

IV Hydralazine	
AIM: to achieve a gradual reduction in blood pressure to safe levels (90mmHg diastolic), rather than a precipitate drop. ***NOTE: the risk of sudden hypotension can be greater in women with a contracted plasma volume***.	
TRADE NAME: **PRESENTATION:** **INCOMPATIBILITIES:**	Apresoline® 20mg ampoule aminophylline, ampicillin, hydrocortisone, sulphadiazine, dextrose diluents
DOSE:	• Hydralazine 5mg as an intravenous bolus. • Repeat if necessary at 20 minute intervals, up to a maximum of 3 doses.
CONCOMITANT ANTIHYPERTENSIVE THERAPY:	• Continue existing oral antihypertensive therapy and review dose regimen; **OR** • If conscious, commence oral antihypertensive therapy (such as clonidine, labetalol or oxprenolol) in addition to the intravenous hydralazine
Persistent hypertension despite 3 boluses of IV hydralazine 5mg may be due to a compensatory reflex tachycardia:	***if heart rate < 125bpm:*** • Commence hydralazine infusion of 10mg/hr. • Load 50 mg of IV hydralazine into 50ml of normal saline (not glucose sol.); • Run the infusion through an infusion pump at a rate of 10ml/hr; • Increase rate by 5ml/hr every 15 minutes until blood pressure is controlled. ***if heart rate > 125 bpm:*** • Give oral clonidine, labetalol or oxprenolol in addition to hydralazine infusion
MATERNAL and FETAL OBSERVATION AND MONITORING	• Continuous CTG throughout administration of hydralazine and until BP is stable (30 minutes after the last dose); • Record BP (Mercury sphygmomanometer, Korotokoff V) and pulse every 5 minutes after each bolus dose; • Continue 5 minute BP and pulse until stable, thence measure hourly; • Record BP every 15 minutes for the first hour of a continuous infusion, thence measure hourly if stable.

APPENDIX 2: MAGNESIUM SULPHATE HEPTAHYDRATE INFUSION NOTES AND EXAMPLE INFUSION PROTOCOLS

Indications for magnesium sulphate infusion:

1. seizure prophylaxis in a woman who has already had an eclamptic seizure;
2. seizure prophylaxis in a woman with severe pre-eclampsia who is at risk of eclampsia (although the efficacy for this is less certain).

Relative contraindications:

NOTE: Magnesium sulphate can be extremely hazardous in the following circumstances:

- renal failure, severe renal compromise or if oliguria is present (magnesium concentration can reach toxic levels as elimination is predominantly renal). Half dose magnesium sulphate should be considered if there is renal compromise;
- in association with hypocalcaemic states;
- myasthenia gravis;
- cardiac conditions, in particular conduction problems or myocardial damage.

Other considerations:

Magnesium sulphate:

- may lower blood pressure (secondary to vasodilatation). Dose of any current antihypertensive medication may require adjustment;
- may have some tocolytic effect;
- may decrease fetal heart rate variability;
- may cause loss of reflexes (patellar reflexes will be absent well before toxic serum levels of magnesium are reached);
- should be used with caution in the presence of calcium antagonists or other respiratory depressants (e.g. valium).

Common maternal side effects:

- Sensation of pain and warmth in arm;
- Flushing of hands, face and neck;
- Nausea.

Signs of maternal toxicity:

- Loss of patellar reflexes;
- Respiratory rate < 10;
- Slurred speech, weakness, feeling extremely sleepy, double vision;
- Muscle paralysis;
- Respiratory/cardiac arrest.

Antidote for magnesium toxicity:

Calcium chloride or calcium gluconate (10ml of 10% solution) by slow intravenous injection over 3 minutes.

Protocol for magnesium sulphate heptahydrate (MgS04) infusion:

- Administration of magnesium sulphate heptahydrate should always be via an infusion pump;
- The intravenous line should not be used to inject other drugs;
- Presentation of magnesium sulphate is most commonly a 50% solution in 5mls of H20.
- Undiluted this is 10mmol of magnesium in 5mls, or a 2mmol per ml solution. Magnesium sulphate is administered intravenously or intramuscularly. Intravenous doses should be diluted to a concentration of magnesium 20% or less.

N.B. Pre-mixed solutions of magnesium sulphate heptahydrate are commercially available for infusion pump use. These preparations are preferred as pre-mixed solutions confer considerable safety benefits over manually prepared solutions. In the event that a maternity service elects not to use pre-mixed solutions, a drug protocol for the manual mixing of the solutions should be developed and approved by the local drug committee. This should then be available and clearly communicated to all staff involved in the use of magnesium sulphate heptahydrate solutions.

- Recommended loading dose: 4 grams (16 mmol) MgS04 heptahydrate over 15-30mins.
- Maintenance infusion: 1gram/hour for at least 24 hours.

Care and observations during infusion
Close observation and assessment (maternal and fetal) is required for the duration of the infusion. Where patient condition is unstable, the frequency of observation will need to be increased.
Routine observations:

- 1-2 hourly recording of maternal blood pressure, respiratory rate, heart rate and urine output. (Cease infusion if respiratory rate is < 10 per minute or if urine output is < 80mls over four hours);
- Patellar reflexes at completion of loading dose and then 2 hourly. (Cease infusion if unable to elicit reflexes.);
- Fetal heart rate monitoring as clinically indicated;
- Serum magnesium levels may be measured 60 minutes after commencing the infusion and thereafter as clinically indicated. Normal therapeutic levels are 1.5-3.5 mmol/L. (Blood for serum levels should not be collected from the limb receiving the infusion.)

<table>
<tr><th colspan="2">Example 1: Mixing solution for infusion pump use</th></tr>
<tr><td>1. Loading Dose

4g MgS04 (50% solution) diluted in Normal Saline via infusion pump over 20-30 minutes
• Using a 500ml flask of Normal Saline, run 100ml into a burette;
• Add 8ml (4g) of MgS04 (50% solution) to the 100ml of Normal Saline in the burette;
• Infuse over 20-30 minutes via infusion pump.</td><td>2. Maintenance Infusion

1 gram MgS04 (50% solution) per hour via infusion pump
• Remove 20ml N/Saline from the N/S remaining in the flask and discard.
• Add 20ml (10g) of MgS04 (50% solution) to the remaining 380ml flask of Normal Saline;
• Infuse at 40mls (1g) per hour via infusion pump;
• Run maintenance infusion for at least 24hours.</td></tr>
<tr><th colspan="2">Example 2: Premixed commercial solution (8 grams Magnesium Sulphate in 100 mls water for injection)</th></tr>
<tr><td>1. Loading Dose

50 mls (4 grams) Magnesium Sulphate premixed solution (8 grams magnesium sulphate heptahydrate in 100 mls water for injection; each 100 mls contains approximately 32 millimoles magnesium and 32 millimoles sulphate)
• Infuse over 15 – 30 minutes</td><td>2. Maintenance Infusion

12.5 mls (1 gram) Magnesium Sulphate premixed solution (8 grams magnesium sulphate heptahydrate in 100 mls water for injection; each 100 mls contains approximately 32 millimoles magnesium and 32 millimoles sulphate) per hour
• Infuse at 12.5 mls per hour</td></tr>
<tr><th colspan="2">Example 3: Premixed commercial solution (40 grams Magnesium Sulphate in 500 mls water for injection)</th></tr>
<tr><td>1. Loading Dose

50 mls (4 grams) Magnesium Sulphate premixed solution (40 grams magnesium sulphate heptahydrate in 500 mls water for injection; each 500 mls contains approximately 162 millimoles magnesium and 162 millimoles sulphate)
• Infuse over 15 – 30 minutes</td><td>2. Maintenance Infusion

12.5 mls (1 gram) Magnesium Sulphate premixed solution (40 grams magnesium sulphate heptahydrate in 500 mls water for injection; each 500 mls contains approximately 162 millimoles magnesium and 162 millimoles sulphate) per hour
• Infuse at 12.5 mls per hour</td></tr>
</table>

CARE PATHWAY FOR WOMEN CONCERNED ABOUT FETAL MOVEMENTS (GL2021_019)

GL2021_019 rescinded GL2020_017

GUIDELINE SUMMARY

The Guideline will assist clinicians and women to understand the importance of responding to the woman's concerns about fetal movements in a singleton pregnancy. It aims to improve clinical care and standardise management of concerns about fetal movements, to optimise pregnancy outcomes and reduce maternal anxiety.

KEY PRINCIPLES

This Guideline outlines the clinical principles and key actions that will support evidenceinformed practices and improvement in maternity services.

Fetal movements are a reliable indicator of fetal wellbeing. Maternal perception of decreased fetal movements is associated with adverse pregnancy outcomes.

The woman's concerns about fetal movements override any definition of DFM. These concerns may include decreased frequency of movements, changed quality of movements or absent movements.

This Guideline aligns the Perinatal Society of Australia and New Zealand (PSANZ) *Clinical practice guideline for the care of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks' gestation* (2019), with additional clarification for the NSW context.

The care of a woman concerned about fetal movements from 25 weeks to 28 weeks gestation should use the same care pathway as for a gestation greater than 28 weeks.

Care planning for the fetus less than 25 weeks gestation should be in consultation with a specialist obstetrician or a maternal fetal medicine specialist.

USE OF THE GUIDELINE

The Chief Executives of local health districts are responsible to ensure maternity services have processes in place to:
Routinely provide verbal and written information to pregnant women about normal fetal movements at each point of contact during the antenatal period. This will include actions to take in the event of concerns about fetal movements.
Guide management, escalation and transfer of care if necessary, for women reporting concerns about fetal movements, in line with the relevant Policies and Guidelines.

Implement the Perinatal Society of Australia and New Zealand *Clinical practice guideline for the care of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks' gestation* (2019) in the NSW context (see Appendix 1).

The complete Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_019

MATERNITY – Rh (D) IMMUNOGLOBULIN (ANTI-D) (GL2015_011)

GL2015_011 rescinds GL2014_017 which rescinded PD2006_074.

PURPOSE

This guideline provides direction to NSW maternity service providers, emergency departments and general practitioners regarding the care of rhesus (Rh) (D) negative women and the use of Rh (D) Immunoglobulin (Anti-D).
Rh (D) Immunoglobulin is used as prophylaxis treatment and or treatment for potential sensitising events for Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation).

KEY PRINCIPLES

All pregnant women should be typed for ABO and Rh (D) as early as possible during each pregnancy.
All Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation), should be provided with information both verbal and written on their rhesus status and Rh (D) Immunoglobulin.
All Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation), should be offered Rh (D) Immunoglobulin prophylactically and or for potential sensitising events.
All Rh negative women should sign the consent/decline to treatment form.

USE OF THE GUIDELINE

The guideline for the use of Rh (D) Immunoglobulin should be used by general practitioners and all staff working in NSW Health Maternity Services or Emergency Departments who are providing care to Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation).

- Midwives
- Nurses
- Obstetricians
- Medical Officers
- General Practitioners

To download the Guidelines please go to
http://www.health.nsw.gov.au/policies/gl/2015/GL2015_011.html

INVESTIGATION, REVIEW AND REPORTING OF PERINATAL DEATHS
(PD2022_046)

PD2022_046 rescinds PD2022_026

POLICY STATEMENT

The NSW Health is committed to review maternal and perinatal morbidity and mortality in the State, through the Perinatal Mortality Review committee (PMRC). The PMRC is a subcommittee of the NSW Maternal and Perinatal Mortality Review Committee (MPMRC), constituted under *Health Administration Act* 1982.

SUMMARY OF POLICY REQUIREMENTS

All NSW Health Services must report and review all perinatal deaths that meets its definition.

Perinatal deaths are defined as stillbirths (fetal deaths) and deaths of infants within the first 28 days of life (neonatal deaths).

Stillbirths include fetuses weighing at least 400 grams or having a gestational age of 20 weeks. Neonatal deaths comprise all deaths of liveborn babies within 28 days of birth, regardless of gestational age at birth.

Perinatal deaths must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047) as set out in section 3 Reportable Incident Brief and Appendix D Reportable Incident Definition.

The investigation review and classification of perinatal deaths is based on the Perinatal Society of Australia and New Zealand (PSANZ) *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death* to support a systematic approach to the provision of care.

Each Maternity service is to have a process in place to undertake clinical reviews and the classification of perinatal deaths. These reviews include analysis through a local perinatal morbidity and mortality committee. The chairperson of the committee is responsible for ensuring timely reporting of death classifications to the Clinical Excellence Commission.

From March 1st, 2022, following a review by the local perinatal mortality review committee, all perinatal mortality reports must be submitted to the Clinical Excellence Commission via local public hospital maternity database systems (eMaternity or CernerMaternity).

Private hospitals may access the Clinical Excellence Commission online form for reporting perinatal deaths.

The Clinical Excellence Commission access the reports quarterly and after the completion of a calendar year. Perinatal deaths for the previous year are to be completed by April 1st in the following year.

1. BACKGROUND

Australia is one of the safest places in the world for a baby to be born, yet every day in Australia 6 babies are stillborn and 2 die within 28 days of birth (neonatal death). Each year in NSW over 800 perinatal deaths impact women, families and the healthcare workers providing their care.

Investigation to determine the cause of death and identify contributing factors is important for both families and maternity services to ensure best practice and inform care in future pregnancies. Review of perinatal deaths by hospital and health services is a key opportunity for clinical staff to engage in the processes of patient safety and quality improvement.

Reporting of perinatal deaths on a state-wide basis allows for benchmarking and assessment of trends that inform system improvement.

In all cases of stillbirth and neonatal death, staff are to provide a supportive and safe environment to minimise the stress and trauma parent(s) and family experience.

1.1 About this document

This document describes the procedures for investigation, review, classification and reporting of perinatal deaths to the Clinical Excellence Commission (CEC) and the NSW Perinatal Mortality Review Committee (PMRC).

1.2 Key definitions

Perinatal Period	Pregnancy at or after 20 weeks gestation up to the first 28 days after birth.
Perinatal Death	Perinatal deaths comprise stillbirths (fetal deaths) and deaths of infants within the first 28 days of life (neonatal deaths). Stillbirths are defined to include fetuses weighing at least 400 grams or having a gestational age of 20 weeks. Neonatal deaths comprise all deaths of liveborn babies within 28 days of birth, *regardless* of gestational age at birth.

1.3 Legal and legislative framework

The NSW Perinatal Mortality Review Committee (PMRC) is a subcommittee of the NSW Maternal and Perinatal Mortality Review Committee (MPMRC), The NSW MPMRC is constituted under Section 20 of the *Health Administration Act* 1982. It has special privilege and is authorised to conduct investigations and research in accordance with section 23 of the *Health Administration Act* 1982.

The members are appointed by the Minister for Health to review maternal and perinatal morbidity and mortality in the State.

2. NSW PERINATAL MORTALITY REVIEW COMMITTEE

The primary purpose of the NSW Maternal and Perinatal Mortality Review Committee is to subject all maternal and perinatal deaths occurring in NSW for peer review. For information relating to the committee, please refer to its Terms of Reference.

The function of the NSW Perinatal Mortality Review Committee in relation to perinatal deaths occurring in NSW is to:

- Review aggregate data on perinatal deaths and identify groups of perinatal deaths which, through detailed inquiry, may provide information for the development of policies designed to reduce perinatal morbidity and mortality
- Identify risk trends or issues of safety and clinical practice which may have contributed to these deaths and/ or any potentially preventable factors
- Provide advice and feedback to the health system with recommendations to impr3ove maternal, neonatal and child health outcomes through annual reports and clinical alerts.

3. INVESTIGATION OF PERINATAL DEATH

Investigation of stillbirths and neonatal deaths is based on the National Perinatal Society of Australia and New Zealand (PSANZ) *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[2] to support a systematic approach to the provision of care.

PSANZ recognises that increased risk of perinatal death exists in Aboriginal and Torres Strait Islander women, some cultural groups and disadvantaged women.

All care is to be culturally responsive, including the provision of Aboriginal Liaison Services, interpreters, religious and cultural supports as required, and private spaces for discussions.

It is recommended that all clinicians providing maternity and newborn care complete the Improving Perinatal Mortality Review and Outcomes Via Education (IMPROVE) e-learning educational program.

3.1 PSANZ Investigation of Stillbirths

A non-selective approach according to the recommended core investigations is to be adopted for all stillbirths (unless the cause of death has been unequivocally determined antenatally).

Core investigations include:

- Comprehensive maternal (medical, social, family) and pregnancy history
- Kleihauer-Betke test/ Flow cytometry for fetal to maternal haemorrhage
- External examination of the baby performed by a trained clinician
- Clinical photographs of the baby
- Autopsy should be discussed and offered for all unexpected intrauterine fetal deaths/stillbirths (as per the definition in 1.2)
- Detailed macroscopic examination of the placenta and cord
- Placental histopathology
- Cytogenetics (Chromosomal microarray (CMA) or karyotype if CMA is not available).

Further sequential and/ or selective investigations must be undertaken according to the clinical scenario based on a comprehensive history, and information gained from core investigations (PSANZ *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*, Appendix A, Stillbirth Investigation Algorithm).

It is recommended that a trained clinician examine the baby to determine the presence of any possible congenital anomalies (refer to PSANZ *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*, Appendix D, Clinical examination of baby checklist).

This is particularly important where a post-mortem examination has been declined by the family following an informed consent process.

3.2 PSANZ Investigation of Neonatal Deaths

It is not feasible to a have a standardised investigation list that accommodates all neonatal death scenarios. Decisions regarding appropriate investigations must be made by the clinical team in consultation with the parents, based on the individual circumstances and accessing additional specialist expertise as required.

Obstetric and neonatal care teams must collaborate closely to ensure that all relevant maternal (pregnancy and birth) and neonatal factors are considered in the investigation of the neonate.

Recommended core investigations relevant to all neonatal deaths:

- Comprehensive maternal (medical, social, family) and pregnancy history
- Comprehensive neonatal history (including death scene analysis)
- A detailed external examination of the baby
- Accurate anthropometric parameters of birth weight, length and head circumference plotted on appropriate gender specific birth growth charts.
- Newborn screening blood sample
- Autopsy should be discussed and offered to parents in all cases of a neonatal death.

3.3 Perinatal Autopsy Including Placental Assessment

The perinatal autopsy remains the gold standard in diagnostic evaluation of the causes of perinatal death.[3] An autopsy can assist to:

- Identify an accurate cause of death
- Exclude some potential causes of death
- Identify disorders that have implications for counselling and monitoring in future pregnancies
- Provide other information related to the death, including excluding possibilities that may alleviate feelings of guilt
- Obtain tissues for genetic tests
- Assist grieving, by helping parents' understanding of the events surrounding the death.

Histopathological examination of the placenta is strongly recommended for all perinatal deaths. Consideration must be given to requests for return of the placenta for cultural reasons.

Pathology of the placenta, cord, or membranes may contribute to stillbirth in 11% to 65%of perinatal deaths.[4,5]

Consent for autopsy is ideally performed by an experienced senior clinician familiar to the family. The clinician must discuss:

- The value of the post-mortem examination
- Options for a full, or limited post-mortem examination
- The issue of retained tissues
- Implications for the timing of burial or cremation
- The possibility that the information gained may not benefit them but may be of benefit to others.

The NSW Health Perinatal Post-mortem Service provides support and information to both families and health professionals.

3.3.1 Alternatives to autopsy if declined

If permission for a full autopsy is not obtained, the following investigations are to be considered. Parents must be informed about the possibility of missing an important finding when a full autopsy is not undertaken:

- Formal external examination by pathologist
- X-ray (babygram)
- Clinical photographs
- Magnetic Resonance Imaging (MRI) in limited circumstances
- Small biopsy samples of a single organ via limited incision may be considered in the appropriate clinical setting
- Limited autopsy for focussed investigation of suspected abnormalities.

4. PERINATAL DEATH REVIEW COMMITTEES

Each Maternity service is to have a process in place to undertake clinical reviews and the classification of perinatal deaths. These reviews include analysis through a local perinatal morbidity and mortality committee.

Perinatal morbidity/ mortality review committees within maternity services provide a forum in which the cause of death, other adverse outcomes and their determinants are discussed.

Individual deaths are best reviewed by the local hospital or regional committees that include members who have had contact with the case. This has immediate benefits for participants in providing feedback and enables identification of possible avoidable factors that may be used to improve local services.

Guidelines for conducting Morbidity and Mortality meetings (M&Ms) can be accessed on the CEC website via CEC M&M meetings guidance.

4.1 Membership

Core membership of the committee includes:

- obstetric
- midwifery/nursing
- neonatology/paediatrics.

Additional membership may include representatives from:

- administration
- anaesthetics
- pathology
- clinical genetics
- pharmacy
- epidemiology/ statistics
- social work
- endocrinology/diabetes management
- general practice.

The committee is kept at a reasonable size to ensure a meaningful discussion of the cases can occur.

The chairperson of the committee is responsible for ensuring timely reporting of death classifications to the CEC. They must create a safe, open, and respectful atmosphere for open discussion and learning, allowing all members to contribute.

4.2 Function

The committee may function at hospital or Local Health District level. Maternity services that have insufficient staff to carry out a multidisciplinary review are encouraged to seek support and collaborate with other maternity services within the Tiered Perinatal Network.

Maternity services are authorised to disclose information from one service to another to support the review of perinatal deaths of babies born at their facility but who died elsewhere. This may include confidential sharing of information (results, discharge summaries) or an invitation to the referring site's morbidity/ mortality meeting for the relevant case presentation.

The perinatal morbidity/ mortality (M&M) committee will abide by principles of confidentiality and impartiality and:

- review all perinatal deaths occurring within the maternity service and perinatal deaths who died elsewhere; (where a death has occurred in a Children's Hospital or other maternity service, the service must ensure that the referral hospital is informed, in order to complete this review and provide details or attend M&M as necessary)
- classify perinatal deaths according to the PSANZ Perinatal Death Classification (PDC) and, where appropriate, the PSANZ Neonatal Death Classification (NDC)
- evaluate the circumstances surrounding the death including a consideration of contributing and avoidable factors
- based on such considerations, identify opportunities for improving processes of care, ensuring feedback to families and clinicians; and
- provide a confidential report to the CEC (see section 4 reporting).

5. REPORTING OF PERINATAL DEATHS TO THE CEC

Perinatal deaths must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047) as set out in the section 3 Reportable Incident Brief and Appendix D Reportable Incident Definition.

If the death is a sudden unexpected death in infancy (SUDI) this is a reportable death under the *Coroners Act* 2009 and management is as per the NSW Health Policy Directive *Management of Sudden Unexpected Death in Infancy (SUDI)* (PD2019_035).

5.1 Electronic Reporting Process

5.1.1 Public hospitals reporting

From March 1st, 2022, following a review by the local perinatal mortality review committee all perinatal mortality reports which include the PSANZ classification of death must also be electronically submitted by completing the perinatal death report in eMaternity or Cerner PowerChart Maternity.

The CEC will upload/ download the reports quarterly and after the completion of a calendar year.

5.1.2 Private hospitals reporting

From March 1st, 2022, following review by the local perinatal mortality review committee all perinatal mortality reports including the PSANZ classification of death, must be electronically submitted by completing an electronic form.

The link to the electronic form will be provided on a quarterly basis to private hospital maternity unit managers, or the person nominated by the maternity unit manager. If the electronic form is not accessible, a soft copy of the report must be submitted to the CEC (cec-patientsafety@health.nsw.gov.au).

5.1.3 Time Frame for reporting

Perinatal deaths for the previous year must be completed by April 1st in the following year.

5.1.4 Requests for information

For additional assistance or further information contact the CEC:
Phone: CEC Clinical Lead, Maternal and Perinatal Patient Safety, 02 9269 5500.
Email: cec-patientsafety@health.nsw.gov.au

6. REFERENCES

1. Centre for Epidemiology and Evidence. *New South Wales Mothers and Babies 2019*. Sydney: NSW Ministry of Health, 2021.
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FRAMEWORK FOR TERMINATION OF PREGNANCY IN NEW SOUTH WALES (PD2021_018)

PD2021_018 rescinds PD2021_001 and PD2019_048

POLICY STATEMENT

All NSW facilities in which termination of pregnancy services occur are to ensure they have in place protocols that are in accordance with the Abortion Law Reform Act 2019 (the Act).

SUMMARY OF POLICY REQUIREMENTS

The Policy Directive outlines the legal framework of the Act and associated legislation in relation to termination of pregnancy in NSW.

The Act allows a medical practitioner to undertake a termination of pregnancy on a woman who is not more than 22 weeks pregnant provided that (except in emergencies) informed consent has been obtained.

A termination of pregnancy for a woman who is more than 22 weeks pregnant must only be performed by a specialist medical practitioner at a hospital controlled by a local health district, statutory health corporation or approved health facility (ancillary services, tests or other medical procedures, or the administration, prescription or supply of medication, can be carried out in other places).

If termination of pregnancy is not provided within the local health district, statutory health corporation hospital or approved health facility, then local referral pathways must be developed to support the woman, so she has timely access to termination services.

Procedures for registered health practitioners who have a conscientious objection to termination of pregnancy who are asked to perform or assist in a termination of pregnancy or advise about the performance of a termination are provided.

Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must not** perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

Pre procedural considerations are defined and include counselling for a woman seeking a termination of pregnancy, assessment of the request related to pregnancy gestation and the requirement for informed consent. Post procedural considerations include examination and care of the woman and the fetus/baby.

In accordance with section 15 of the Act, termination of pregnancy must be notified to the Ministry of Health within 28 days. Refer to: www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-health-professionals.aspx for further information.

In addition to routine clinical notes concerning the care and treatment of the woman, her gestational age and weight, signs of life following a termination and the specialist medical practitioners involved in the procedure must also be documented.

Framework for Termination of Pregnancy in New South Wales: Procedure.

1 BACKGROUND

1.1 About this document

This Policy Directive provides a framework to support termination of pregnancy services in accordance with the *Abortion Law Reform Act 2019* (the Act). The Framework aims to provide clarity and safety for registered health practitioners providing terminations of pregnancy.

All facilities in which termination of pregnancy services occur must ensure they have protocols in place that are consistent with and address the content of this policy directive.

For the purpose of section 14 of the Act, the Health Secretary has approved this framework as a guideline that applies to hospitals controlled by local health districts, statutory health corporations and approved health facilities when providing termination of pregnancy services after 22 weeks gestation.

1.2 Key definitions

Approved health facility
A hospital or other facility approved by the Health Secretary under the Abortion Law Reform Act 2019.

Gestational age
The number of weeks of pregnancy calculated either from the last menstrual period or using ultrasound dating.

Sex-linked condition
A medical condition that is substantially more common in one sex than another.

Specialist medical practitioner
A medical practitioner who, under the Health Practitioner Regulation National Law, holds specialist registration in obstetrics and gynaecology.

This also refers to a medical practitioner who has other expertise that is relevant to the performance of termination of pregnancy, for example a general practitioner who has additional experience or qualifications in pregnancy care. This would include a medical practitioner who has qualifications from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and has pregnancy care in their scope of practice.

Termination of pregnancy
An intentional termination of pregnancy in any way, such as by administering a drug or using an instrument or other thing.

Woman
A pregnant person, regardless of age or identified gender.

Note: definitions used for the purposes of public health data collections such as the NSW Perinatal Data Collection, may differ from reporting requirements under the Births, Deaths and Marriages Registration Act 1995.

2 LEGAL CONTEXT

2.1 Abortion Law Reform Act 2019

In New South Wales, the law on termination is governed by the *Abortion Law Reform Act 2019.* The Act amended the Crimes Act 1900 to repeal the provisions of that Act relating to termination of pregnancy and to abolish the common law offences relating to termination of pregnancy.

The Act establishes a health regime that allows:

- medical practitioners to perform a termination of pregnancy
- certain registered health practitioners (nurses, midwives, pharmacists and Aboriginal and Torres Strait Islander health practitioners) to assist in performing a termination. Assisting a termination includes a pharmacist dispensing medication on prescription of a medical practitioner subject to the requirements of the Act.

The NSW Parliament has opposed the performance of termination of pregnancy for the sole purpose of sex selection. Refer to section 5 of this document.

It is an offence under the Crimes Act 1900 for an unqualified person to perform or assist in performing a termination of pregnancy.

Termination at not more than 22 weeks

The termination of a pregnancy equal to or less than 22 weeks gestation is a decision for the pregnant woman. The Act allows a medical practitioner to undertake a termination of pregnancy on a woman who is not more than 22 weeks pregnant provided that (except in emergencies) informed consent has been obtained. The medical practitioner must also assess whether it would be beneficial to discuss counselling with the woman.

Termination at more than 22 weeks

The decision for termination of pregnancy after 22 weeks is one between an individual woman and her treating specialist medical practitioner. A termination of pregnancy for a woman who is more than 22 weeks pregnant must only be performed:

- by a specialist medical practitioner
- at a hospital controlled by a local health district, statutory health corporation or approved health facility (ancillary services, being tests or other medical procedures or the administration, prescription or supply of medication, can be carried out in other places).

The specialist medical practitioner may request that the hospital or approved health facility make available a hospital advisory committee or multi-disciplinary team to provide advice about the proposed termination. The provision of advice from a multidisciplinary team is not a mandatory component of the assessment of request but serves to assist the treating practitioner in complex clinical situations.

The specialist medical practitioner may perform a termination of pregnancy if:

- the practitioner has obtained informed consent for the procedure
- the practitioner has provided all necessary information to the woman about access to counselling, including publicly funded counselling
- the practitioner considers that in all the circumstances there are sufficient grounds for the termination to be performed. This assessment is to be made after considering:
    - all relevant medical circumstances
    - the woman’s current and future physical, psychological and social circumstances
    - the professional standards and guidelines that apply to the practitioner in relation to termination of pregnancy
    - any advice received from the hospital advisory committee or multidisciplinary team.
- the practitioner has consulted with another specialist medical practitioner who also considers that in all the circumstances there are sufficient grounds for the termination to be performed. The second practitioner must also consider:
    - all relevant medical circumstances
    - the woman’s current and future physical, psychological and social circumstances
    - the professional standards and guidelines that apply to the practitioner in relation to termination of pregnancy.

In an emergency, to save the woman's life or the life of another fetus, any medical practitioner can perform a termination without meeting the above requirements.

2.2 Births, Deaths and Marriages Registration Act

Under section 12 of the *Births, Deaths and Marriages Registration Act 1995* ("the Registration Act"), a child born alive, irrespective of gestational age, must be registered as a birth. If the child subsequently dies, the death must also be registered and notified to the Registrar together with the cause of death in accordance with the Registration Act or alternatively reported to the Coroner.

Under the Registration Act, the term "birth" includes a "stillbirth", which means the birth of a "stillborn child" (a fetus of at least 20 weeks gestation or, if the gestational age is not known, having a body mass of at least 400 grams at birth). If the gestational age of the fetus is not accurately known, the weight of the fetus becomes relevant.

When notice of a stillbirth is given, the responsible person must also give a doctor's certificate certifying the cause of fetal death. No registration of "death" is required in respect of stillborn children.

2.3 Duty of care

This section outlines the legal responsibilities in relation to both adult and child patients in the context of termination of pregnancy.

2.3.1 Duty of care to the woman

A medical practitioner must exercise reasonable care and skill in the provision of professional advice and treatment to a woman undergoing a termination of pregnancy, as with all patients.

Except in an emergency, appropriate and adequate information must be provided to a woman considering a termination of pregnancy in order for her to make an informed choice about treatment.

2.3.2 Duty of care to the child

For the purposes of this section "child" refers to a child who has been expelled or removed from the woman's uterus alive. A fetus in utero is not recognised as a separate legal entity. However, once a fetus has been expelled or removed from the woman's uterus, and is born alive, the child has the legal status of a person whose rights exist independently of the rights of the parents.

Where a child is born alive, registered health practitioners have an obligation to work together with families to make medically appropriate and compassionate decisions. A medical practitioner is not obliged to provide medical treatment that is not in the child's best interest or treatment that is considered medically futile.

2.4 Coroners Act

"Death" in the *Coroners Act 2009* is to be construed in the same way as "death" in the Registration Act. The delivery of a fetus that "exhibits no sign of respiration or heartbeat, or other sign of life" (that is a stillbirth) after expulsion from the uterus is not a "death" for the purposes of the Coroners Act.

A fetus becomes a person if after expulsion or extraction from the woman and before being determined to be dead, signs of life are exhibited.

The reporting obligations are set out in the Coroners Act and NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054).

3 LOCAL CLINICAL PROTOCOLS

Local clinical protocols must be in place for all forms of termination of pregnancy procedures and will include pathways to access counselling for both women, their families and staff. These protocols must incorporate the roles and responsibilities of the relevant professional groups, the variety of medical and surgical procedures available and relevant product information including prescribing, administration, indication of use, contraindications, precautions, adverse reactions and drug interactions for those therapeutic agents used for such procedures.

Local protocols and information must align with the Act and be consistent with any information and guidelines approved by the Secretary, NSW Health.

4 CONSCIENTIOUS OBJECTION

Any registered health practitioner who is asked to perform, assist in or advise on a termination of pregnancy, and who has a conscientious objection to termination of pregnancy must inform the person who made the request that they have a conscientious objection to the performance of a termination of pregnancy and in a timely fashion.

In addition, if a registered health practitioner is asked to perform a termination, or advise about the performance of a termination, the practitioner must, without delay:

1. give information to the woman on how to locate or contact a medical practitioner whom they believe does not have a conscientious objection to the performance of the termination; or
2. transfer the woman's care to another registered health practitioner, or health service provider, who can provide the requested service and does not have a conscientious objection to the performance of the termination.

A registered health practitioner who has a conscientious objection may meet this requirement by providing the woman with the details of a NSW Health supported information service. This service must have capacity to provide information about medical practitioners who do not have a conscientious objection to the performance of termination; as well as general information and support services for reproductive and sexual health (up-to-date information for these services is available at www.health.nsw.gov.au/pregnancyoptions).

Public health organisations and approved health facilities have a duty of care to ensure that women seeking a termination receive timely, accurate information from a professional who does not hold an objection to the health service she seeks.

Any health practitioner having a conscientious objection to termination of pregnancy must notify their manager in a timely manner of their conscientious objection. Public health organisations must ensure that no person, either a woman or staff member is disadvantaged because of a conscientious objection to termination of pregnancy.

The exception to this is termination of pregnancy in emergency situations. Medical practitioners, midwives, nurses and other staff must perform a termination of pregnancy, or assist in the termination, in those rare emergency cases where it is necessary to preserve the life of the pregnant woman, regardless of their objection to termination of pregnancy.

5 TERMINATION OF PREGNANCY FOR THE SOLE PURPOSE OF SEX SELECTION

These procedures relate to when a termination of pregnancy is sought for the sole purpose of sex selection. These procedures to not apply to a termination due to the possibility of a sex-linked medical condition in the fetus.

Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must not** perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

These will often be complex clinical and/or ethical scenarios. In all cases, the woman's physical and psychological wellbeing must be the medical practitioner's priority. When a medical practitioner is uncertain about the degree of risk to the woman's health and safety arising from the refusal, further advice and support may be sought from either another medical practitioner, a multidisciplinary team, a hospital advisory committee or the local clinical ethics committee.

When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

Women can be referred to www.health.nsw.gov.au/pregnancyoptions to find the most upto-date information about the NSW pregnancy options helpline. The helpline provides unbiased, non-judgmental information on pregnancy options, including continuing a pregnancy, terminating a pregnancy and seeking pregnancy options counselling.

Further resources and guidance for women and health professionals can be found at: www.health.nsw.gov.au/pregnancyoptions

6 PRE-PROCEDURE ISSUES

6.1 Counselling

All women seeking a termination of pregnancy are to be offered counselling. This counselling does not replace but is additional to any genetic counselling that may be indicated.

In the context of an anomalous fetus, consideration needs to be given to the immediate and future implications of the range of genetic tests available. Testing may benefit women and their families in a number of ways, but it may also create dilemmas for the woman being tested and other members of their families that requires sensitive management. Pre-test and post-test counselling are an essential element of genetic testing.

Certain test results and fetal conditions must be reported to the NSW Register of Congenital conditions as set out in NSW Health Policy Directive *NSW Register of Congenital Conditions - Reporting Requirements* (PD2018_006). Where there is prenatal diagnosis using amniocentesis, chorionic villus sampling or fetal blood sampling it is recommended that where possible women are counselled face-to-face at least one day before the procedure. Counselling must address a clear and simple explanation of the probability of an affected fetus, explanation of the process of the procedure, options to be considered if the result is abnormal, acknowledgment of the individual nature of decisions about continuing or terminating the pregnancy and methods of termination of pregnancy.

If pre-termination counselling from an appropriately qualified health care professional occurs, documentation of the counselling must be included in the woman's healthcare record.

6.2 Assessment of request

The termination of a pregnancy equal to or less than 22 weeks gestation is a decision for the pregnant woman. The decision for termination of pregnancy after 22 weeks is one between an individual woman and her treating specialist medical practitioner.

For each proposed termination of pregnancy the following criteria must be considered and documented:

- the woman's physical and psychological condition
- accurate assessment of gestational age
- whether the termination is requested solely for the purpose of sex selection
- in cases of congenital condition, the diagnostic probability
- in cases of congenital condition, the prognosis for the fetus.

Except where there is an imminent threat to the life or physical health of a woman necessitating a termination as a matter of urgency, the following process (see 6.2.1 – 6.2.3) is to be followed.

6.2.1 Less than or equal to 14 weeks gestation

An appropriate health assessment is to be undertaken by the treating medical practitioner in consultation with the woman after appropriate counselling has been offered.

6.2.2 Between 14 weeks (+1 day) to 22 weeks (+0 days) gestation

The assessment of request is to be undertaken by the treating medical practitioner in consultation with the woman after appropriate testing and counselling has been offered and the results / reports provided to the treating practitioner. The treating practitioner may need to consult further with other relevant specialists as part of the assessment. If termination of pregnancy is not provided within the local health district, statutory health corporation hospital or approved health facility, then local referral pathways must be developed to support the woman, so she has timely access to termination services.

6.2.3 More than 22 weeks gestation

A termination of pregnancy on a woman who is more than 22 weeks pregnant must be performed by a specialist medical practitioner in an appropriate role delineated hospital controlled by a local health district or statutory health corporation that has the appropriate support services available for the procedure proposed, or an approved health facility.

Before performing the termination, the specialist medical practitioner must consider that there are sufficient grounds for the termination, after considering all the circumstances (including the medical circumstances and the woman's current and future physical, psychological and social circumstances and, if requested, any advice of a multidisciplinary team or hospital advisory committee).

The specialist medical practitioner must consult with another specialist medical practitioner who also, after considering all the circumstances, considers that there are sufficient grounds for the termination.

The decision of the treating specialist medical practitioner and the advice of the second specialist medical practitioner must be documented in the woman's file.

The specialist medical practitioner may request that the local health district or statutory health corporation hospital or approved health facility provide opportunity for a case conference with a multidisciplinary team or hospital advisory committee with a mix of skills and experience to provide advice to the treating medical practitioner so that they are able to undertake an informed assessment of request for termination of pregnancy.

The provision of a case conference or multidisciplinary team is not a mandatory component of the assessment of request but serves to assist the treating practitioner in complex clinical situations. The multidisciplinary team may include experts in the areas of psychiatry or specialist mental health, fetal medicine, neonatology and the other specialty or specialties relevant to the condition of the woman and fetus.

Such a multidisciplinary team or hospital advisory committee is neither a constituted ethics committee nor does it have clinical decision-making ability. Its sole purpose is to provide the treating specialist medical practitioner with advice of a clinical or technical nature. Consultation and advice are to be documented by the treating practitioner.

A termination of pregnancy at more than 22 weeks must (except in an emergency) be performed in a local health district or statutory health corporation hospital or approved health facility. However, ancillary services to the termination of pregnancy (being tests or other medical procedures and the administration, prescription or supply of medication) are not required to be carried out only at the hospital or approved health facility.

If termination of pregnancy is not provided within the local health district, statutory health corporation hospital or approved health facility then local referral pathways must be developed and operationalised to ensure the woman has timely access to termination of pregnancy services.

6.3 Patient information/informed consent

Women must be provided with sufficient information to be able to make their own decision about undergoing the termination (informed consent). This information will include treatment options, benefits, possible adverse effects or complications, and the likely result if the treatment is not undertaken.

A medical practitioner has a legal duty to warn a woman of any material risks to her physical or mental health from the proposed termination. Where applicable, the woman is to be informed of the potential for the baby to be born exhibiting signs of life and the implications should this eventuate.

Informed written consent from the woman is to be obtained by the treating medical practitioner before a termination of pregnancy is performed using the NSW Health *Consent for Medical Procedure/Treatment (Adults and Mature Minors) Form* which can be found in Attachment A of the NSW Health *Consent to Medical and Healthcare Treatment Manual (2020).*

Unless the woman lacks capacity, only her consent is required before a termination may be performed, not the consent of other family members, even though on many occasions the woman may choose to discuss the matter with other family members.

If the woman lacks capacity, informed consent can be obtained from the relevant substituted decision maker as outlined in section 7 of the NSW Health *Consent to Medical and Healthcare Treatment Manual (2020).* Health practitioners are to assume that women have capacity to consent to or refuse treatment unless there is evidence to contradict this assumption.

Further information about consent for pregnancy related procedures and refusal of recommended treatment is available in section 10.2 of the NSW Health *Consent to Medical and Healthcare Treatment Manual (2020).*

7 POST-PROCEDURE CARE

7.1 Care of the woman

Clinical guidelines must be in place regarding immediate post procedure care. This will include clinical observations and frequency required, and management of clinical emergencies in accordance with NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018).

The medical practitioner responsible for the care of the woman is to be informed of the completion of the procedure, the condition of the woman and, where relevant, the fetus/baby.

The woman must also receive appropriate post procedure information.
The woman's wishes regarding the fetus/baby must be respected and arrangements for viewing and handling of the baby are to accord with her wishes. If an autopsy is considered appropriate, the woman’s consent must be sought.

The woman must be informed of any further requirements that may be necessary, and provided with assistance in fulfilling these, for example, funeral arrangements and birth registration.

Counselling is to be offered to the woman, and as appropriate to the family, after the procedure. Information must also be provided regarding options for future contraception and support services available. A discharge plan is to be developed.

7.2 Care of the fetus/baby

7.2.1 Post-procedure examination and care

Health practitioners have a responsibility to deliver all aspects of healthcare in a compassionate, reasoned and ethical manner. Such responsibility applies to every interaction between a health practitioner and their patient, including post-procedure examination and care following a termination of pregnancy procedure.

Examination of the fetus/baby must occur immediately upon delivery. Where a medical termination of pregnancy results in a baby showing signs of life it is important that staff involved are aware of their responsibilities and duty of care toward the child. This includes assessment of the condition of the child at birth and any abnormalities present. If upon examination the condition of the child warrants further specialist examination, staff are to immediately consult a neonatologist.

Where a baby is born alive but medical consensus is that treatment (other than palliative treatment) would be over burdensome and of negligible benefit to the baby (futile), whether due to pre-viability, prematurity, the effect of a disease or condition or some other reason, the medical practitioner has no legal obligation to provide that treatment. Healthcare professionals have an obligation to work together with families to make compassionate decisions.

Any baby born with signs of life as a result of a termination of pregnancy, irrespective of gestation or condition, must be afforded the right of dignity, maintenance of privacy and physical comfort whilst signs of life exist. Parents are to be encouraged to be part of this care.

The requirements of the Registration Act are to be fulfilled. Refer to section 2.2 of this document.

8 NOTIFICATION TO NSW MINISTRY OF HEALTH

In accordance with section 15 of the *Abortion Law Reform Act 2019*, termination of pregnancy must be notified to the Ministry of Health within 28 days.

Information provided to the Ministry of Health must not include any particulars that would allow a woman to be identified. For further information on how to notify the Ministry of Health of a termination of pregnancy, refer to:
www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-health-professionals.aspx Births, perinatal deaths and certain congenital conditions are category 1 conditions under the *Public Health Act 2010* requiring separate notification to the Ministry of Health.

9 RECORDS MANAGEMENT

Health professionals are required to keep accurate health care records of patients. In addition to routine clinical notes concerning the care and treatment of the woman the following information must also be documented:

1. Gestational age/weight - gestational age is to be recorded where known, including the method used to calculate the gestational age. If appropriate, weight should be recorded.
2. Signs of life following a medical termination - where a medical termination is performed the extent and duration of any signs of life are to be recorded and what actions were taken.
3. The named specialist medical practitioner who organised the procedure (primary specialist) and the specialist medical practitioner who agreed with the decision to proceed to termination of pregnancy (secondary specialist).

10 RELATED DOCUMENTS

This Policy Directive is intended to be read in conjunction with the following NSW Health Policy Directives:

PD2007_066	Genetic Testing
PD2007_094	Client Registration Policy
PD2010_054	Coroners Cases and the Coroners Act 2009
PD2011_076	Deaths - Review and Reporting of Perinatal Deaths
PD2012_069	Health Care Records - Documentation and Management
PD2015_025	NSW Perinatal Data Collection (PDC) Reporting and Submission Requirements from 1 January 2016
PD2016_001	Donation, Use and Retention of Tissue from Living Persons
PD2017_013	Infection Prevention and Control Policy
PD2017_044	Interpreters - Standard Procedures for Working with Health Care Interpreters
PD2018_006	NSW Register of Congenital Conditions - Reporting Requirements
PD2020_011	Verification of Death and Medical Certificate of Cause of Death
PD2020_014	Tiered Networking Arrangements for Perinatal Care in NSW
PD2020_018	Recognition and Management of Patients who are Deteriorating
Consent to Medical and Healthcare Treatment Manual (2020)	

PREVENTION OF TERMINATION OF PREGNANCY FOR THE SOLE PURPOSE OF SEX SELECTION (GL2021_008)

GUIDELINE SUMMARY

This Guideline has been issued under s14 of the Abortion Law Reform Act 2019 for practitioners who perform termination of pregnancy in NSW and provides guidance for these practitioners when a termination of pregnancy is sought for the sole purpose of sex selection.

Under section 14 of the NSW Abortion Law Reform Act 2019 (the Act), a registered health practitioner performing a termination of pregnancy or assisting in the performance of a termination of pregnancy, must practice in accordance with this Guideline.

Further information can be found in NSW Health Policy Directive: *Framework for Termination of Pregnancy in New South Wales* (PD2021_018)

KEY PRINCIPLES

In NSW, the law on termination of pregnancy is governed by the Act. The Act amended the Crimes Act 1900 to repeal the provisions relating to termination of pregnancy and to abolish the common law offences relating to termination of pregnancy.

The NSW Parliament has opposed the performance of termination of pregnancy for the sole purpose of sex selection.

This Guideline relates to when a termination of pregnancy is sought for the sole purpose of sex selection. This Guideline does not apply to a termination due to the possibility of a sex-linked medical condition in the fetus.

Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must not** perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

These will often be complex clinical and/or ethical scenarios. In all cases, the woman's physical and psychological wellbeing must be the medical practitioner's priority.

When a medical practitioner is uncertain about the degree of risk to the woman's health and safety arising from the refusal, further advice and support may be sought from either another medical practitioner, a multidisciplinary team, a hospital advisory committee or the local clinical ethics committee.

When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

Women can be referred to www.health.nsw.gov.au/pregnancyoptions to find the most up-to-date information about the NSW pregnancy options helpline. The helpline provides unbiased, non-judgmental information on pregnancy options, including continuing a pregnancy, terminating a pregnancy and seeking pregnancy options counselling.

Further resources and guidance for women and health professionals can be found at: www.health.nsw.gov.au/pregnancyoptions

Notification to NSW Ministry of Health
In accordance with section 15 of the Act, all terminations of pregnancy must be notified to the NSW Ministry of Health within 28 days. Information provided to the Ministry must **not** include any particulars that would allow a woman to be identified.
For further information on how to notify the NSW Ministry of Health of a termination of pregnancy, refer to www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-healthprofessionals.aspx

USE OF THE GUIDELINE

This Guideline is intended for use by all termination of pregnancy providers in NSW in line with:

1. NSW Abortion Law Reform Act 2019
2. NSW Health Policy Directive *Framework for Termination of Pregnancy in New South Wales* (PD2021_018)
3. Preventing gender-biased sex selection: An Interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO

MATERNITY – RESUSCITATION OF THE NEWBORN INFANT (GL2018_016)

GL2018_016 rescinds PD2008_027

PURPOSE

This Guideline aims to optimise, facilitate and standardise newborn resuscitation by endorsing the Australian and New Zealand Committee on Resuscitation (ANZCOR) Guidelines - Section 13: Neonatal Guidelines (2016- 17)1 for use by NSW Health.

KEY PRINCIPLES

This Guideline applies to all clinicians who care for newborn infants in maternity and related environments and to the resuscitation of the newborn immediately following birth and during the birth admission.

USE OF THE GUIDELINE

This Guideline:

- replaces the Policy Directive PD2008_027 Maternity - Clinical Care and Resuscitation of the Newborn Infant
- endorses ANZCOR Guidelines (2016-2017) Section 13 - Neonatal guidelines 13.1-13.10 and the Newborn Life Support algorithm (Attachment 1)
- outlines local health district responsibilities to develop systems to ensure:
    - clinicians are appropriately targeted to complete mandatory and recommended newborn basic life support education, training and proficiency requirements
    - locally determined clinicians complete newborn advanced life support education, training and proficiency requirements, and are in attendance at the birth of newborn infants who are at higher risk of requiring resuscitation at birth
    - standardised newborn resuscitation equipment is available and operational and clinicians are familiar with the equipment
    - local procedures are in place to review resuscitation interventions and outcomes to monitor patient

To download the Guideline please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_016

POSTPARTUM HAEMORRHAGE (PPH) (GL2021_017)

GL2021_017 rescinds GL2021_010

GUIDELINE SUMMARY

This Guideline outlines the roles and responsibilities of NSW Health organisations and health practitioners in the prevention, early detection, escalation and management of postpartum haemorrhage (PPH). NSW Health places a high priority on health practitioners working collaboratively with woman and their families, as well as each other, throughout all phases of maternity care.

KEY PRINCIPLES

The key principles that support prevention, early detection, escalation and management of PPH include, identification of women with risk factors and the development of strategies to prevent and/or manage PPH. These strategies include prompt, appropriate clinical and pharmacological management of women experiencing a PPH, and development of a Maternity Massive Transfusion Protocol (MTP) for managing obstetric critical bleeding in local Maternity Services.

USE OF THE GUIDELINE

This Guideline is designed for use by NSW Health staff who are part of the maternity care team. This Guideline should form the basis for:

- Development and implementation of evidenced based local procedures and escalation plans for the prevention, detection, escalation and management of primary PPH that are aligned and consistent with this Guideline
- Provision of culturally safe and responsive maternity care services
- Access to education and training in relation to PPH for clinicians who may be required to care for women before, during and after birth. This may be mandatory or targeted education and training at the discretion of the health entity, based on its assessment of local needs.

To download the Postpartum Haemorrhage (PPH): Guideline please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_017

MATERNITY – TIMING OF PLANNED OR PRE-LABOUR CAESAREAN SECTION AT TERM (GL2016_015)

GL2016_015 rescinds PD2007_024

PURPOSE

The purpose of this document is to provide guidance for the timing of planned or pre-labour caesarean section at term. Where there are no identified maternal, fetal or obstetric risks, it is advised that a planned or pre-labour caesarean section at term should not routinely take place prior to 39 weeks gestation (39^{+0} weeks).

KEY PRINCIPLES

The risks of maternal and neonatal morbidity incurred by planned caesarean section birth prior to 39^{+0} weeks should be weighed carefully on a case by case basis, against the risks of spontaneous labour occurring prior to the planned procedure.

The risks of maternal and neonatal morbidity include a higher risk of neonatal respiratory distress syndrome, transient tachypnoea of the newborn, mechanical ventilation, transfer and admission to neonatal intensive care units, breastfeeding difficulties, increased maternal blood loss, and longer hospital stay.

Clinical decision-making about the timing of a planned caesarean section at term should follow a discussion with the woman and her family about the risks and benefits of all options for birth, and include information about the risks and benefits of birth after 39^{+0} weeks.

USE OF THE GUIDELINE

The Chief Executives of NSW PHOs are responsible for the implementation of this Guideline within their services / facilities to ensure that local protocols or operating procedures are in place, aligned and consistent with this Guideline. All maternity services staff should be aware of the Guideline and actively participate in its implementation.

To download the Maternity – Timing of Planned or Pre-Labour Caesarean Section at Term guideline please go to: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2016_015

MATERNITY - SAFETY AND QUALITY ESSENTIALS (PD2023_031)

PD2023_031 replaced PD2009_003

POLICY STATEMENT

NSW Health is committed to the implementation of safe, reliable, and resilient safety systems across all maternity services in NSW.

This Policy Directive outlines a clinical governance framework for maternity services, derived from the NSW Health Safety Systems Model and aligned with the National Safety and Quality Health Service (NSQHS) Standards.

SUMMARY OF POLICY REQUIREMENTS

Embedding Safety Strategically

All local health district (District) maternity services are to implement governance structures that promote safety and quality. Districts require managerial and clinical leadership positions that are responsible for operational and strategic aspects of maternity services. Regular monitoring, evaluation and reporting of the key deliverables assigned to maternity leadership positions are essential.

Collaborative agreements are required to enable shared leadership across the Tiered Perinatal Networks (TPN).

Consumers are to be supported and encouraged to be actively involved in maternity service activities.

Accountable Leadership and Culture

Accountable leadership plays a crucial role in driving improvements in safety and quality and extends beyond the sole responsibility of maternity leaders. Districts are required to:

- Ensure all staff are informed and aware of the importance of safety and quality, and their individual roles and responsibilities in safety improvement.
- Ensure safety and quality behaviour and capability is included in performance review discussions for all maternity staff.
- Implement the Clinical Excellence Commission Safety Culture Framework, undertake regular safety culture measurements, and utilise the Aboriginal Cultural Engagement Self-Assessment tool to ensure delivery of culturally safe and accessible maternity services for Aboriginal women and women having an Aboriginal baby (sections 3.1 Patient Safety Culture and 3.2 Organisational Safety Culture).
- Districts are required to ensure allocation of resources that support staff self-care and emotional and psychological support (section 3 Accountable Leadership and Culture).

Safety Governance

Districts are required to:

- Complete the Governance and Accountability in NSW Health Maternity Services – Self-Assessment Tool annually and associated monitoring and reporting (section 4 Safety Governance).
- Implement a clearly defined and documented governance structure (section 4.1 Maternity Safety Governance Structure).
- Establish multidisciplinary Maternity Safety and Quality Committees with clearly defined and articulated reporting lines.

Safety Intelligence

Districts are required to:

- Ensure the development, implementation and utilisation of a maternity safety and quality surveillance strategy and have dedicated data and analytics support and resources for maternity services (section 5.2 Data Surveillance Strategy).
- Ensure near real time data is accessible to clinicians to support women to make informed decisions through the continuum of their pregnancy, birth, and the postnatal period.

Safety and Improvement Capability

Ensuring safety and quality improvement capability requires Districts to have clear executive sponsorship, and a collective governance commitment across maternity services.

Districts are to ensure that the healthcare safety and quality capabilities are included in position descriptions for all maternity leadership positions, recruitment selection criteria, professional career development goals and to guide safety and quality capability development of other clinicians.

It is recommended that all District and facility maternity leaders complete the Safety and Quality Essentials Pathway.

Safety Improvement

Embedding safety and quality improvement as business as usual is pivotal to improving the safety and quality of maternity services.

Districts are required to implement a number of processes to achieve this including identifying quality improvement opportunities and having clear quality improvement goals, ensuring regular auditing processes, implementing morbidity and mortality review meetings, and disseminating outcomes and lessons learnt from these processes (section 7 Safety Improvement).

The full Maternity - Safety and Quality Essentials policy is available at:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_031

MATERNITY - MANAGEMENT OF EARLY PREGNANCY COMPLICATIONS
(PD2012_022)

PD2012_022 rescinds PD2009_058.

PURPOSE
This is a policy for maternity services with respect to the management of early pregnancy complications in Early Pregnancy Assessment Services (EPAS). It also acts as a guide as to what is deemed suitable for ambulatory management.

This policy provides information related to the diagnosis and clinical management of women with early pregnancy loss, defined as a loss within the first 12 completed weeks of pregnancy. It mainly addresses the management of spontaneous miscarriage, but is also relevant to women affected by ectopic pregnancy and gestational trophoblastic disease, although specific guidelines for these conditions should be examined separately.

This policy recognises the importance and value of a dedicated outpatient EPAS within hospitals, as the EPAS has been shown to provide clinical benefits.

It is recognised that EPAS may care for women between 12 to 20 weeks gestation. However, the clinical and psychological needs of such women are often different compared to those with early pregnancy complications. Consideration needs to be given to a lower threshold for admission to hospital to ensure that such clinical and psychological needs can be met. The carers in environments to which such women are admitted need to be cognisant of the particular clinical and psychological needs of these women.

MANDATORY REQUIREMENTS

The place of the different diagnostic modalities must be clearly defined within service-specific algorithms (Appendix B), and the full range of therapeutic options (expectant and surgical) must be available to women who miscarry whenever possible. Apart from certain specific clinical circumstances, women should be able to choose their preferred method of management.

All maternity services must provide or be networked to a dedicated outpatient Early Pregnancy Assessment Service (section 2).

IMPLEMENTATION

Chief Executives or delegated officers are to ensure a written local protocol is in place and implemented as described in this policy.

Health professionals in all relevant health care settings must be familiar with the various diagnostic tools necessary to help delineate viable from non-viable pregnancy and ectopic from intrauterine pregnancy.

Maternity services and Emergency Departments must ensure that there are appropriate local policies and algorithms for each therapeutic intervention with clearly outlined pathways for each of the options available.

All health professionals must be aware of the psychological sequelae associated with pregnancy loss and must provide support, follow-up and access to formal counselling when necessary (section 5).

1. INTRODUCTION

This Policy Directive is based on *Management of Early Pregnancy Loss Clinical Practice Guideline* (2008). The complete guideline can be found at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg25/

This policy directive should be read in conjunction with:

- PD2005_406 Consent to Medical Treatment - Patient information
- PD2005_341 Human Tissue - Use/Retention, including Organ Donation
- GL2015_011 Rh (D) immunoglobulin (Anti D)

The Woman's Hospitals of Australasia Clinical Practice Guideline (2008) was adapted from the Green-top Guideline No. 25, Management of Early Pregnancy Loss, October 2006, produced by the Royal College of Obstetricians and Gynaecologists (RCOG) of the United Kingdom.
This policy has been recommended for use in NSW by the Maternal and Perinatal Health Priority Taskforce and the Early Pregnancy Assessment Service Clinical Advisory Group.

1.1 Types of Evidence defined

The definitions of the types of evidence used in the original RCOG Guideline, come from the US Agency for Health Care Policy and Research (AHCPR). Where possible, recommendations are based on, and explicitly linked to, the evidence that supports them. Areas lacking evidence are annotated as 'good practice points. Refer Appendix A.

1.2 Purpose and scope

This is a policy for maternity services with respect to the management of early pregnancy complications in Early Pregnancy Assessment Services (EPAS). It also acts as a guide to Emergency Departments as to what is deemed suitable for ambulatory management.

This policy provides information related to the diagnosis and clinical management of women with early pregnancy loss, defined as a loss within the first 12 completed weeks of pregnancy. It mainly addresses the management of spontaneous miscarriage, but is also relevant to women affected by ectopic pregnancy and gestational trophoblastic disease, although specific guidelines for these conditions should be examined separately.[2,3,4]

This policy recognises the importance and value of a dedicated outpatient Early Pregnancy Assessment Service (EPAS) within hospitals, as the EPAS has been shown to provide clinical benefits.[(12)]

It is recognised that EPAS may care for women between 12 to 20 weeks gestation. However, the clinical and psychological needs of such women are often different to those with early pregnancy complications. Consideration needs to be given to a lower threshold for admission to hospital to ensure that such clinical and psychological needs can be met. The health professionals in the environment in which such women are admitted must be cognisant of the particular clinical and psychological needs of these women.

The place of the different diagnostic modalities must be clearly defined within service-specific algorithms (refer Appendix B), and the full range of therapeutic options (expectant and surgical) must be available to women who miscarry whenever possible. And apart from certain specific clinical circumstances, women should be able to choose their preferred method of management.

Chief Executives or delegated officers are to ensure a written local protocol is in place and implemented as described in this policy.

Health professionals in all relevant health care settings must be familiar with the various diagnostic tools necessary to help delineate viable from non-viable pregnancy and ectopic from intrauterine pregnancy.

Maternity services must ensure that there are appropriate local policies and algorithms as above for each therapeutic intervention with clearly outlined pathways for each of the options available.

All health professionals must be aware of the psychological sequelae associated with pregnancy loss and must provide support, follow-up and access to formal counselling when necessary (section 5).

It is acknowledged that Specialist Obstetricians & Gynaecologists and GP Obstetricians have been and will continue to provide such services. The algorithms in this document are also appropriate for their use.

1.3 Background

Miscarriage occurs in 10 to 20% of clinical pregnancies[5] and accounts for 55,000 couples experiencing early pregnancy loss each year in Australia.[6]

While the rate of miscarriage has remained fairly predictable, better diagnostic and therapeutic interventions have changed standard treatments; what once was 'routine surgical evacuation' has become less so.[1] In the last five years, with the advent of more refined diagnostic techniques and therapeutic interventions, treatment is now provided more and more on an outpatient basis, in both GP and outpatient hospital settings.[7]

In addition to the obvious medical (and possibly surgical) implications of miscarriage, research over the last two decades indicates that significant psychological effects can occur in women who suffer a miscarriage,[81] while further research has shown that appropriate support during and after the event can have positive, lasting effects.[8]

Changes in medical terminology for miscarriage were recommended as early as ten years ago[9,10] however many textbooks and research articles continue to use terminology which women find distressing. In this policy the medical terminology has been reviewed and the preferred terminology has been recommended.

This policy is primarily aimed at health professionals from all disciplines and managers who support women at the time of pregnancy loss.

1.4 Appropriate terminology

The recommended medical term for pregnancy loss less than 20 weeks in Australia and New Zealand is 'miscarriage'. The word miscarriage should be used in clinical practice.

C

The inadvertent use by health professionals of inappropriate terms such as 'pregnancy **failure**', or '**incompetent** cervix' can contribute to women's negative self-perceptions and worsen any sense of failure, shame, guilt and insecurity related to the miscarriage.[9]

Evidence Level IV

It is important to note that the terminology that describes different types of clinical miscarriage (e.g. 'incomplete' or 'missed') remains relevant, as medical interventions vary depending on the type of miscarriage. Appendix C outlines both revised terms and terms recommended for use with women experiencing an early pregnancy loss.

2. SERVICE PROVISION

2.1 What is the ideal setting for assessment of women with possible diagnosis of early pregnancy loss?

All maternity services must provide or be networked to a dedicated outpatient early pregnancy assessment service (EPAS). There are clinical benefits associated with this type of service.

Management of women with threatened or actual early pregnancy loss can be streamlined with the implementation of EPAS, with improvement in the efficiency of the service and quality of care. Admission to hospital was shown to be avoided in the UK by 40% of women, with a further 20% requiring shorter hospital stay.[12]

Dedicated EPAS have been established in various locations across NSW. These services in general augment existing hospitals and non hospital services for women with early pregnancy problems. It is acknowledged that Specialist Obstetricians & Gynaecologists and GP Obstetricians have been and will continue to provide such services. It is recognised that lower role delineated facilities across the State will have established pathways for dealing with early pregnancy problems. For such services networking to a dedicated EPAS for consultation is recommended with referral only where required.

2.2 What are the requirements for running an effective early pregnancy assessment service (EPAS)?

To be effective, an EPAS requires the following:

- an appointments system;
- a discrete waiting area and appropriate consultation room;
- ultrasound equipment (including transvaginal probes) or access to ultrasound evaluation;
- easy access to laboratory facilities for rhesus antibody testing, selective serum human chorionic gonadotrophin (hCG), and ideally progesterone estimation.[13]

Evidence Level IV

The EPAS should be available on a daily basis during the normal working week, and if possible, services available on weekends and after hours.

There must be written pathways for clinical management, clearly defined lines of communication, governance, and accountability for clinical practice.

Inclusion and/or exclusion criteria for the EPAS should be delineated by the facility and should include guidance for appointment booking (i.e. with referral only or self-referral).

Standardised patient information leaflets, referral and transfer of care (discharge) letters must also be readily available, utilised, and regularly reviewed.

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3. DIAGNOSIS AND INVESTIGATION

Diagnosis is made through a combination of patient history, physical examination and clinical investigation.

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3.1. What is the role of transvaginal ultrasound in the EPAS setting?

EPAS should have access to transvaginal ultrasound with staff appropriately trained and credentialed in its use.

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Transvaginal scanning will be required in the majority of women referred to an EPAS. Ultrasound assessment is particularly reliable in confirming the diagnosis of complete miscarriage (positive predictive value 98%).[14] The sonographer should be formally trained in the use of both transabdominal (TAS) and trans-vaginal ultrasound (TVS), as TAS and TVS are complementary and the appropriate modality should be used.

Ideally, ultrasound reports should use standardised documentation (see Appendix D for sample report). Ultrasound practice is guided by the Australian Society of Ultrasound in Medicine, RANZCOG, other professional bodies, and local governance policies.

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Appropriate infection control measures must be taken when disinfecting transvaginal ultrasound probes and facilities must ensure that there is strict adherence to current standards for disinfection.

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3.2. How should cases of suspected early pregnancy loss be managed in the EPAS?

EPAS must use diagnostic and therapeutic algorithms of care. In particular, these must be available for the management of suspected ectopic pregnancy, intrauterine pregnancy of uncertain viability and for pregnancy of unknown location.

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The use of the term 'indeterminate' is confusing and more specific definitions should be used, that is, 'pregnancy of unknown location' and 'pregnancy of uncertain viability'.

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'Indeterminate' is a term used in clinical practice that has led to confusion. Some practitioners have used the term to mean 'pregnancy of indeterminate site' or 'pregnancy of indeterminate viability'. Therefore the term 'indeterminate' should no longer be used, and replaced with the two separate terms "pregnancy of unknown location" and "pregnancy of uncertain viability" (see table 1 for definitions). Both terms should only be used after assessment by TVS.

Evidence Level IV

Even with expert use of TVS using agreed criteria, it may not be possible to confirm if a pregnancy is intrauterine or extra uterine in 8 - 31% of cases in the first visit. These women should be classified as having a "pregnancy of unknown location."[13] In specialised scanning services, the overall incidence of pregnancy of unknown location is as low as 8 - 10%.

Evidence Level IV

The number of cases falling into these two groups can be kept to a minimum by using a thorough and critical approach to TVS in conjunction with strict diagnostic criteria.[17] The sonographer should record whether an 'apparently empty' sac is eccentrically placed in the fundus, whether it exhibits a 'double-ring' pattern, and so on. These findings will help to delineate whether this is likely to be an intra- or extra uterine pregnancy.

Evidence Level IV

A basic ultrasound diagnostic algorithm can be found in Appendix B. It includes terminology described above, with the aim of encouraging a consistent approach across EPAS. TVS is only one part of the diagnostic process in the assessment of potential early pregnancy loss. Women should be managed within a service-specific policy that includes the use of serum hCG assay. Several published guidelines for the diagnosis, management, and treatment of early pregnancy are available on which to base clinical practice.[13,18]

Evidence Level IV

Serial serum hCG assay is particularly useful in the diagnosis of asymptomatic ectopic pregnancy.

B

3.3. What is the role of serial hCG assessment in predicting pregnancy outcome?

Modern monoclonal antibody based kits can detect hCG at 25 iu/l, a level reached nine days post conception (day 23 of a 28-day cycle).[19] Service-specific discriminatory zones for serum hCG should be defined to help exclude possible ectopic pregnancy. At levels above 1500 iu/l, an ectopic pregnancy will usually be visualised with TVS.[13] However, the importance of levels that plateau below 1000 iu/l must be recognised. In these cases, pregnancy of unknown location and miscarriage are both possible outcomes. The potential for rarer diagnoses, such as gestational trophoblastic disease or cranial germ cell tumour, must be considered although, in these cases, serum hCG levels are likely to be greater than 1000 iu/l.[13] In a study of 152 women with a history and TVS findings suggestive of complete miscarriage, serial hCG assessment revealed a 5.9% incidence of ectopic pregnancy.[20]

Evidence Level III

Early ectopic pregnancy can be difficult to diagnose and access to serial serum hCG estimation is essential, with results available within 24 hours.[7] Staff must be familiar with what is an acceptable normal rise in 48 hours. Although a doubling of hCG titre is often expected, this can vary depending on gestation.

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Serum hCG levels need caution in interpretation. In cases of twin pregnancy or heterotopic pregnancy, a suboptimal rise may be misleading.

Women with miscarriage or ectopic pregnancy who are managed expectantly may also require serial serum hCG monitoring.

3.4. Does serum progesterone assay have a role in predicting pregnancy outcome?

Serum progesterone can be a useful adjunct when ultrasound suggests pregnancy of unknown location. TVS, serial serum hCG levels and progesterone may all be required in order to establish a definite diagnosis.

B

When ultrasound findings suggest pregnancy of unknown location, serum progesterone levels below 25 nmol/l are associated with pregnancies subsequently confirmed to be non-viable.[13,21–24] However, care must be taken in terms of active intervention, and uterine evacuation should not be undertaken based on a low initial progesterone. Viable pregnancies have been reported with initial levels less than 15.9 nmol/l. In the presence of pregnancy of unknown location, a serum progesterone less than 20 nmol/l predicts spontaneous pregnancy resolution with a sensitivity of 93% and specificity of 94%. One advantage is that the need for formal uterine evacuation can be reduced if a policy of expectant management is adopted.

Levels above 25nmol/l are 'likely to indicate' and above 60 nmol/l are 'strongly associated with' pregnancies subsequently shown to be normal. Overall, it is not possible to define a specific discriminatory value for a single serum progesterone result that will allow absolute clinical confirmation of viability or non-viability.

If the pregnancy test is positive yet ultrasound is unable to visualize the pregnancy, this is by definition a "pregnancy of unknown location." There are threshold hCG levels whereby an intrauterine pregnancy would not be expected to be seen with ultrasound (approximately 1500i/u for T/V and 2000i/u for T/A) and the role of progesterone in the assessment of pregnancy nonviability is less important than hCG in the acute setting.

3.5. Should all women with early pregnancy loss receive anti-D immunoglobulin?

Non-sensitised rhesus (Rh) negative women must receive anti-D immunoglobulin in the following situations: ectopic pregnancy and any miscarriage, regardless of gestational age of the fetus or uterine evacuation method.

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Rh D Immunoglobulin (Anti-D) must be administered in accordance with GL2015_011.

The National Blood Authority guidelines[77] on the prophylactic use of Rh D immunoglobulin (anti-D) in obstetrics recommends the following:

General

For successful immunoprophylaxis, Rh D immunoglobulin should be administered as soon as possible after the sensitising event, but always within 72 hours. If Rh D immunoglobulin has not been offered within 72 hours, a dose offered within 9-10 days may provide protection. Blood should be taken from the mother before administration of the Rh D immunoglobulin to assess the magnitude of fetomaternal haemorrhage (FMH). Where FMH quantitation shows that FMH greater than that covered by the dose already administered has occurred, administration of an additional dose/s sufficient to provide immunoprophylaxis must be administered and preferably within 72 hours.

Evidence Level I

Sensitising events in the first trimester

- A dose of 250 IU (50 µg) Rh D immunoglobulin should be offered to every Rh negative woman with no preformed anti-D to ensure adequate protection against immunisation for the following indications up to and including 12 weeks gestation (Level IV evidence):
  - miscarriage; (Level IV)
  - termination of pregnancy; (Level IV)
  - ectopic pregnancy; and (Level IV)
  - chorionic villus sampling. (Level III)
- A dose of 250 IU (50 µg) Rh D immunoglobulin is sufficient to prevent immunisation by a fetomaternal haemorrhage of 2.5 ml of fetal red cells (5 ml whole blood) (Level IV evidence).
- There is insufficient evidence to support the use of Rh D immunoglobulin in bleeding prior to 12 weeks gestation in an ongoing pregnancy, although if the pregnancy then requires curettage, Rh D immunoglobulin should be given. If miscarriage or termination occurs after 12 weeks gestation, 625 IU (125 µg) Rh D immunoglobulin should be offered.

Sensitising events beyond the first trimester

- Although some of the recent evidence related to the use of immuno-prophylaxis is based upon studies of potentially sensitising events occurring up to 20 weeks gestation, for practical purposes the working party recommends that a dose of 250 IU (50 µg) be used for first trimester events (up to and including 12 weeks gestation) and 625 IU (125 µg) be used beyond first trimester. Future revisions of these guidelines may, in the face of further recommendations, extend the use of the 250IU (50µg) dose beyond 12 weeks gestation.

- A dose of 625 IU (125 µg) Rh D immunoglobulin should be offered to every Rh D negative woman with no preformed anti-D to ensure adequate protection against immunisation for the following indications after 12 weeks gestation (Level IV evidence):
  - Genetic studies (chorionic villus sampling, amniocentesis, cordocentesis);(Level III)
  - Abdominal trauma considered sufficient to cause fetomaternal haemorrhage; (Level IV)
  - Each occasion of revealed or concealed antepartum haemorrhage (where the patient suffers unexplained uterine pain the possibility of concealed antepartum haemorrhage should be considered, with a view to immunoprophylaxis); (Level IV)
  - External cephalic version (performed or attempted); (Level III)
  - Miscarriage or termination of pregnancy. (Level IV)
- As evidence for the efficacy of this dose for these indications is not available, it is recommended that the magnitude of fetomaternal haemorrhage be assessed and further doses of Rh D immunoglobulin administered if required, especially where transplacental access or puncture of fetal blood vessels occurs.

Upon transfer of care (discharge) from the EPAS, documentation that clearly states whether or not anti-D was given and the dosage must be annotated.

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4. TREATMENT

The options for treatment include: expectant management and/or surgical uterine evacuation. To the fullest extent possible, a woman should be given the choice of treatment option.

Protocols must be developed locally with selection criteria, therapeutic regimens, and arrangements for follow-up. **A**

Concerns have been raised about the infective risks of non-surgical management[58] but published data suggest a reduction in clinical pelvic infection and no adverse affects on future fertility.[28,57,66] **Evidence Level Ia**

Expectant management should be offered by EPAS where women have access to a telephone and emergency hospital admission, if required. A plan to access medical assistance when required, should be developed in consultation with each woman in areas where there is geographical and/or social isolation.

Expectant management may be followed by minimal bleeding, as any retained tissue will usually undergo reabsorption. Occasionally, the passage of tissue may be associated with significant bleeding (ie >spotting). It is important that all women undergoing expectant management have direct telephone access to staff for advice and support. Hospital beds must be available should admission be required. **Evidence Level IV**

Expectant management is an effective method to use in selected cases of confirmed first-trimester miscarriage. This means no specific intervention is undertaken and allows spontaneous passage of fetal tissue. **A**

4.1 Expectant Management

Expectant management is an effective and acceptable method to offer women who miscarry. Patient counselling is particularly important for those women **with an intact sac** who wish to take an expectant approach. They should be aware that complete resolution may take several weeks and that overall efficacy rates are lower. They may wish to consider a medical approach or to commence expectant management with the option of surgical evacuation at a later date, if required. Expectant management for incomplete miscarriage is highly effective.

Observational and controlled trials of expectant compared with surgical management also show wide variations in reported efficacy (25-100%).[55-64] Similar factors affect the success rates; these factors include the type of miscarriage, duration of follow-up, and whether ultrasound or clinical assessment was used for review. A low serum progesterone level can be used to predict those pregnancies which are most likely to resolve spontaneously.[65] **Evidence Level Ib**

Ultrasound criteria used to define 'retained products' varies between studies. One study included patients with an 'AP tissue diameter of 15-50mm' with ultrasound review at 3 days (efficacy 71%),[55] while another included all those with an 'AP tissue diameter < 50mm' and reviewed patients clinically on three occasions up to 6 months (efficacy 100%).[57] The mean anteroposterior (AP) diameter of tissue in those managed expectantly in the latter study was only 11 mm, which would have been defined as 'complete miscarriage' by the former study and therefore would have been excluded. When ultrasound assessment of the uterine cavity shows heterogenous shadows with a maximum AP diameter of 15 mm or less, genuine retained products are less likely to be confirmed histologically.[14] These could, of course, include some cases of 'incomplete miscarriage' but are best managed conservatively as there is a trend towards a lower complication rate compared with surgical management (3.0 versus 5.8%, $P = 0.06$).[59] **Evidence Level Ib**

Several randomised trials have compared expectant with surgical management. In a trial with 122 women, efficacy rates were confirmed at six weeks of 47% (expectant) and 95% (surgical).[61] After seven days, 37% of women managed expectantly had achieved a complete miscarriage. A meta-analysis of 13 trials comparing expectant with medical management[63] showed that the type of miscarriage was a significant factor affecting the efficacy with an expectant approach. For missed miscarriage, complete evacuation rates for expectant versus surgical management were 28% (49/173, range 14-47%) and 81% (242/298, range 60-83%), respectively. For women with incomplete miscarriage, the rates were 94% (31/33, range 80-100%) and 99% (75/76, range 99-100%).

Evidence Level Ia

4.2 When should surgical uterine evacuation be used?

Clinical indications for offering surgical evacuation include: persistent excessive bleeding, haemodynamic instability, evidence of infected retained tissue and suspected gestational trophoblastic disease. Surgical uterine evacuation should be offered to women who prefer that option.

C

Surgical uterine evacuation (ERPC) has been the standard treatment offered to women who miscarry. Until recently, up to 88% of women who miscarried were offered ERPC. This was based on an assumption that retained tissue increases the risks of infection and haemorrhage and would not be passed spontaneously. It remains the treatment of choice if there is excessive and persistent bleeding, if vital signs are unstable or in the presence of retained infected tissue. Studies suggest that these complications affect less than 10% of women who miscarry.[27] At least 34% of women express a 'strong' preference for a surgical approach to uterine evacuation.[28]

Evidence Level IV

4.3. How should surgical uterine evacuation be performed?

Surgical uterine evacuation for miscarriage should be performed using suction curettage.

A

Vacuum aspiration has been used as the method of choice for management of miscarriage where there is an intact intrauterine sac. A Cochrane review concluded that vacuum aspiration is preferable to sharp curettage in cases of incomplete miscarriage. Two trials were included: vacuum aspiration was associated with statistically significantly decreased blood loss (mean difference -17 ml, 95%CI -24 to -10ml), less pain (RR 0.74, 95% CI 0.61 to 0.90) and shorter duration of procedure (mean difference -1.2 minutes,95% CI -1.5 to -0.87 minutes).[29] Routine use of a metal curette after suction curettage is not required. Use of oxytocin is associated with a statistically significant (but not clinically significant) difference in median blood loss (17.6 ml versus 24.5 ml).[30] Where infection is suspected, delaying surgical intervention for 12 hours is recommended to allow intravenous antibiotic administration.

Evidence Level Ia

Reported serious complications of surgery include perforation, cervical tears, intra-abdominal trauma, intrauterine adhesions and haemorrhage. The incidence of serious morbidity using a similar surgical technique in induced pregnancy termination is 2.1%[31] with a mortality of 0.5/100 000.[32]

Evidence Level III

The advantages of prostaglandin administration prior to surgical evacuation are well established, with significant reductions in dilatation force, haemorrhage and uterine/cervical trauma. There is no randomised evidence to guide practice in cases of first-trimester miscarriage, particularly in the presence of an intact sac. Practitioners may consider oral or vaginal cervical preparation based on individual patient circumstance. 'Timing' of the administration should be considered to allow for maximum effect whilst minimizing the possibility of the loss of uterine contents into the bed or toilet.

Curettage under local anaesthesia is well described. It is used commonly in the USA[33] and many European, Asian and African countries. In a UK study of 58 women with incomplete and missed miscarriage, uterine evacuation was achieved in all cases using a manual vacuum aspiration technique under systemic analgesia or patient-controlled anaesthesia. Levels of patient satisfaction and acceptability were high.[34]

Evidence Level III

4.4 Which women should be screened for genital tract infection?

Screening for infection, including *Chlamydia trachomatis*, should be considered in women undergoing surgical uterine evacuation.	**C**
Consider vaginal swabs to diagnose bacterial vaginosis if clinically indicated or population prevalence dictates.	**√**

Women with *C. trachomatis*, *Neisseria gonorrhoea* or bacterial vaginosis in the lower genital tract at the time of induced pregnancy termination are at an increased risk of subsequent pelvic inflammatory disease;[26] until further research is published, no definitive recommendations can be made for women undergoing surgical evacuation for miscarriage management.

Evidence Level IV

4.5 Should prophylactic antibiotics be given prior to surgical evacuation?

There is insufficient evidence to recommend routine antibiotic prophylaxis prior to surgical uterine evacuation.	**A**
Antibiotic prophylaxis must be given based on individual clinical indications.	**√**

A randomised trial of prophylactic doxycycline in curettage for incomplete miscarriage did not demonstrate an obvious benefit but the study was of insufficient power to detect a clinically meaningful change in infectious morbidity. Until further research is available, antibiotic prophylaxis should only be given based on individual clinical indications.

Evidence Level Ib

4.6 What are the advantages of arranging histological examination of tissue passed at the time of miscarriage?

Tissue obtained via surgical evacuation should be histologically examined/evaluated to confirm pregnancy and to exclude ectopic pregnancy or unsuspected gestational trophoblastic disease.	**C**

Heath, et al., suggested that there is no obvious benefit in routine histological investigation of tissue obtained from cases of pregnancy termination and miscarriage.[68] However, within a subgroup of 468 undergoing surgical evacuation for miscarriage, there were two cases of ectopic pregnancy diagnosed 25 and 28 days post-evacuation (an incidence of 0.42%). Neither was suspected on scan, but histology had reported 'decidua only'. In view of the maternal risks associated with ectopic pregnancy and molar pregnancy, it is recommended that practitioners send tissue obtained at the time of surgical uterine evacuation for histological examination. This may confirm the diagnosis of miscarriage and can help to exclude ectopic pregnancy or gestational trophoblastic disease.[7]

Evidence Level IV

Practitioners must be aware of their local public health requirements or guidelines related to the appropriate disposal of fetal remains, should the woman request to take the remains home. Medical, nursing and midwifery staff must provide current and sensitive information to ensure proper burial or cremation. √

5. PSYCHOLOGICAL ASPECTS OF EARLY PREGNANCY LOSS

5.1 Is there potential benefit from support and follow-up after pregnancy loss?

All professionals must be aware of the psychological sequelae associated with pregnancy loss and must provide support, follow-up and access to formal counselling when necessary. Appropriate support can result in significant positive psychological gain. C

Plans for follow-up must be clearly recorded in the referral or transfer of care (discharge) letter from the EPAS or ward. √

A system must be in place for informing all relevant primary health care professionals in cases of pregnancy loss. √

The negative psychological impact of early pregnancy loss can be both severe and protracted and affects both women and their families[71-73] and may be different for every couple. Information should be made available which highlights the options available for appropriate and sensitive disposal of fetal tissue.[69] Each woman's (and couple's, as appropriate) needs should be identified and acknowledged, assistance and referral given to facilitate the grieving process. The provision of information on miscarriage should be offered to each woman or couple.

Evidence Level III

A randomised trial assessing the effects of caring-based counselling on women's emotional wellbeing in the first year after miscarriage found a significant beneficial effect with reduction in overall emotional disturbance, anger and depression.[8] A continuing awareness of the potential effects of miscarriage is required, with a willingness to involve appropriate support and counselling services when needed. The needs of the partner should also be considered. The opportunity for follow-up should be offered to all women after pregnancy loss but unfortunately this does not always occur. In a recent national audit study in the UK, 38% of women reported that there had been no offer of or arrangement for follow-up.[74] Follow-up can involve any member of the multidisciplinary team based in hospital or community practice.

Evidence Level III

5.2 Should informed choice be encouraged in deciding which intervention to use to achieve uterine evacuation?

In terms of therapeutic intervention, the woman's choice should be encouraged, as it is associated with positive quality-of-life outcomes. A

Objective assessment of psychological morbidity in a controlled trial of expectant versus surgical management of miscarriage revealed no differences related to the procedure itself.[75] However, women with miscarriage who chose their own treatment had the best health-related quality-of-life (HRQL) assessments compared with women who were randomised to one or other treatment modality.[76] This confirms the importance of allowing and encouraging patient choice in the management of early miscarriage.

6. RECOMMENDED AUDITABLE STANDARDS

- Patient satisfaction with elements of the EPAS.
- Appropriate use of anti-D prophylaxis.
- Appropriate screening for genital tract infection.
- Appropriate use of serial serum hCG/serum progesterone assessment.
- Uptake rates for expectant, and surgical interventions.
- Complications of the various interventions (including failure rates).
- Involvement of patient in choice of treatment.
- Number of visits required to reach definitive diagnosis.
- Standards of documentation.

7. SUPPORT GROUP WEBSITES

Association of Early Pregnancy Units, www.earlypregnancy.org.uk
Small Miracles Foundation, http://www.smallmiraclesfoundation.org/
SIDS and Kids, www.sidsandkids.org
Stillbirth and Neonatal Death Support, www.sands.org.au
Bears of Hope, http://www.bearsofhope.org.au
Stillbirth Foundation, http://www.stillbirthfoundation.org.au

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9. APPENDICES

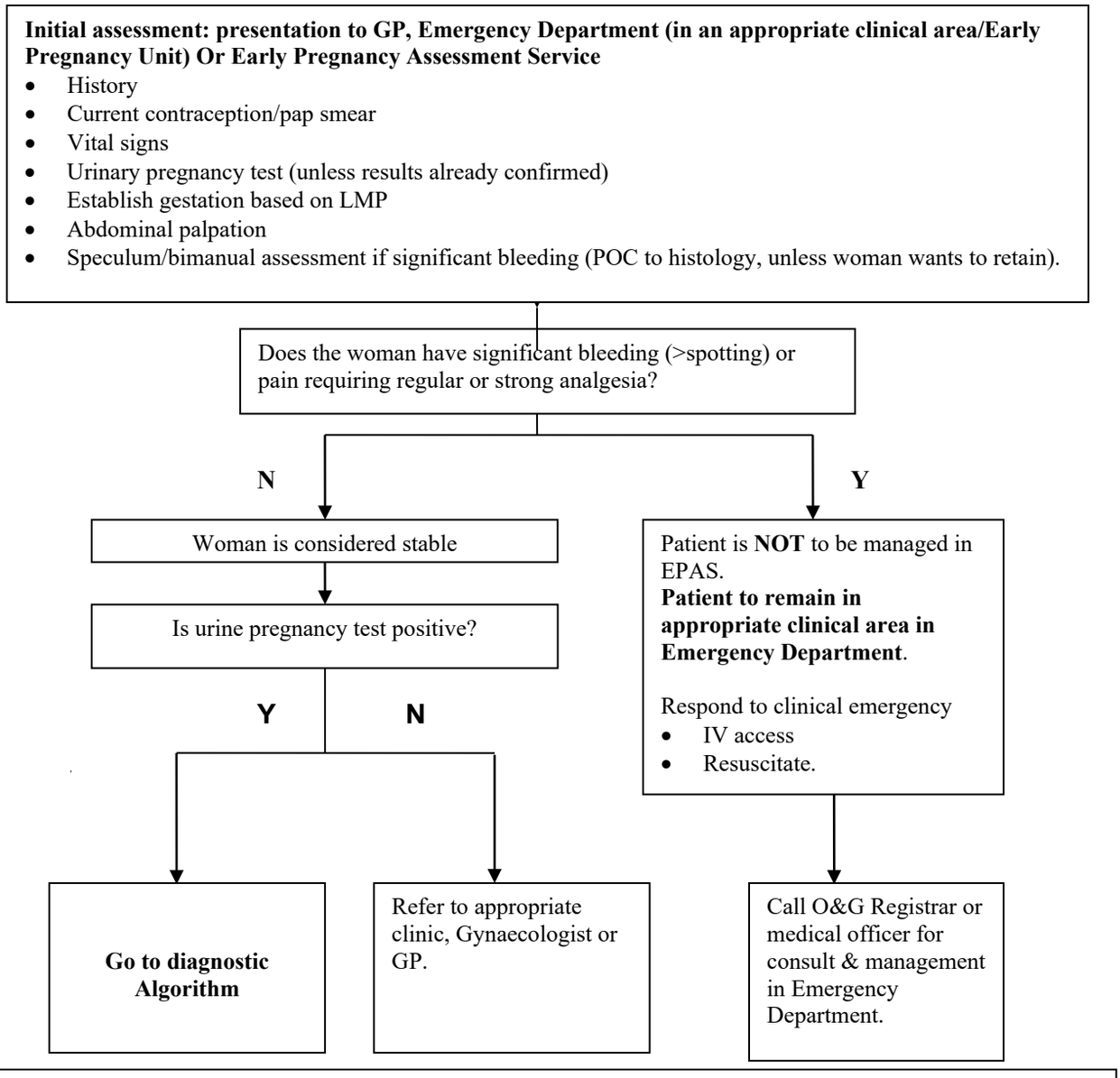
Appendix A Evidence levels

Classification of evidence levels	Grades of recommendations
Ia Evidence obtained from meta-analysis of randomised controlled trials **Ib** Evidence obtained from at least one randomised controlled trial **IIa** Evidence obtained from at least one well-designed controlled study without randomisation **IIb** Evidence obtained from at least one other type of well-designed quasiexperimental study **III** Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies **IV** Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities	**A** Requires at least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (Evidence levels Ia, Ib) **B** Requires the availability of well controlled clinical studies but no randomised clinical trials on the topic of recommendations. (Evidence levels IIa, IIb, III) **C** Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (Evidence level IV) **√ Good practice point** Recommended best practice based on the clinical experience of the guideline development group.

Appendix B Algorithms

Algorithms

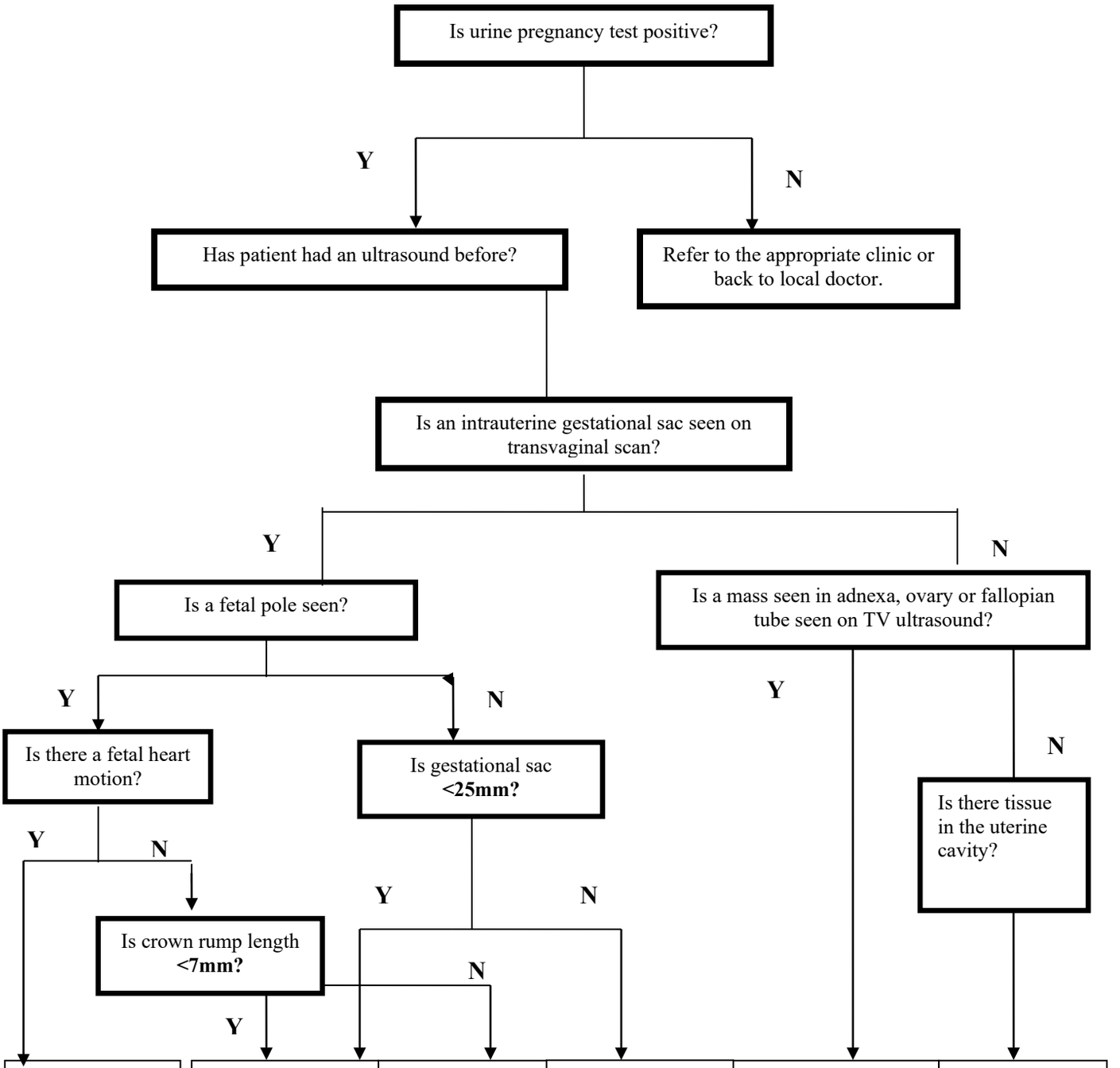
Initial assessment and triage of women with bleeding/pain in early pregnancy less than 12 weeks gestation



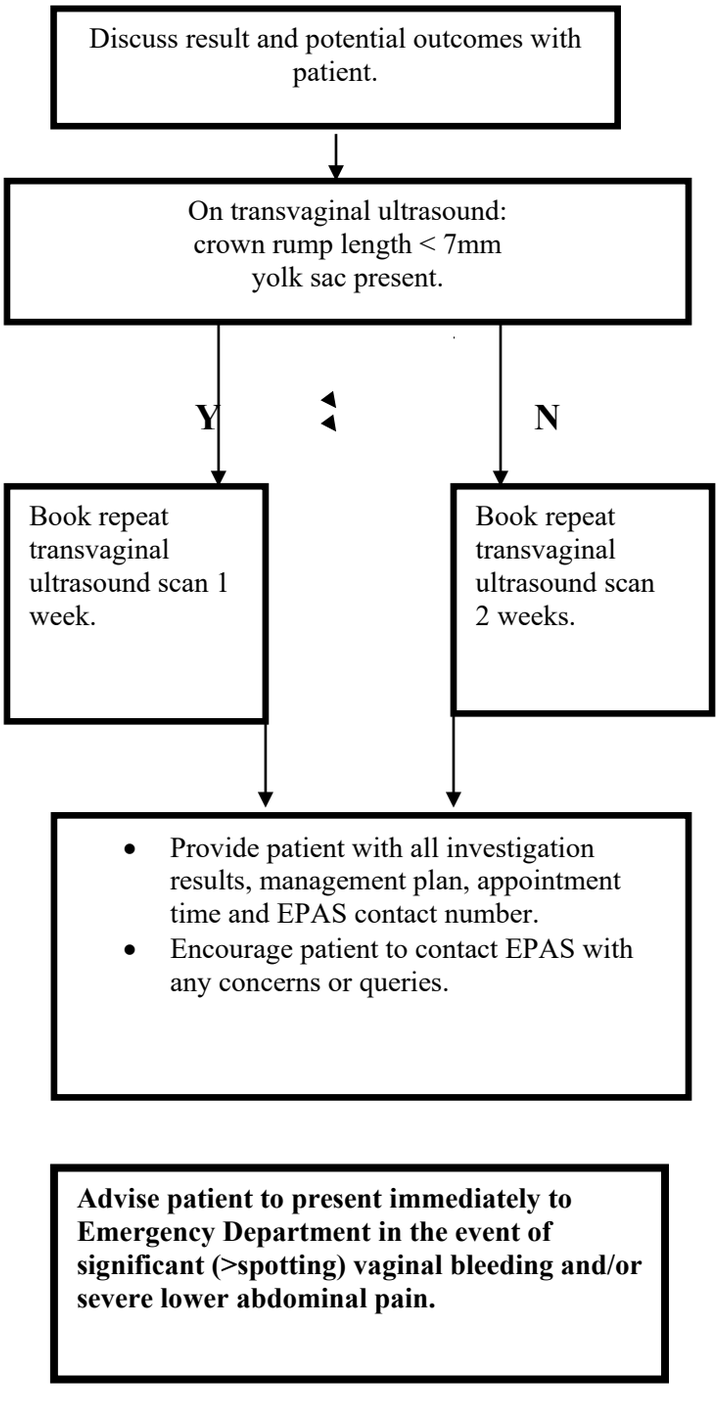
When referring to EPAS:

- Ensure that findings from initial assessment are documented and made available to EPAS. If possible, commence documentation on the EPAS record.
- Advise woman:
  - what time to attend EPAS and where to go
  - that she is likely to have a vaginal ultrasound scan
  - if possible to come with partner or friend/relative
  - if possible avoid bringing children to EPAS.
  - to be prepared to stay for up to **3** hours in the EPAS, as blood tests may be required
- Provide EPAS information leaflet.

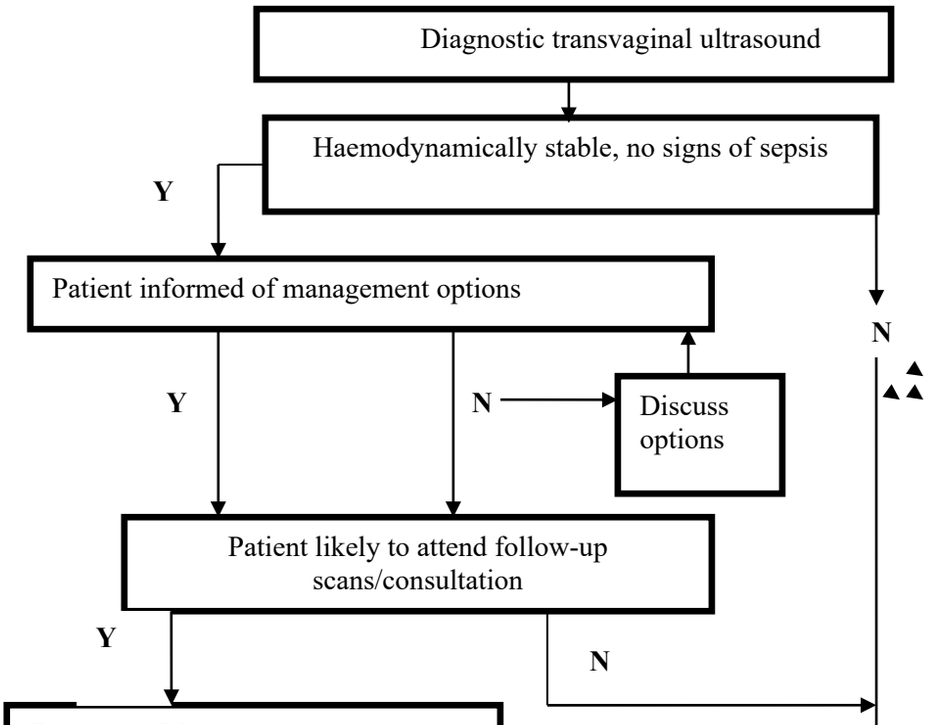
EPAS Diagnostic Algorithm



EPAS Algorithm: Pathway B
Intrauterine Pregnancy Uncertain Viability (IPUV)
Gestational sac < 20mm



EPAS ALGORITHM: PATHWAY C
Missed Miscarriage



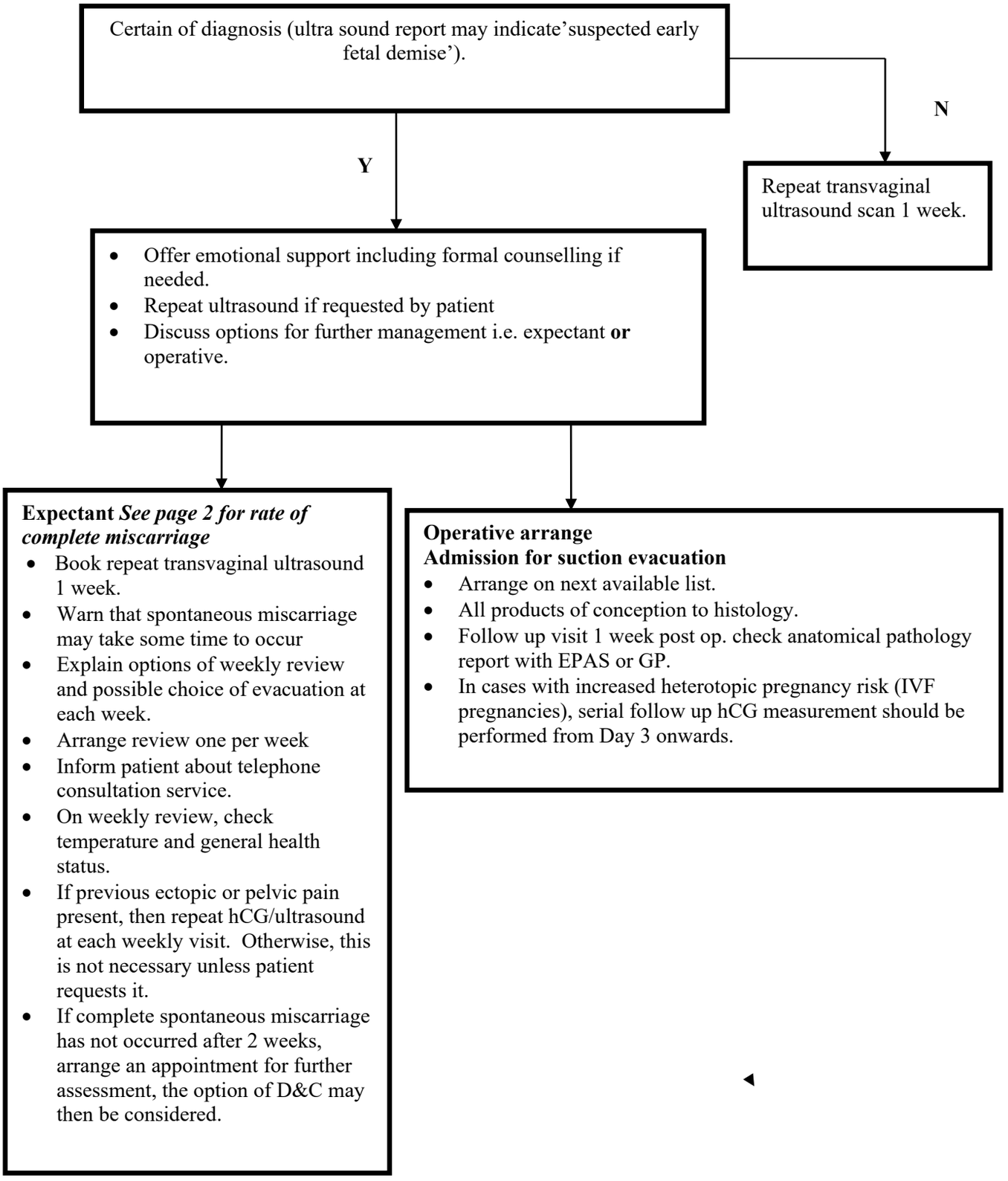
Expectant Management
See page 2 for rate of complete miscarriage

- Book repeat transvaginal ultrasound 1 week.
- Warn that spontaneous miscarriage may take some time to occur.
- Explain options of weekly review and possible choice of evacuation at each week.
- Arrange review one per week
- Inform patient about telephone consultation service.
- On weekly review, check temperature and general health status.
- If previous ectopic or pelvic pain present, then repeat hCG/ ultrasound at each weekly visit. Otherwise, this is not necessary unless requested by the patient.
- If complete spontaneous miscarriage has not occurred after 2 weeks, arrange an appointment for further assessment, the option of D&C may be considered.

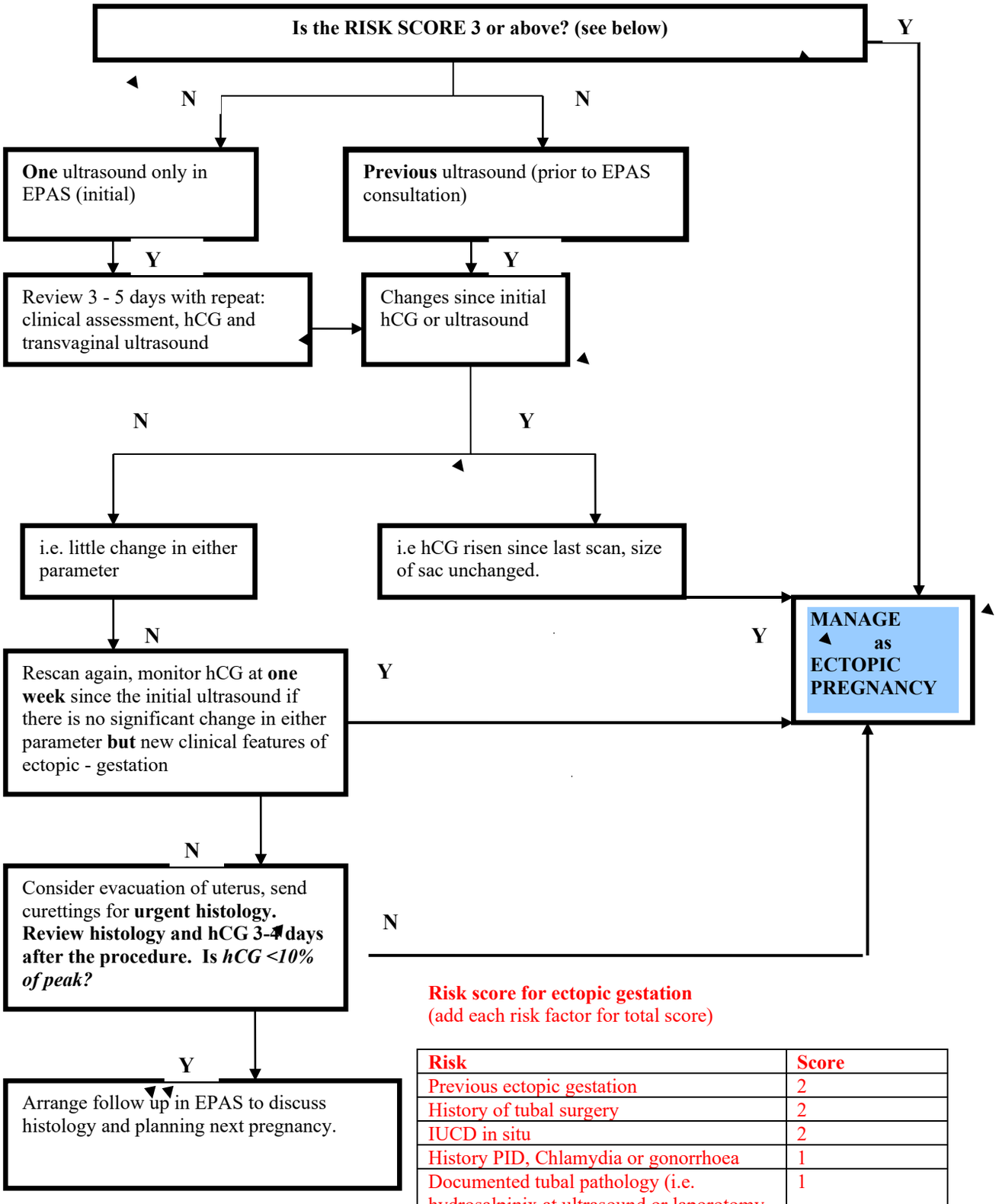
Operative Arrange
Admit for suction evacuation

- **Arrange for place on the Emergency List for women assessed as not clinically stable**
- Arrange on next available list for women assessed as clinically stable.
- All products of conception to histology.
- Follow up visit 1 week post op. check anatomical pathology report with EPAS or GP.
- In cases where heterotopic pregnancies is possibility (IVF pregnancies), serial follow up hCG measurement should be performed from Day 3 onwards.

EPAS ALGORITHM: PATHWAY D
Early fetal demise



EPAS ALGORITHM: PATHWAY E
Management of Ectopic Pregnancy



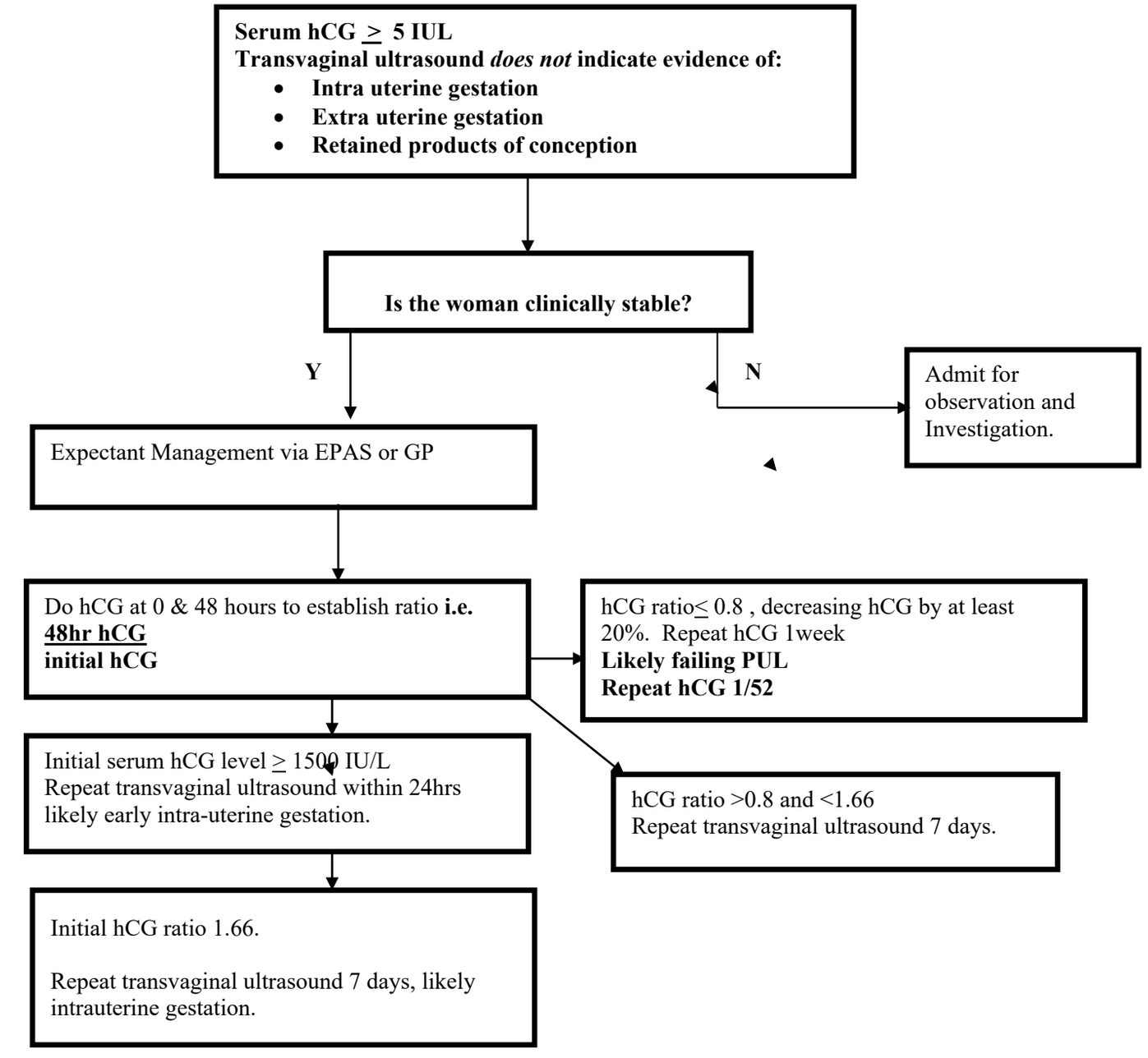
Risk score for ectopic gestation
(add each risk factor for total score)

Risk	Score
Previous ectopic gestation	2
History of tubal surgery	2
IUCD in situ	2
History PID, Chlamydia or gonorrhoea	1
Documented tubal pathology (i.e. hydrosalpinix at ultrasound or laporotomy	1
Assisted conception	1

EPAS Algorithm: Pathway F
Pregnancy of unknown location
(PUL)

Pregnancy of unknown location can be defined when:

- Serum hCG is positive i.e. ≥ 5 IU/L
- Transvaginal ultrasound (performed by a Senior Sonographer or Trained Sonologist) indicates no sign of either intra or extra uterine gestation or evidence of retained products of conception



All women must be advised to contact EPAS or present to Emergency Department if an increase in lower abdominal pain and/or vaginal bleeding, experiences faintness or shoulder tip pain.

Management of Ectopic Pregnancy

Ectopic pregnancy affects approximately 1 in 80 pregnancies. Statistics indicate the incidence is rising, however the associated mortality is decreasing due to improved diagnostic performance of transvaginal sonography and biochemical sensitivity and establishment of Early Pregnancy Services and Clinics.

Ectopic pregnancies are most commonly situated in the fallopian tube (approximately 95%). Less common sites are: interstitial, cervix, ovary, caesarean scar or rarely abdomen.

Risk factors may only be present in 25% - 50% of patients diagnosed with an ectopic pregnancy. These include:

- Previous ectopic pregnancy.
- Tubal surgery.
- Assisted reproductive technology.
- Intra uterine contraceptive device in situ.
- Use of emergency contraception.
- History pelvic inflammatory/sexually transmitted disease.
- Documented Tubal Pathology.

Management

Will depend on:

- clinical state of the woman;
- size ectopic visualised on transvaginal ultrasound;
- presence/absence of haemoperitoneum;
- serum hCG level;
- patient choice **and** potential compliance.

Surgical Management

Laparoscopy is the method of choice for stable women who are medically fit and of appropriate BMI.

Laporotomy is preferred in cases of haemorrhagic shock or:

If the surgeon has insufficient experience of operative laparoscopy or suboptimal quality of laparoscopic equipment.

Medical Management: Systemic Methotrexate

Methotrexate is an anti-metabolite which prevents the growth of rapidly dividing cells by interfering with DNA synthesis. A single intramuscular dose of Methotrexate $50mg/m^2$ is well tolerated and effective.

Indications for Methotrexate use:

- Haemodynamically stable.
- Baseline serum hCG < 5,000IU/L.
- Ectopic pregnancy < 3cm diameter on transvaginal ultrasound.
- Absence of fetal heart motion on transvaginal ultrasound.
- No significant haemoperitoneum.

Exclusion criteria

- Evidence of significant haemoperitoneum on transvaginal ultrasound.
- Presence of fetal heart motion

- Active liver disease, aplastic anaemia, thrombocytopenia.
- Women on concurrent corticosteroids.
- Contraindications to Methotrexate.
- Woman potentially non compliant to prolonged follow up (35 – 109 days).
- Ectopic mass > 3.0cm.

Expectant Management
Spontaneous resolution will occur in approximately 18% of all ectopic pregnancies. This has been well documented in numerous reports.

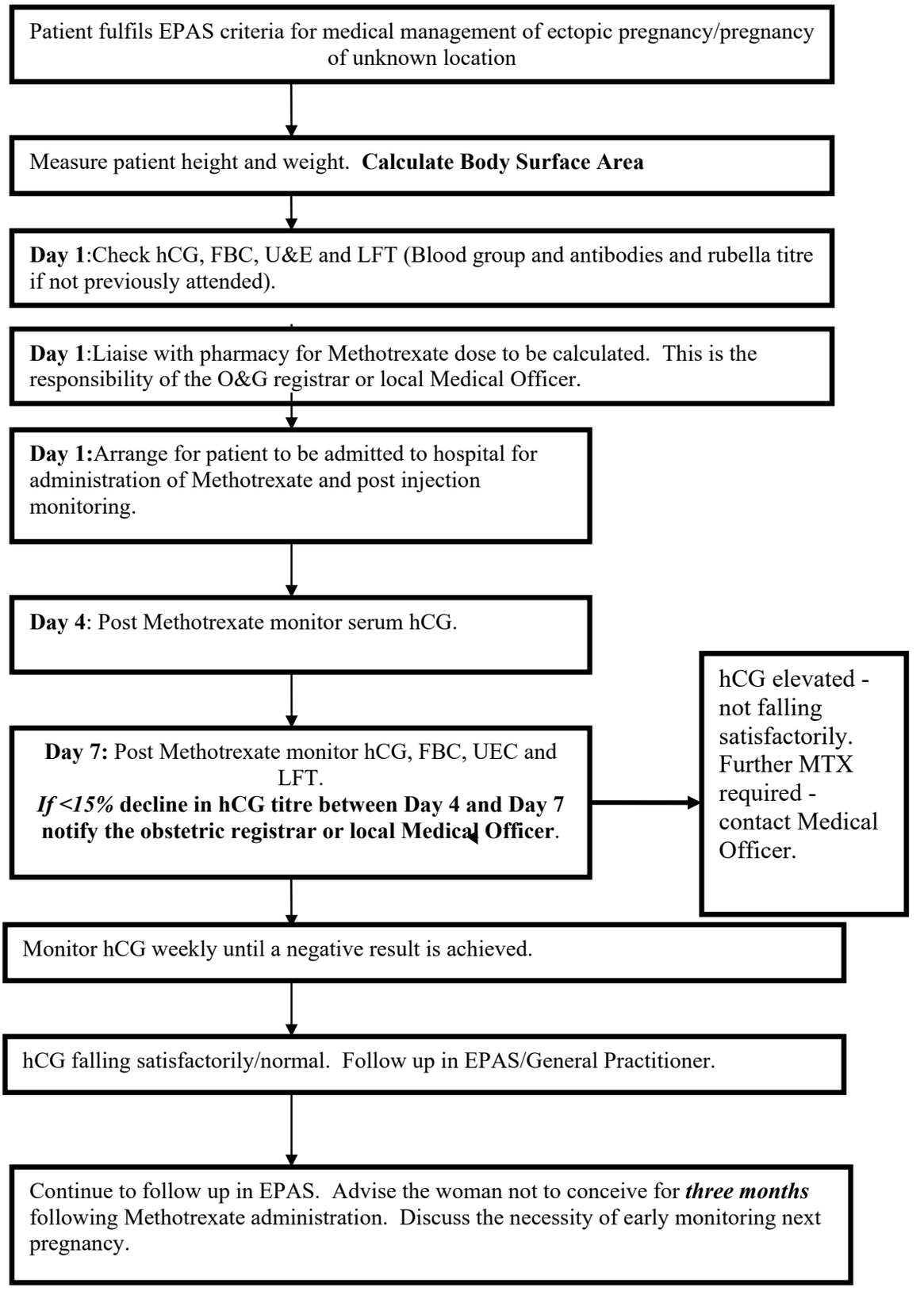
Indications for Expectant Management
- Serum hCG < 1000IU/L and declining.
- Tubal mass less than 3cm.
- No signs of tubal rupture or haemoperitoneum on transvaginal ultrasound.
- Patient clinically stable.

Exclusion criteria
- Patient is potentially non compliant or not motivated to long term recovery.

Follow up
- Monitor serum hCG every 48 - 72 hrs until **less than 20 IU/L.**
- **Once hCG levels less than 20 IU/L monitor once a week until negative.**
- Repeat transvaginal ultrasound if clinically indicated.

RUPTURE of ECTOPIC PREGNANCY can occur until hCG < 15 IU/L following expectant, medical or surgical management.

EPAS Algorithm: Methotrexate (MTX) Protocol



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Appendix C Terminology

Table of appropriate terminology

Previous Term	Recommended Term	Definition	Notes
Spontaneous abortion	Miscarriage	Pregnancy loss occurring before 20 completed weeks of gestation or of a fetus less than 400gm weight if gestation is unknown[#]	
Threatened abortion	Threatened miscarriage	Any vaginal bleeding other than spotting before 20 completed weeks of gestation[#]	
Inevitable abortion	Inevitable miscarriage	Miscarriage is imminent or is in the process of happening [#] Threatened miscarriage with an open cervical os and/or rupture of the membranes[#]	
Incomplete abortion	Incomplete miscarriage	A miscarriage where some of the fetus or placenta are unable to be naturally expelled by the mother [#] A confirmed non-viable pregnancy on ultrasound with bleeding. Some products of conception remain in the uterus [#]	
Complete abortion	Complete miscarriage	A miscarriage needing no medical or surgical interventions [#] Products of conception have been passed; USS shows no apparent products; bleeding generally settles[#]	
Missed abortion	Missed miscarriage or Silent miscarriage	A confirmed, non-viable pregnancy on USS with no bleeding[#] Signs of this would be a loss of pregnancy symptoms and the absence of fetal heart tones found on an ultrasound[#]	A 'missed miscarriage' is when the fetus dies but the woman's cervix stays closed, there is no bleeding and the fetus continues to stay inside the uterus[#]

Previous Term	Recommended Term	Definition	Notes
Anembryonic pregnancy* or Blighted ovum*	Early fetal demise or Delayed miscarriage	Also called an **anembryonic pregnancy**. A fertilized egg implants into the uterine wall, but fetal development never begins. Often there is a gestational sac with or without a yolk sac, but there is an absence of fetal growth[#]	*these reflect different stages in the same process
Septic abortion	Miscarriage with infection (sepsis)	A miscarriage complicated by a pelvic infection[#]	
Recurrent abortion	Recurrent miscarriage	3 or more consecutive miscarriages by the same woman[#]	
	Biochemical pregnancy loss[11]	Pregnancy not located on scan[+]	
	Empty sac[11]	Sac with absent or minimal structures[+]	
	Fetal loss[11]	Previous CRL measurement with subsequent loss of fetal heart activity (FHA)[+]	
	Early pregnancy loss[11]	Confirmed empty sac or sac with fetus but no FHA <12 weeks[+]	
	Delayed miscarriage[11]	As 'early pregnancy loss'[+]	
	Late pregnancy loss[11]	Loss of FHA >12 weeks[+]	
Suspected ectopic	Pregnancy of unknown location[11] (PUL)	No signs of either intra- or extra uterine pregnancy or retained products of conception in a woman with a positive pregnancy test. No identifiable pregnancy on scan with positive hCG [+]	
	Viable pregnancy	Live ongoing embryonic pregnancy[+]	
	Pregnancy of uncertain viability	Intrauterine sac (<25mm mean diameter) with no obvious yolk sac or fetus or Fetal echo <7mm crown-rump length with no obvious fetal heart activity.	In order to confirm or refute viability, a repeat scan at a minimal interval of 1 week is necessary.[16]

Previous Term	Recommended Term	Definition	Notes
	Ectopic pregnancy	A pregnancy located outside the uterus, usually in the fallopian tubes, but may be ovarian. #	
	Molar pregnancy	The result of a genetic error during the fertilization process that leads to growth of abnormal tissue within the uterus. Molar pregnancies rarely involve a developing embryo, but often entail the most common symptoms of pregnancy including a missed period, positive pregnancy test and severe nausea.#	
Incompetent cervix	Cervical weakness	The opening of the cervix before a fetus is mature enough to be born. It may lead to miscarriage or premature delivery.	Cervical weakness is not routinely evaluated and therefore not usually diagnosed until after a second trimester loss has occurred.
	Expectant miscarriage management	No specific intervention; allows spontaneous passage of fetal tissue.[78]	
	Surgical miscarriage management	Surgical evacuation (with or without curettage) of the retained fetal tissue. [78]	
Heterotopic pregnancy	Heterotopic pregnancy	Concurrent/simultaneous intra-uterine and extra uterine pregnancies	

Definitions from the Health Data Standards Committee. 2006. National Health Data Dictionary Version 13.2. http://meteor.aihw.gov.au/content/index.phtml/itemId/357718

+Definitions from The European Society for Human Reproduction Special Interest Group for Early Pregnancy, who have revised the nomenclature for use in early pregnancy loss in order to improve clarity and consistency.[11]

Appendix D Sample ultrasound report form

This example has been kindly provided by Gold Coast Health Service, Queensland Health

EARLY PREGNANCY ASSESSMENT CLINIC
ULTRASOUND INTERIM REPORT FORM

AFFIX PATIENT ID LABEL

DATE:
Patient History

LNMP :	**EDD by LNMP :**
PREVIOUS U/S :	Yes □ No □
BHCG :	**DATE TAKEN :**

ULTRASOUND FINDINGS T/A T/V

Intrauterine sac	Yes □ No □	Single □ Multiple □
Mean Sac Diameter	mm	Gestation =
Yolk sac seen	Yes □ No □	
Fetal Pole	Yes □ No □	Length =
FHM seen	Yes □ No □	
FHR	bpm	
Peri gestational bleed	Yes □ No □	Size =
Gestational age by this u/s	Weeks days	
EDD by this u/s	/ /	
? RPOC	Yes □ No □ N/A □	Size =

RIGHT OVARY: ……....
LEFT OVARY: …….
RIGHT ADNEXA: ……..…..
LEFT ADNEXA: …….....
FREE FLUID: Yes □ No □ Minimal □ Moderate □ Extensive □

Signature:

Sonographer: **Reporting Radiologist:** **O&G/A&E Medical Officer**

PLEASE TURN OVER

EARLY PREGNANCY ASSESSMENT CLINIC
ULTRASOUND INTERIM REPORT FORM

AFFIX PATIENT ID LABEL

COMMENTS/DIAGNOSIS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNED: _____

DESIGNATION: _____

DATE: _____

MATERNAL & CHILD HEALTH PRIMARY HEALTH CARE POLICY (PD2010_017)

(A component of the NSW Health/*Families NSW* Supporting Families Early Package)

PURPOSE

This policy is to ensure a consistent statewide approach to the provision of primary health care and health home visiting to parents expecting or caring for a new baby is implemented throughout NSW.

The policy identifies a primary health model of care for the provision of universal assessment, coordinated care, and home visiting, by NSW Health's maternity and community health services, for all parents expecting or caring for a new baby.

MANDATORY REQUIREMENTS

All Area Health Services (AHS) are to ensure that:

- a comprehensive assessment process, consistent with the SAFE START model, is implemented in both maternity and early childhood health services (Reference: Policy Section 3)
- risk factors and vulnerabilities are determined using a team-management approach to case discussion and care planning (Reference: Policy Section 3)
- the continuity-of-care model is implemented in accordance with this policy (Reference: Policy Section 3)
- effective communication systems from maternity services to early childhood health services are established (Reference: Policy Section 3)
- Universal Health Home Visiting (UHHV) is implemented and that every family in NSW is offered a home visit by a child and family health nurse within two weeks of the baby's birth (Reference: Policy Section 4)
- Sustained Health Home Visiting (SHHV) is implemented in accordance with this policy (Reference: Policy Section 4) *NB: SHHV is not provided in all AHS and is not mandatory.*

IMPLEMENTATION

Chief Executives are to ensure this policy is implemented in accordance with the Implementation Requirements (Reference: Policy Section 5) and personnel, resources and the assignment of responsibly is adequate to effectively implement the policy.

AHS are to provide to NSW Department of Health data as requested on UHHV and SHHV (from those AHS funded to implement SHHV).

This policy must be read in conjunction with the following documents that comprise the **NSW Supporting Families Early Package.**

- PD2010_016 SAFE START Strategic Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html
- GL2010_004 SAFE START Guidelines: Improving mental health outcomes for parents and infants available at: http://www.health.nsw.gov.au/policies/gl/2010/GL2010_004.html

The Maternal & Child Health Primary Care Policy can be downloaded from http://www.health.nsw.gov.au/policies/pd/2010/PD2010_017.html

MATERNITY- NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL (PD2020_008)

PD2020_008 rescinded PD2010_022

POLICY STATEMENT

This is a Policy Directive for maternity services with respect to appropriate consultation and referral by midwives.

This Policy establishes the requirement that all midwives providing midwifery care utilise the *Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral©1.* The ACM Guidelines provide an evidenced-based framework to support midwives in their clinical decision making across all practice areas and facilitate appropriate consultation and referral to peer midwives, medical and allied health staff during pregnancy, birth and the postnatal period.

It is recognised that safe maternity care is reliant on robust systems and processes. This includes careful risk assessment with pathways for escalation to an appropriately role delineated service.

SUMMARY OF POLICY REQUIREMENTS

Local Health Districts:

- Must ensure that all midwives who are providing maternity care refer to and use the *Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral©.*
- Must ensure the availability of the *ACM National Midwifery Guidelines for Consultation and Referral©* to all midwives within their maternity services.
- Provide ongoing education on the use of the *ACM National Midwifery Guidelines for Consultation and Referral©.*
- Are to include an audit of the usage of the *ACM National Midwifery Guidelines for Consultation and Referral©* in their quality framework.

Maternity services must be aware of their designated higher level maternity service for consultation and/or referral and transfer. Equally, higher designated maternity services must be aware of their obligations and responsibilities for lower level maternity services.

Chief Executives or delegated officers are to ensure a written local protocol is in place within maternity services and is implemented as described in this Policy.

Health professionals in all relevant health care settings must be familiar with and use the *ACM National Midwifery Guidelines for Consultation and Referral©.*

Maternity services must ensure that the *ACM National Midwifery Guidelines for Consultation and Referral©* are available to all midwives in all areas of maternity care.

These areas include but are not limited to:

- Antenatal Clinics, both medical and midwifery
- Antenatal inpatient units
- Postnatal inpatient units
- Day Assessment Units
- Delivery Suites/Birthing Centres
- Community Midwifery Programs
- Midwifery Continuity of Care Programs
- Privately Practicing Endorsed Midwives with access rights.

Instructions for accessing the ACM National Midwifery Guidelines for Consultation and Referral© can be found at the Australian College of Midwives website.

Local Health Districts should have in place a local implementation plan for education in the use of the *ACM National Midwifery Guidelines for Consultation and Referral©*

The ACM National Midwifery Guidelines for Consultation and Referral are appropriate for use by other clinicians when providing maternity care.

MATERNITY - FETAL HEART RATE MONITORING (GL2018_025)

GL2018_025 rescinds GL2016_001

PURPOSE

This Guideline provides guidance for fetal heart rate (FHR) monitoring using intermittent auscultation (IA), antenatal and intrapartum electronic fetal heart rate monitoring (EFM), and fetal blood scalp sampling (FBS) to monitor fetal wellbeing.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations (PHOs) providing maternity services where fetal welfare assessment is conducted. The Guideline:

- clarifies the indicators for FHR assessment, monitoring and FBS
- defines the terms used to describe FHR features used by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and the International Federation of Gynaecologists and Obstetricians (FIGO)
- clarifies the features of the preterm FHR response compared to the term fetus
- introduces new assessment tools (algorithms and documentation labels) for the interpretation of antenatal and intrapartum FHR features
- facilitates standardisation of clinical management, consultation and escalation of abnormal FHR features in line with Policy Directive PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating and the GL2016_018 NSW Maternity and Neonatal Service Capability Framework.

USE OF THE GUIDELINE

The Chief Executives are responsible for:

- the implementation of this Guideline in NSW PHO maternity services
- the development of local protocols, pathways and Clinical Emergency Response Systems (CERS) to facilitate consultation and escalation of concern where abnormal FHR features are identified
- monitoring patient safety and quality outcomes related to fetal monitoring, particularly for women with identified risks
- processes are in place to ensure that all relevant maternity services staff (this includes permanent, casual staff, agency and locum staff) receive appropriate education.

To download the Guideline please go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_025

CONNECTING, LISTENING AND RESPONDING: A BLUEPRINT FOR ACTION – MATERNITY CARE IN NSW (IB2023_006)

IB2023_006 rescinded PD2010_045

PURPOSE

This Information Bulletin is to notify the NSW Health system of the release of Connecting, Listening and Responding: A Blueprint for Action – Maternity Care in NSW (the Blueprint).

KEY INFORMATION

The Blueprint is guided by the Woman-centred care: Strategic directions for Australian maternity services and aligns with the NSW Health Policy Directive First 2000 Days Framework (PD2019_008). It has been developed in consultation with local health districts, NSW Health pillars, consumers and key stakeholders.

The Blueprint aims to strengthen maternity care services to ensure they are collaborative, equitable and woman-centred, while acknowledging and striving to address the contemporary organisational challenges for maternity care in NSW.

The Blueprint's vision is that 'all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes'. The Blueprint is supported by 10 goals:

1. Women receive maternity care that is socially and culturally respectful
2. Women's views actively inform improvements to maternity care
3. Women have enough information before conception to optimise their health, pregnancy experience and outcomes
4. Women are connected to information and care early in pregnancy
5. Antenatal care reflects the individual preferences and needs of women, babies and families
6. Women are offered different care options, are actively involved in decision-making about their care and their choices are respected
7. Women with additional needs during pregnancy are connected to appropriate services
8. Women are informed of the possible outcomes of all aspects of care during labour and birth
9. Women receive safe, high quality, evidence-based care that is appropriate to their individual needs and expectations
10. Women are connected to the care and support they need after the birth.

The NSW Ministry of Health will work with key stakeholders to develop an implementation plan for the Blueprint. The implementation plan will set out the short, medium and long-term priorities and further guide decisions on actions required to strengthen implementation.

Key actions

All local health districts and speciality health networks are to:

- promote and utilise the Blueprint for ongoing system reform and service redesign to strengthen maternity care across NSW including preconception, antenatal, labour, birth, postnatal care and transition to care in the community.
- promote the use of the Blueprint to inform direction and local actions to ensure all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes.
- provide input to the NSW Health implementation plan and to support local implementation of the goals, objectives and actions documented in the Blueprint.

Further information

For further information, contact the Health and Social Policy Branch, NSW Ministry of Health at MOH-HSPB@health.nsw.gov.au.

MATERNITY - OXYTOCIN FOR THE INDUCTION OF LABOUR AT OR BEYOND TERM
(PD2011_075)

PURPOSE

This Policy Directive was developed to ensure safe and uniform clinical practice in relation to the use of oxytocin (Syntocinon®) for the induction of labour at or beyond term in maternity hospitals throughout NSW. It applies to induction of labour at or beyond term with a live baby. It is acknowledged that fetal death in utero at any stage of pregnancy may require induction of labour with similar or alternative agents acting upon the uterus not mentioned in the policy directive.

This policy directive provides direction to NSW maternity services regarding safe and uniform practice in relation to the induction of labour. It follows an audit of NSW maternity services undertaken in 2008 that demonstrated a wide variation in clinical practice. This policy directive should help inform maternity services in the development and implementation of local clinical practice guidelines and protocols.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations providing maternity services must have clinical practice guidelines and protocols for the use of oxytocin for the induction of labour at or beyond term. Such clinical practice guidelines and protocols must reflect a Local Health District wide, standardised, evidence based policy for the induction of labour. The Local Health District policy must have statements that reflect the appropriateness of the procedure for the role level of maternity services.

All appropriately role delineated NSW public hospitals providing maternity services must have clinical practice guidelines for the induction of labour at term. Such guidelines must include a clear local plan of action for all clinicians to follow with appropriate early involvement of senior consultants in obstetrics in the event of uterine hyperstimulation (tachysystole), unsuccessful induction of labour, cord prolapse, uterine rupture and maternal collapse.

Health services and hospitals should comply with the educational program components as outlined in IB2008_002 *Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training* (FONT). In particular, fetal welfare and maternity emergencies education days must include cord prolapse and maternal collapse/resuscitation in the program content. All clinicians working in maternity units are expected to complete the various components of the FONT program.

This policy directive must be read in conjunction with:
- PD2009_003 Maternity - Clinical Risk Management Program.
- GL2015_004 Maternity - Fetal Heart rate Monitoring.
- PD2010_045 Maternity - Towards normal Birth in NSW.

IMPLEMENTATION

The Chief Executives of Local Health Districts are ultimately responsible for the implementation of this policy directive within their respective facilities.

1. BACKGROUND

1.1 About this document

This Policy Directive was developed to ensure safe and uniform clinical practice in relation to the use of oxytocin (Syntocinon®) for the induction of labour at or beyond term in maternity hospitals throughout NSW. It applies to induction of labour at or beyond term with a live baby. It is acknowledged that fetal death in utero at any stage of pregnancy may require induction of labour with similar or alternative agents acting upon the uterus not mentioned in the policy directive.

The development of this policy has been undertaken following:

- Literature review on induction of labour.
- An audit of clinical practice for induction of labour undertaken in NSW maternity services in role delineated levels 3, 4, 5 and 6.

An audit of maternity services undertaken in 2008 identified variance in practice in relation to induction of labour and the use of oxytocin for induction and augmentation of labour.

A review of the literature found a range of research papers, systematic reviews and evidence-based clinical practice guidelines describing international best practice for induction of labour. Relevant references are provided at the end of this Policy Directive.

This Policy Directive has been endorsed by the Maternal and Perinatal Committee and the Maternal and Perinatal Health Priority Taskforce.

1.2 Key Definitions

In this document the term:

must – indicates a mandatory action required by a NSW Health policy directive, law or industrial instrument; and

should – indicates an action that should be followed unless there are justifiable reasons for taking a different course of action.

1.3 Local Health District Requirements

Local Health Districts (LHD) must have a LHD wide, standardised, evidence based policy for Induction of Labour. The LHD policy must have statements that reflect the appropriateness of the procedure for the role level of the maternity service.

1.4 Woman Centred Care

Induced labour has an impact on the birth experience for women. Labour is often more painful than spontaneous labour, and epidural analgesia and assisted delivery are more likely to be required.

Treatment and care should take into account a woman's individual needs and preferences. Women who are having, or being offered, induction of labour must have the opportunity to receive accurate information and make informed decisions about their care and treatment, in partnership with their health care professionals.

Effective communication between health care professionals and women is essential. Communication should be supported by evidence-based written information, where possible, tailored to the needs of the individual woman. Treatment and care, and the information provided should be culturally appropriate. It should also be accessible to women, their partners and families, taking into account any additional needs such as physical or cognitive disabilities, and inability to speak or read English.

1.5 Information and decision making

Only GP Obstetricians and Specialist Obstetricians who have been credentialed and have these procedures in their scope of practice may supervise induction or augmentation of labour including the use of oxytocin. It is recommended that scheduling of inductions should be by arrangement with the Birthing Unit Manager, in order to take into account the availability of staff, equipment, support services and expertise.

Women should be informed that most women will go into labour spontaneously by 42 weeks gestation. The median and mode for uncomplicated singleton pregnancy are 40 weeks two days and 40 weeks three days, respectively, not '40 weeks', and two standard deviations beyond that is approximately 13 days. Approximately one-quarter of pregnant women may not have laboured by 41 weeks.[1]

At term, women must be offered information about the risks associated with prolonged pregnancies, and the options available to them.[2]

The information must cover:

- The risks and benefits of membrane sweeping during a vaginal examination:
  - what a membrane sweep is;
  - that membrane sweeping makes spontaneous labour more likely, and so reduces the need for induction of labour to prevent prolonged pregnancy;
  - that discomfort and slight vaginal bleeding are possible from the procedure;
- The risks and benefits of induction of labour from 41[3] weeks gestation; and
- The risks and benefits of expectant management (waiting for labour to start).

Induction of labour must not routinely be offered on maternal request alone.

Health care professionals must explain the following points to women being offered induction of labour:[2]

- the reasons for induction being offered;
- when, where and how induction could be carried out;
- the arrangements for support and management of pain in labour (recognising that women are likely to find induced labour more painful than spontaneous labour) ;
- the alternative options if the woman chooses not to have induction of labour;
- the risks and benefits of induction of labour in specific circumstances and the proposed induction methods; and
- that induction may not be successful and what the woman's options would be in this situation.

Health care professionals offering induction of labour must:

- provide the woman with adequate time to discuss the information with her partner/support person before coming to a decision;
- encourage the woman to access a variety of sources of information;
- invite the woman to ask questions, and encourage her to think about her options; and
- support the woman in whatever decision she makes.

1.6 Special Considerations

Induction of labour carries inherent risk and must be exercised with caution. There needs to be clear benefits for the mother and/or the fetus.

Induction of labour may lead to further interventions hence consideration of the context must be undertaken in line with the designated role delineated level of the maternity service. Such interventions may include the necessity to perform an emergency caesarean section.

Local Health Districts are required to provide guidance for clinicians in circumstances where clinical decision making is particularly difficult such as breech presentation, pre-labour rupture of membranes at term, multiple pregnancy, and previous caesarean section.

Women with a history of previous caesarean section must be informed of the following risks with induction of labour:

- an increased risk of need for emergency caesarean section during induced labour; and
- an increased risk of uterine rupture.

In the case of women with a history of previous caesarean section, Local Health Districts must ensure that medical induction of labour or augmentation with oxytocin (Syntocinon®) does not occur at role delineated level 3, 2 or 1 maternity services.

2. PRIOR TO INDUCTION OF LABOUR WITH OXYTOCIN

2.1 Membrane Sweeping

Membrane sweeping involves the examining finger passing through the cervix to rotate against the wall of the uterus, to separate the chorionic membrane from the decidua. If the cervix will not admit a finger, massaging around the cervix in the vaginal fornices may achieve a similar effect.

For the purpose of this policy directive, membrane sweeping is regarded as an adjunct to induction of labour rather than an actual method of induction.

2.2 Modified Bishop's Score

Before induction of labour is carried out, a modified Bishop's score[3,4,5] must be assessed and recorded to assist with decision making about the best approach. The recommended modified Bishop's score assessment tool is found in Appendix A.

2.3 Prostaglandins for Cervical Ripening

Prostaglandins like dinoprostone (Prostin®) gel or Cervidil® pessary) are widely used throughout many countries for both cervical ripening and induction of labour. In Australia, prostaglandins are promoted for cervical ripening with intact membranes and a modified Bishop Score <5. Health care professionals must comply with the requirements of PD2005_406 *Consent to Medical treatment – Patient Information.*

Before induction of labour is carried out, modified Bishop's score must be assessed and recorded, and a normal fetal heart rate pattern must be confirmed using electronic fetal monitoring. After administration of vaginal PGE2, when contractions begin, fetal wellbeing should be assessed with continuous electronic fetal monitoring. Once the CTG is confirmed as normal, intermittent auscultation should be used unless there are clear indications for continuous electronic fetal

monitoring as described in GL2015_004 *Maternity - Fetal Heart Rate Monitoring.* If the fetal heart rate is abnormal after administration of vaginal PGE2, management of fetal compromise should be attended as per the recommendations in GL2015_004 *Maternity - Fetal Heart Rate Monitoring*.

For Prostin® gel:

- 1 or 2mg for the initial dose. If Prostin® gel is used and a second dose is required, it must not be given within 6 hours of the first dose.
- For Prostin® gel, the maximum dose, regardless of parity, is 3mg for all women in a 12 hour period.
- There is no evidence that further doses of Prostin® gel have any benefit.
- Oxytocin (Syntocinon®), if used, must not be started for six hours following the administration of the last insertion of Prostin® gel.
- Amniotomy may be attended four hours following the administration of the last insertion of Prostin® gel.

For Cervidil®:

- 1 x 10mg pessary is inserted and removed at or before 12 hours has passed depending on uterine activity. At 12 hours after insertion, approximately 4mg of dinoprostone has been absorbed.
- Oxytocin (Syntocinon®) must not be commenced less than 30 minutes after removal of the pessary.

The optimal timing of the doses of prostaglandins needs to be determined locally.

It is recognised that there is ongoing research into other regimes for both Prostin® gel and Cervidil® and that maternity services may be participating in clinical trials that cause variation from this policy directive.

The use of misoprostol for cervical ripening as outlined in this PD is not supported.

NB: Cervical ripening is not an approved indication for the use of misoprostol. Prior to using any drug for an unapproved (off-label) indication, approval should be sought from the local hospital or LHD Drug Committee, and informed patient consent obtained.

2.4 Mechanical Methods for Cervical Ripening

Mechanical methods used for induction of labour include various types of balloon catheters introduced via the cervical canal into the extra-amniotic space. There is emerging evidence favouring the use of balloon catheters for cervical ripening in women with an unfavourable cervix. Mechanical methods of cervical ripening must be supported by local evidence-based guidelines to support staff in their proper use.

3. INDUCTION OF LABOUR

3.1 Surgical Methods of Induction of Labour

Amniotomy is often used in conjunction with methods of cervical ripening and/or oxytocin (Syntocinon®) to effect the initiation of labour. Amniotomy alone may be appropriate in some circumstances. In the absence of contractions, and with a high presenting part, amniotomy carries inherent risk such as compound presentation and/or cord prolapse. Appropriate risk management procedures must be in place to deal with such clinical scenarios.

3.2 Medical Methods of Induction of Labour - Oxytocin

In women with intact membranes, amniotomy should be performed where feasible prior to commencement of an infusion of oxytocin.[2, 3] Even in the situation where induction of labour is being undertaken for prelabour rupture of membranes a vaginal examination should be performed to ensure that any forewaters are ruptured. With intact membranes intravenous oxytocin alone should not be used for induction of labour.

It must be noted that water intoxication is a rare but recognised complication of synthetic oxytocin (Syntocinon®) infusion. Care must be exercised with the solution used, the concentration and the total volume infused.

A fluid balance chart must be accurately maintained for women receiving this infusion. Careful review of fluid status needs to be undertaken after 2 litres of solution have been administered.

3.2.1 Solution

A non-dextrose solution must be used as the vehicle for delivering oxytocin (Syntocinon®). The solutions of choice are normal saline or Hartmann's solution.

3.2.2 Administration

Oxytocin must be administered with an infusion pump to ensure accurate administration.[2,11] It is not acceptable to use visual methods such as counting drops or utilising a burette to administer oxytocin (Syntocinon®).

3.2.3 Concentration

To reduce error, a standard concentration must always be used regardless of parity. The recommended concentration is:

- 10iu oxytocin (Syntocinon®) in 1000ml infusion fluid; **OR**
- 5iu oxytocin (Syntocinon®) in 500ml infusion fluid.

This equates to 10 milliunits per ml.

3.2.4 Starting dose

The same starting dose must be initiated regardless of parity, i.e. 15ml per hour or 150 milliunits per hour.

3.2.4.1 Increments

The rate must not be increased less than 30 minutes following the commencement of the regimen.

The purpose of the administration of oxytocin (Syntocinon®) infusion is to achieve 4 to 5 contractions every 10 minutes. In normal circumstances, this would mean contractions that are 50-70 seconds in duration, and with a minimum resting tone of 90 seconds.

Incremental increases must occur as follows until this is achieved.

Table 1 - Incremental Regimen

Time	Milliunits per minute	Mls per hour
Start	2.5	15
Min 30 mins	5	30
½ hourly	10	60
	15	90
	20	120
	25	150
	30	180
Medical Review		
½ hourly	35	210
	40	240

It is reasonable to consider reduction or cessation of the infusion in circumstances where spontaneous uterine activity is apparent particularly in multiparous women.

If ceased for an insertion of an epidural, recommence at the rate being infused at cessation unless otherwise indicated by the uterine activity.

3.2.4.2 Maximum dose

The maximum dose **must not** exceed 40 milliunits per minute or 240 ml per hour.

Once the dose has reached 30 milliunits/minute (180ml/hour), a medical reassessment must be undertaken before any further increase is undertaken. The management plan must be clearly documented in the health record.

3.2.4.3 Fetal Heart Rate Monitoring

Medical induction of labour must only occur where there are facilities for continuous external uterine contraction and fetal heart rate monitoring.[2]

For women who are healthy and have had an otherwise uncomplicated pregnancy, fetal wellbeing should be established before and after the administration of prostaglandins. Once a reassuring fetal heart rate is shown, intermittent auscultation should be used.[2]

When oxytocin is being infused continuous electronic fetal monitoring should be used as per GL2015_004 *Maternity - Fetal Heart Rate Monitoring.*

Local Health Districts must establish district wide procedures to assess and document the following:
- Maternal Blood Pressure, pulse and temperature.
- Maternal uterine contractions.

Local Health Districts must establish district wide procedures in the event of the following:
- Tachysystole (uterine hyperstimulation).
- Unsuccessful Induction of Labour.
- Cord prolapse.
- Uterine rupture.
- Maternal Collapse.

4. OTHER CONSIDERATIONS

4.1 Mobility

Women should be offered the opportunity to ambulate throughout the induction of labour.

4.2 Managing pain

Women should be informed of the different ways to manage and cope with pain in labour in different settings.

Women should be offered support and analgesia as required, and staff should encourage women to use their own coping strategies for pain relief. This includes the opportunity to labour in water.

4.3 Failed induction

If induction fails, clinicians must discuss this with the woman and provide support. The woman's condition and the pregnancy in general should be fully reassessed and fetal wellbeing should be assessed using electronic fetal monitoring.[2] If induction of labour fails, subsequent management options should be discussed with the woman. Such options may include a further attempt to induce labour, the timing of which will be dependent on the clinical situation and woman's wishes. Caesarean section operation may be appropriate in some circumstances.

4.4 Evaluation

In accordance with PD2009_003 *Maternity - Clinical Risk Management Program*, the local Maternity Clinical Risk Management Committees are charged with auditing the following on an annual basis:

- Gestational age less than 39 weeks for elective induction of labour.
- Documentation of modified Bishop's Score.
- Documentation of fetal welfare.
- Recognition and management of uterine hyperstimulation (tachysystole).

5. REFERENCES

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2. National Collaborating Centre for Women's and Children's Health. *Induction of Labour - Clinical Guideline.* July 2008. RCOG Press.
3. Government of South Australia, Department of Health. Perinatal Practice Guidelines. Available at URL: http://www.health.sa.gov.au/ppg
4. British Columbia Reproductive Program. Obstetric Guideline 1: Cervical Ripening and Induction of Labour. (2005)
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6. Calder AA, Embrey MP, Hillier K. Extra-amniotic prostaglandin E2 for the induction of labour at term. *Journal of Obstetrics & Gynaecology of the British Commonwealth* 1974: 81(1); 39-46

6. APPENDIX A

Modified Bishop[6] Cervical Score System

Characteristic	0	1	2	3	Score
Dilatation (cm)	< 1	1-2	2-4	> 4	
Length (cm)	> 4	2-4	1-2	< 1	
Consistency	firm	average	soft	-	
Position of cervix	posterior	middle/anterior	-	-	
Station	-3	-2	-1 to 0	+1 to +2	
					Total =

Attachment 1: Implementation checklist

Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. A Local Health District standardised local practice procedure, based on this policy directive, must be implemented within 6 months of issue of this policy directive.	❑	❑	❑
	Notes:		
2. All medical, midwifery, nursing and other staff must be educated about the content of this policy directive within 12 months of issue.	❑	❑	❑
	Notes:		

MATERNITY – SUPPORTING WOMEN IN THEIR NEXT BIRTH AFTER CAESAREAN SECTION (NBAC) (GL2014_004)

PURPOSE

The *Guideline: Maternity - Supporting Women in their Next Birth After Caesarean Section (NBAC)* provides direction to the NSW maternity services staff to provide consistent, evidence-based information to women. This information will support pregnant women in their decision making about their next birth after caesarean section.

This Guideline should be read in conjunction with PD2010_045 *Maternity - Towards Normal Birth in NSW* [1], which aims to increase the vaginal birth rate in NSW.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations (PHOs) providing maternity services. It guides all NSW PHOs to support women in their decision making around their NBAC which includes ensuring that:

- Women are provided with access to vaginal birth after caesarean section (VBAC) services.
- Women are provided with consistent evidence-based information regarding NBAC.
- Clinicians have access to consistent evidence-based information in order to support women to make informed choices about birth after a previous caesarean section.

IMPLEMENTATION

The Chief Executives of NSW PHOs are responsible for the implementation of this Guideline within their services/facilities to ensure that local VBAC protocols or operating procedures are in place, aligned and consistent with the Guideline.

All maternity services staff should be aware of the Guideline and actively participate in its implementation to support pregnant women who have had a previous caesarean section in their decision making around their NBAC.

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_004.html

MATERNITY – INDICATIONS FOR PLACENTAL HISTOLOGICAL EXAMINATION (GL2014_006)

PURPOSE

This guideline describes indications for placental histological examination for births occurring in NSW hospitals as well as recommendations for storage, transport and submission of placentas for pathological review.

This document is intended to support clinical practice. The information provided in this document has been guided by the *Clinical Practice Guideline for Perinatal Mortality* produced by the Perinatal Society of Australia and New Zealand (PSANZ).

KEY PRINCIPLES

Within NSW, all placentas should be grossly examined at the time of birth. Specialist medical practitioners and midwives present at the time of delivery who have knowledge of placental anatomy and pathology as well as an understanding of the abnormalities and variations that affect the placenta may carry out the examination.

As the vast majority of pregnancies, newborns and placentas are normal, formal pathological examination of all placentas is neither required nor feasible for many institutions. Therefore, only a subset of placentas requires submission for histological examination. Formal histological examination of the placenta may provide valuable explanation for pregnancies affected by medical complications, pregnancy loss or neonatal death, as well as information relevant to the management of the infant and/or subsequent pregnancies.

USE OF THE GUIDELINE

This guideline should be brought to the attention of staff involved in the delivery of maternity and neonatal care including maternity services units, neonatal intensive care units and general and specialist pathology departments.

The decision regarding the indications for referral of placenta for histological examination should be agreed at a local level by obstetricians, neonatologists, midwives and other relevant maternity services staff. Further advice can be found in Appendix 1 of the Guideline - Guide to Indications for Placental Histological Examination. Submission of placentas following other pregnancy complications or adverse outcomes that are not listed in the guide at Appendix 1, may depend on local resources and availability of pathology services.

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_006.html

MATERNITY – PREGNANCY AND BIRTHING CARE FOR WOMEN AFFECTED BY FEMALE GENITAL MUTILATION/CUTTING (GL2014_016)

PURPOSE

The purpose of this document is to assist health care professionals within NSW Public Health Organisations to provide sensitive and culturally appropriate, evidence-based antenatal, intrapartum and postnatal care for women and their families affected by Female Genital Mutilation/Cutting (FGM/C). It is an expectation that clinical care provided to women with FGM/C will be provided in accordance with these guidelines.

KEY PRINCIPLES

Women with FGM/C are significantly more likely than those without FGM/C to have adverse obstetric outcomes. As more women from these countries settle in Australia, clinicians working within maternity services will increasingly need to become familiar with the skills required to optimise the health of women affected by FGM/C during pregnancy and childbirth.

USE OF THE GUIDELINE

Tiered Maternity Networks (Section 1.5.1)

Delivering best practice care will require a coordinated approach within NSW public hospitals for women affected by FGM/C, including support, counselling and related surgery.

Consultation and referral pathways should also be in place to facilitate the woman's movement between services within her tiered maternity network, to enable her to access skilled care. Local Health Districts (LHDs) should ensure that local guidelines for referral and transfer remain current and are in line with State policy.

Maternity Units in LHDs with a high population of women from countries that practice FGM/C (section 1.5.2)

These facilities should consider establishing an experienced designated team specialising in FGM/C issues, potentially comprising the following staff:

- Midwife
- Doctor
- Nurses, including women's health nurse, child and family health nurse
- Mental Health workers.

The designated team members should:

- Have a sound knowledge of FGM/C and understand the cultural and social complexities around the practice of FGM/C and its health effects through established contact with the NSW Education Program on FGM (SWLHD)[2]
- Undertake regular clinical education/training on FGM/C. More information can be obtained through the NSW Education Program on FGM (SWLHD)[2]
- Act in an advisory capacity or a referral point for maternity units that see fewer affected women.

Maternity Units in LHDs with a low population of women from countries that practice FGM/C

Although all LHDs should be familiar with guidance provided in this guideline it may not be practical for facilities to establish or maintain substantial local expertise. This may be due to factors such as low incidence of FGM/C, staff turnover and difficulty in accessing clinical education/training on FGM/C. In such instances, it will be necessary for these hospitals to establish and maintain links with hospitals that have staff with the required expertise in their tiered maternity network or source the nearest facility that offers FGM/C expertise. These arrangements will be best determined locally. Advice on appropriate contacts and clinical education/training can be sourced from the NSW Education Program on FGM.

To download the Guidelines please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_016.html

GUIDELINES FOR THE MANAGEMENT OF SUBSTANCE USE DURING PREGNANCY, BIRTH AND THE POSTNATAL PERIOD (GL2014_022)

PURPOSE

These clinical guidelines are intended to support a range of health care workers who care for pregnant and breastfeeding women with substance use issues, and their infants and families.

KEY PRINCIPLES

The guidelines emphasise the importance of establishing a sound therapeutic relationship with the woman based on respect and non-judgmental attitudes, of engaging the woman into adequate antenatal care through this relationship, and of maintaining continuity of care and of carers throughout the pregnancy and postnatal period.

The guidelines recommend that pregnant women with significant problematic substance use will benefit from an appropriate referral for specialist drug and alcohol assessment (in addition to midwifery and obstetric care), appointment of a consistent and continuous case manager and care team who use effective communication systems, and specific treatments for their substance use, which may include counselling, pharmacotherapies and relapse prevention strategies.

USE OF THE GUIDELINE

These guidelines are intended for use by all health care practitioners in NSW working with pregnant women who are using substances during pregnancy, and the postnatal period. Substances refers to both licit purposes, such as those prescribed for pain relief, substance use treatment or other issues, and illicit purposes, which can include prescribed substances used for purposes other than that prescribed, and illicit substances.

Substances discussed in these guidelines include the licit substances of alcohol and tobacco; illicit substances of opioids, amphetamine-type stimulants (ATS), cocaine, cannabis and inhalants; and prescription medication which can be used licitly or illicitly. Other topics covered include breastfeeding, vertical transmission of blood-borne viruses, obstetric implications, pain management during labour, psychosocial issues, the management of Neonatal Abstinence Syndrome and early childhood development. This NSW revision of the guidelines has chapters specifically addressing the needs of women who are incarcerated or at risk of incarceration, women who live in rural and/or remote locations, and Aboriginal women. New legislation pertaining to child protection in NSW is also covered in detail.

The Guideline can be downloaded at
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_022.html

NEONATAL AND INFANT HEPATITIS B PREVENTION AND VACCINATION PROGRAM (PD2023_032)

PD2023_032 replaced PD2017_036

POLICY STATEMENT

NSW Health is committed to reducing the risk of hepatitis B transmission to neonates born in NSW. This Policy Directive focuses on the screening of all pregnant women for hepatitis B disease, appropriate referral to a specialist hepatology service/ specialist hepatologist as required, and the follow-up and management of all infants born to hepatitis B surface antigen (HBsAg) positive women.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive must be read in conjunction with the current edition of The Australian Immunisation Handbook.

The Policy Directive aims to ensure consistent implementation of the NSW Neonatal and Infant Hepatitis B Prevention and Vaccination Program in all local health districts; and applies to NSW ante- and post-natal services, maternity hospitals, and public health units within the local health district.

All maternity facilities must offer hepatitis B surface antigen (HBsAg) screening and referral where appropriate to all pregnant women. HBsAg positive pregnant women with a high viral load (>200,000 or 5.3 log10 IU/mL) are recommended to be referred to a hepatology service/ specialist hepatologist.for management and follow up. HBsAg positive pregnant women with a low viral load (≤200,000 or 5.3 log10 IU/mL) can be managed by either their general practitioner or hepatology service.

All maternity facilities are required to offer Hepatitis B immunoglobulin (HBIG) to all neonates born to HBsAg positive mothers within 12-hours of birth. In addition, all neonates regardless of mothers HBsAg status must be offered the hepatitis B vaccine within 7-days of birth.

For reporting requirements, all maternity facilities are required to enter hepatitis B data onto eMaternity or Cerner as appropriate and report regularly to their Local Health District

The Neonatal Hepatitis B Hospital Coordinator must forward a copy of the Neonatal and Infant Hepatitis B Follow Up Letter to the LHD Neonatal and Infant Hepatitis B Lead and the mother's nominated doctor, if known to assist with following up babies born to a HBsAg positive mother.

In addition, the Neonatal Hepatitis B Hospital Coordinator must complete the Maternity Unit Record Form for every infant born to a HBsAg positive mother. The completed form must be sent to the LHD Neonatal and Infant Hepatitis B Lead to ensure all reporting and monitoring responsibilities are met.

The LHD Neonatal and Infant Hepatitis B Lead is required to send a copy of the *Neonatal and Infant Hepatitis B Follow Up Letter to General Practitioners* and the *Maternity Unit Record Form* to the local PHU Immunisation Coordinator for monitoring and follow up of vaccination course completion.

All neonates born to HBsAg positive mothers outside of NSW Health facilities should be notified to the local public health unit to assist with monitoring the completion of their primary hepatitis B vaccination course.

Following collection of the data, the local health district is responsible for reporting program performance and follow-up all neonates born to HBsAg positive mothers who are overdue for vaccination.

The full Neonatal and Infant Hepatitis B Prevention and Vaccination Program policy is available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_032

MATERNITY – EXTERNAL CEPHALIC VERSION (GL2017_007)

GL2017_007 rescinds GL2016_024

PURPOSE

This Guideline describes the procedure for external cephalic version (ECV) and clinical care required when a woman presents at or near term with a singleton breech presentation.

KEY PRINCIPLES

ECV should be an option for women who have a baby that is in a breech presentation and meet criteria for the procedure to be undertaken safely.

USE OF THE GUIDELINE

This Guideline recommends consistent, evidence-based information regarding the option of ECV be provided to the woman by experienced clinicians.

ECV should be offered as noted in GL2016_018 NSW Maternity and Neonatal Service Capability Framework. Each Tiered Maternity Network in NSW should have consultation, referral and transfer processes in place to ensure all women are provided with the option of ECV in the presence of a term singleton breech presentation. The woman's management plan should be documented in her medical record.

To download the full Maternity – External Cephalic Version guideline go to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_007

MATERNITY – SUPPORTING WOMEN PLANNING A VAGINAL BREECH BIRTH (GL2017_008)

PURPOSE

This Guideline provides guidance to Local Health Districts (LHDs) to establish a planned vaginal breech birth service in order to ensure all women have access to this birth option. Alternatively, LHDs are encouraged to ensure that a consultation and referral process is in place for access to vaginal breech birth within their Tiered Maternity and Neonatal Network.

KEY PRINCIPLES

Local and international guidelines support the provision of vaginal breech birth in selected circumstances. For women with a singleton breech presentation at term, research has demonstrated that in maternity units with policies and guidelines to direct clinical care, there s no significant excess additional risk associated with planned vaginal birth compared with planned caesarean section.

USE OF THE GUIDELINE

Access to a supportive vaginal breech birth service within NSW is limited. It is an obligation of NSW Health to provide women with birthing options that offer appropriate safety controls and processes within a tiered network of maternity services.

Consultation, referral and transfer processes should be in place to ensure all women are provided with the option of vaginal breech birth.

To ensure the best outcomes for mothers and babies, vaginal breech birth should be managed in services with expertise in this birth option, including support for informed decision making. Information should be provided on the benefits and risks, both forcurrent and future pregnancies, of planned caesarean section versus planned vaginal birth for breech presentation at term.

Download the Maternity – Supporting Women Planning a Vaginal Breech Birth guideline at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_008

VISITING ENDORSED MIDWIFE PRACTICE (PD2023_036)

PD2023_036 replaced PD2022_018

POLICY STATEMENT

NSW Health is committed to facilitating women's options for maternity care. NSW Health also supports public hospitals to enable admitting and practice rights for Visiting Endorsed Midwives (VEMs), in accordance with Commonwealth maternity reforms.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive provides options for endorsed midwives to apply for an Access Agreement with an NSW Public Health Organisation (PHO). These options include in the capacity as a VEM who provides private midwifery services in NSW Health facilities in an individual capacity, or as a VEM who is separately employed by a midwifery practice or Health Care Service.

Planned births at home that require escalation or transfer of care to a public maternity facility is not included in the scope of this Policy Directive.

An Access Agreement outlines the terms and conditions under which a PHO agrees to grant a VEM the right of access to NSW Health facilities operated by that organisation.

A collaborative arrangement must be agreed and in place between the VEM and either a NSW Health maternity service, or an Obstetric Specified Medical Practitioner who also has rights of practice at the same service.

PHOs must establish Verification Committees to assess applications for Access Agreements from VEMs, and applications from midwifery practices or Health Care Services that employ a VEM requesting an Access Agreement. Verification Committees make recommendations to the Chief Executive (or their delegate) of the PHO to approve or decline applications. Verification Committees are also responsible for credentialing and determining the scope of practice of VEMs. Verification Committees verify, cite and authenticate relevant documents supplied by a VEM to validate their professional qualifications and experience, and also validate the endorsement of VEMs for use of scheduled medicines.

Verification Committees also consider and approve amendments to Collaborative Arrangements. Verification Committees review the right of access of the VEM, midwifery practice or Health Care Service at one year from the commencement date of the Access Agreement, and then each 12-month period thereafter (a new application for an Access Agreement is required every five years).

Download the complete Visiting Endorsed Midwife Practice policy at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_036

NAUSEA AND VOMITING IN PREGNANCY AND HYPEREMESIS GRAVIDARUM (GL2022_009)

GUIDELINE SUMMARY

Nausea and vomiting in pregnancy and hyperemesis gravidarum can cause significant emotional, psychological, physical and financial distress for women and their families.

This Guideline provides evidenced-based guidance to support consistency of practice, decision-making and care coordination for the diagnosis and management of nausea and vomiting in pregnancy and hyperemesis gravidarum.

This Guideline applies to NSW Health and non-NSW Health clinicians (such as general practitioners) who provide care to pregnant women.

KEY PRINCIPLES

This Guideline reflects evidence based best clinical practice and expert consensus opinion to standardise the diagnosis and management of nausea and vomiting in pregnancy and hyperemesis gravidarum.

The Guideline provides recommendations for the care of priority populations including the care of Aboriginal and/or Torres Strait Islander families, culturally and linguistically diverse families and care of LGBTIQ+ people.

Comprehensive assessment, including the Pregnancy Unique Quantification of Emesis (PUQE-24) scoring index, will assist with defining the severity of illness and to guide care pathways which promote community and ambulatory care settings.

Holistic and multidisciplinary care must consider the woman's social and emotional wellbeing. Individual care plans are to be developed in partnership with the woman and must include advice on how to adjust treatment if symptoms improve, fluctuate or deteriorate, and how to access care if required.

Continuity of care models, including access to specialist care, must be developed to support women accessing care closer to home. This may include community or ambulatory care for women with mild to moderate severity; Hospital in the Home for women with more severe symptoms; and virtual care as appropriate.

Transfer of care between maternity services and community-based services is to be coordinated, ensuring that women receive consistent information, assessment, management, treatment, and continuity of care.

Pre-conception support, counselling and early or pre-emptive treatment, including an early pregnancy booking, is to be offered to women who have experienced hyperemesis gravidarum in a previous pregnancy.

Local Health Districts and Specialty Health Networks must ensure:

- implementation of this Guideline
- relevant staff receive education and training based on the Guideline
- local protocols or operating procedures are in place and consistent with this Guideline
- monitoring of practice.

Download the Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum guideline at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_009

REDUCING THE EFFECTS OF SMOKING AND VAPING ON PREGNANCY AND NEWBORN OUTCOMES (PD2022_050)

POLICY STATEMENT

NSW Health services and clinical staff are committed to provide evidence-based and high-quality smoking and vaping cessation support to women before, during and after pregnancy.

Smoking during pregnancy is the most significant preventable cause of complications for pregnant women and their children, and is associated with preterm birth, low birth weight, babies who are small-for-gestational-age and perinatal death.

SUMMARY OF POLICY REQUIREMENTS

All clinicians working in Maternity and Newborn, Child and Family Health, Perinatal Infant Mental Health Services (PIMHS), Aboriginal Maternal and Infant Health Services (AMIHS), Building Strong Foundations for Aboriginal Children, Families and Communities (BSF), Oral Health Services, Primary Care and Aboriginal Community Controlled Health Services (ACCHSs), and other relevant services are to be appropriately skilled in the management of smoking and vaping in pregnancy.

Carbon monoxide (CO) monitoring is to be offered to all women before asking about smoking status:

- at first pregnancy visit and at the 28 weeks gestation visit.
- at every health visit for women who are known to smoke, or who have recently quit (i.e., in the last 12 months).

The carbon monoxide measurement is to be used as a tool to engage in discussion on smoking status, avoiding second-hand smoke, and to motivate quitting. The expired carbon monoxide reading is to be recorded in the woman's health care record.

Clinicians are to use a sensitive and empathetic approach when discussing smoking and vaping with pregnant women. The 'Ask, Advise, Help' smoking and vaping cessation brief intervention model must be used at every health visit.

Clinicians are to ask and record the smoking and vaping status of all pregnant women and that of their partner and/or household members at all health visits. Clinicians are to advise on the short and long term benefits of quitting and effective ways to quit, and offer culturally appropriate support (help) and resources to assist their attempts to quit.

Clinicians are to provide all Aboriginal women with care that is safe, respectful and trauma informed. A comprehensive, holistic approach must be taken when addressing smoking and/or vaping. This includes the physical, spiritual, cultural, emotional, and social wellbeing of women. This is especially important for Aboriginal women and women having an Aboriginal baby.

Clinicians are to offer consultation with an Aboriginal health worker that the woman is comfortable with, or referral to a culturally safe service, such as Aboriginal Quitline (accessed by calling Quitline and asking to speak to an Aboriginal Advisor).

Support and interventions to quit smoking and vaping are to be self-determined and adopt a strengths-based approach to ensure women and their families feel supported in their progress to quit. A strengths-based approach acknowledges the strengths of Aboriginal people, their families, and their communities, including connection to culture, resilience, and a holistic view of health, and moves away from deficit discourse.

People who smoke or vape may have complex needs associated with their nicotine/tobacco use, including psychosocial issues, trauma, mental health conditions, and drug and alcohol related health issues. Clinicians are to provide smoking and vaping cessation support that is safe, respectful and trauma informed.

Clinical staff are to document carbon monoxide readings, smoking and vaping status, support offered, and outcomes of discussions in the woman's health care record to ensure continuity of care and appropriate follow-up.

Download the complete Reducing the effects of Smoking and Vaping on Pregnancy and Newborn Outcomes policy at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_050

344(14/10/22)

CARE OF WOMEN WITH SUSPECTED OR CONFIRMED FETAL GROWTH RESTRICTION (GL2023_004)

GUIDELINE SUMMARY

Fetal growth restriction is a common complication in pregnancy that is associated with adverse perinatal and neurodevelopmental outcomes including stillbirth, neonatal mortality and short- and long-term morbidity. This Guideline provides evidence-based guidance to support maternity services in the care planning for pregnant women with suspected or confirmed fetal growth restriction, ensuring women and their families are fully informed of risks, potential outcomes and their options of care.

This Guideline applies to all NSW Health maternity services.

KEY PRINCIPLES

This Guideline reflects evidence based clinical practice for the screening, management, and escalation of Fetal Growth Restriction (FGR) during pregnancy. Women with confirmed FGR require as a minimum, a multidisciplinary collaborative care plan in line with the Tiered Perinatal Networks.

Throughout all pregnancy and perinatal care, women and their families must be fully informed of risks, potential outcomes and their options of care. Women and their support person(s) are always included in care planning and decision making, and consent for healthcare treatment must be established.

Throughout the antenatal period, all women must be assessed for risk factors associated FGR in line with the NSW Fetal Safety Risk Assessment Pathway and an appropriate care plan developed in collaboration with the woman.

FGR is associated with adverse perinatal outcome including stillbirth. Aboriginal and Torres Strait Islander women experience higher rates of stillbirth. Risk factor identification is vital to support perinatal risk reduction and reduce adverse outcomes for Aboriginal and Torres Strait Islander women.

Serial plotting of symphysis fundal height (SFH) measurements on the NSW Health International Symphysis-Fundal Height Standards chart are to be conducted as part of routine antenatal care starting from 24 to 28 weeks gestation, to monitor for potential FGR.

Women who are unsuitable for symphysis fundal height measurements or have FGR risk factors as per the NSW Fetal Safety Risk Assessment Pathway will require growth ultrasound assessments.

Where FGR is identified, consultation and referral for specialist obstetric care must be offered and arranged as appropriate.

346(24/02/23)

In the presence of FGR, decisions for planning birth should include consideration of the gestational age and be balanced against the benefits of ongoing pregnancy, in collaboration with the woman.

Optimal care planning includes ensuring the availability of multidisciplinary team members including the neonatal team, to support stabilisation and potential admission of the baby to a neonatal unit.

For future pregnancies, women with a history of FGR require as a minimum, multidisciplinary collaborative care planning involving midwifery and medical consultation.

All women should be provided the opportunity to debrief with clinicians about their pregnancy and birth experience and appropriate follow up support be made available. This should include psychosocial support where indicated with appropriate wellbeing support made available.

Download the complete Care of women with suspected or confirmed Fetal Growth Restriction guideline at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_004

DOMESTIC VIOLENCE ROUTINE SCREENING (PD2023_009)

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning.

All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

The full Domestic Violence Routine Screening policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_009

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

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CHAPTER 18 - OUTPATIENTS

TABLE OF CONTENTS

	PD/IB/GL NUMBER
Management of Outpatient (Non-Admitted) Services	GL2023_014

Last updated August 2023

MANAGEMENT OF OUTPATIENT (NON-ADMITTED) SERVICES
(GL2023_014)

GL2023_014 replaced GL2019_011

GUIDELINE SUMMARY

This Guideline sets out expectations for the management of outpatient services across NSW Health to ensure patients receive responsive and appropriate care that is patient-centred and focuses on outcomes that matter. It provides guidance for the planning, provision, and delivery of outpatient services. Adherence to this Guideline is intended to optimise outpatient care provided to the NSW population.

KEY PRINCIPLES

Local Health Districts and Specialty Health Networks are to use this Guideline to:

- understand the expectations of the NSW Ministry of Health regarding standards to be met for the planning, provision and delivery of NSW Health outpatient services,
- identify gaps or required improvements to meet these standards, and
- establish goals and timeframes to implement solutions and change processes.

Articulating principles, procedures and processes for the optimal provision of outpatient services aims to improve patient and clinician experiences, and support patients to receive care within clinically recommended timeframes.

NSW Health organisations are to plan, deliver and manage outpatient services in accordance with this Guideline.

While access to care in the outpatient setting is prioritised based on clinical need, the way in which the care itself is provided once this prioritisation has occurred is to be respectful of, and responsive to the needs, values and preferences of patients.

Processes are to be in place to facilitate safe, timely and effective referral management. This includes ensuring referral screening takes place efficiently upon receipt of a referral, and appropriate management occurs thereafter. NSW Health organisations are, at a minimum, required to communicate with patients and referrers regarding referral receipt and triage outcome.

Categorisation of clinical urgency is based on clinical need, regardless of financial classification status or expected wait times. Every effort is to be made to ensure patients are seen within clinically recommended timeframes.

Active management of outpatient waitlists is to be part of routine processes to ensure timely access to care. This includes confirming waitlists are accurate and complete, managing changes in clinical urgency categories, waitlist suspensions, waitlist removals and waitlist reinstatements. In addition, waitlists are to be regularly audited as a core component of evaluating access performance and identification of potential risks.

Appointment management is to be patient-focused and take place based on clinical urgency and the ‘Treat in Turn’ principle. Adequate information is to be provided to patients to support accessing their outpatient appointment. Regular communication with referrers and General Practitioners (GPs), if not the referrer, should is to occur throughout the episode of care to maintain collaborative management of the patient.

Discharge (or transfer of care) planning is to commence at the first appointment with the aim to ensure patients are transferred back to the care of the referrer in a timely manner. Transfer of care summaries provided to referrers and/or GPs are to include ongoing management plans. Clear escalation pathways to streamline re-entry into outpatient services and forego the need for a re-referral are to be considered and communicated to referrers, where clinically indicated.

Download the complete Management of Outpatient (Non-Admitted) Services guideline at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_014

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 19 - PATHOLOGY

TABLE OF CONTENTS

	PD/IB/GL NUMBER
Blood Management	PD2018_042
Cord Blood - Public and Private Cord Blood Banking	PD2015_048
Responsibilities of Medical Officers with Regard to Drivers	IB2013_059
Forensic Drug and Alcohol Sampling in Emergency Departments	PD2021_010
Management of Sudden Unexpected Death in Infancy (SUDI)	PD2019_035
Non-Coronial Post Mortems	PD2013_051
Destitute Persons - Cremation or Burial	PD2008_012
Coroners' Cases and the Coroners Act 2009	PD2010_054
Coronial Checklist	IB2010_058
Accreditation of Pathology Laboratories in NSW Health	PD2017_011
Point of Care Testing (PoCT) Service	PD2018_028
Transport of Pathology Specimens to Laboratories	PD2023_001

BLOOD MANAGEMENT (PD2018_042)

PD2018_042 rescinds PD2012_016

PURPOSE

The purpose of this Policy Directive is to support health services and health service staff to comply with their responsibilities as described in the Australian Health Ministers Conference (AHMAC) Statement on National Expectations for the Supply of Blood and Blood Products1 by:

1. Providing policy and system direction for the use of evidence based best practice blood management guidelines for NSW Health facilities
2. Establishing a consistent, system wide approach to blood management in all facilities providing transfusion therapy
3. Minimising NSW patients exposure to risks associated with the clinical storage, prescribing, handling and administration of blood products in NSW facilities
4. Supporting health facilities to comply with the relevant National Safety and Quality Service Standards, and other accreditation requirements in relation to blood management.

MANDATORY REQUIREMENTS

NSW health services that provide transfusion therapy are responsible for:

1. Developing and maintaining effective systems to ensure safe, effective, appropriate and patient centred blood management processes and procedures
2. Adopting and implementing best practice procedures relating to blood management and the clinical storage, prescribing, handling and administration of blood products
3. Complying with the relevant National Safety and Quality Health Service Standards (NSQHS).

Health service staff involved in blood management and/or transfusion related activities are responsible for:

1. Complying with relevant blood management systems, processes and procedures, including those outlined in this Policy Directive
2. Providing safe, effective, appropriate and patient centred care.

It is recognised that some of the requirements in this policy such as the role of the Local Health Districts/Special health networks are not applicable to private health facilities. Private health facilities are expected to comply with the general principles described in this Policy Directive in compliance with the *Private Health Facilities Act 2007* (NSW) and the *Private Health Facilities Regulation 2017* (NSW).

IMPLEMENTATION

Chief Executives are responsible for:

- Assigning responsibility for implementing and complying with this Policy Directive and reporting on the implementation of this policy document as required
- Monitoring compliance with this Policy Directive by achieving and maintaining accreditation to the relevant NSQHS standard

Health service staff are responsible for:

- Complying with this Policy Directive

Clinical Excellence Commission is responsible for:

- Reviewing and ensuring the currency of this Policy Directive
- Supporting the implementation and evaluation of strategies related to this Policy Directive.

1 Statement endorsed by the Australian Health Ministers' Conference, 12 November 2010 (see attachment 5.1)

Blood Management Procedures

1 BACKGROUND

1.1 About this document

In line with the Australian Health Ministers' Conference Statement on National Stewardship Expectations for the Supply of Blood and Blood Products[2], this Policy Directive provides clinicians; pathology providers; support personnel and health service managers, with direction to ensure safety and quality in blood management related activities.

1.2 Key definitions

Word or Phrase	Definition
Blood Products	Includes fresh blood components (red blood cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma) and plasma-derived (fractionated) blood products such (albumin, coagulation factors and immunoglobulins).
Blood Service	The Australian Red Cross Blood Service, responsible for the collection, manufacture and distribution of blood products to NSW hospitals.
Haemovigilance	A set of surveillance procedures covering the entire transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to patients, to their follow-up. It includes monitoring, reporting, investigation and analysis of adverse events related to donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.
Health care record	Includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.
Traceability	The ability to trace the fate of a blood product from the donor through to the final recipient/s, via accurate documented and/or electronically stored blood service, laboratory and patient records.
Transfusion history	A list of transfusions that a patient has had before presentation, including details of any adverse reactions to the transfusion and any special transfusion requirements. The completeness of the history will depend on the availability of information. It is expected that information will be obtained by reviewing any available referral information and interviewing the patient (and/or their carer).
Transfusion related activity	Transfusion related activity includes but is not limited to: • Prescribing and ordering • Obtaining patient blood samples • Obtaining patient consent for transfusion • Pre transfusion laboratory testing and product issue • Storage • Transport • Administration • Monitoring and patient assessment.

2 Statement endorsed by the Australian Health Ministers' Conference, 12 November 2010 (see attachment 5.1)

1.3 Legal and legislative framework

Blood, blood components and plasma derivatives are regulated under the *Therapeutics Goods Act 1989* (Cth)3.

The *Human Tissues Act 1983* (NSW) sets out the legislative requirements for the collection of blood from donors[4] and the regulation of businesses supplying blood and blood products5.

Under the *National Blood Authority Act 2003* (Cth)6, the National Blood Authority manages and coordinates arrangements for the supply of blood and blood products and services on behalf of the Australian Government and state and territory governments.

Jurisdictional issues relating to the national blood supply, including planning, production, supply and budgeting are managed through the Jurisdictional Blood Committee (JBC). The Deputy Secretary, Population & Public Health is the NSW representative on the JBC.

2 CLINICAL USE OF BLOOD PRODUCTS

2.1 Transportation and Storage

Health services providing transfusion therapy must have procedures in place to ensure the safe storage and where relevant, transport of blood and blood products.

The transport and storage of blood products must comply with the:

- National Pathology Accreditation Advisory Council (NPAAC) Requirements for Transfusion Laboratory Practice or any subsequent versions
- Australia and New Zealand Society of Blood Transfusion (ANZSBT) Guidelines for Transfusion and Immunohaematology Laboratory Practice or any subsequent versions.

2.1.1 Transportation

Transport of blood products between facilities, including packing configurations and the use of validated shipping containers, should be managed in compliance with the:

- Relevant NSW Health Pathology policy directives and procedures[7] (or other accredited pathology provider policy and procedures, see 3.2.2)
- Blood Service Shippers – Receipt and Use by External Institutions8.

2.1.2 Storage

Storage of blood products must comply with:

- Australian Standard AS 3864 - Medical Refrigeration Equipment – for the storage of blood and blood products
- Relevant NSW Health Pathology policy or procedures9 outlining storage requirements of blood products (or other accredited pathology provider policy and procedures, see 3.2.2).

3 Australian Government, Department of Health; Therapeutic Goods Administration, *Therapeutics Goods Act 1989* (Cth)
4 *Human Tissues Act 1983* (NSW) ss19-20H
5 Ibid ss21-21C
6 *National Blood Authority Act 2003* (Cth)
7 NSWHP Policy Red Blood Cell Storage, NSWHP Procedure Retrieval Transfusion Procedure, and any other NSWHP policy directive or procedure related to storage and transport published subsequent to this Policy Directive
8 Australian Red Cross Blood Service Shippers – Receipt and Use by External Institutions (WI-00635; version 1) or any subsequent version
9 Ibid above 7 and Australian Standard AS 3864 - *Medical Refrigeration Equipment –for the storage of blood and blood products* (1997) or any Australian Standard that supersedes this.

This includes:

- Storage in dedicated fridges and/or freezers that are remote from a transfusion laboratory (satellite)
- Storage in facilities without dedicated blood storage equipment, including the use of validated shipping containers for short term storage
- Storage of blood products accompanying transferred patients
- Storage of products for use by emergency retrieval teams.

Blood products delivered to a clinical environment, e.g. ward, operating theatre must:

- Be stored in accordance with this Policy Directive, or
- Be administered to the patient within the appropriate time frame as described in the ANZSBT Guidelines for Administration of Blood Products or any subsequent versions.

A blood product must not be transfused, except at the discretion of the laboratory director, where it is:

- Stored at temperatures outside specified limits
- Stored in non-conforming equipment
- There is doubt regarding storage equipment.

2.2 Consent

Health services providing transfusion therapy must have procedures and processes in place to ensure clinicians are able to obtain and document informed consent for the use of blood products.

These procedures and processes must comply with the requirements for consent as outlined in the NSW Health Policy Directive *Consent to Medical Treatment – Patient Information,* or any subsequent versions, and include:

- The use of the relevant consent forms as described in the above Policy Directive
- Who can obtain consent
- The right to decline any proposed treatment
- Patients who are unable to provide consent (including minors)
- Emergency treatment.

Informed consent requires:

- A discussion of the risks and benefits of the use of blood products
- The availability of other treatment options as relevant to the patient's clinical condition
- The likely outcome(s) if the treatment is not provided or declined
- The documentation of refusal (and associated care planning requirements)

Information for patients on the use of blood products is available to support the consent process at:

- CEC Blood Watch patient information page, including information in multiple languages, and information for children and parents
- Blood Service My Transfusion web site

Where treatment involves the administration of blood products over a period of time for the same clinical indication, it is not necessary to obtain consent for every transfusion episode. Initial consent should be obtained and documented as outlined in the above Policy Directive. It should include the length of time blood products will be required, or the length of time the consent will remain valid for.

Requirements for long term consent should be described in health service procedural documents. For patients with long term transfusion requirements, reviewing and obtaining consent at regular intervals of at least 1 year (but no greater than 2 years) is considered best practice.

A new consent should be obtained if:

- A new treatment is proposed which was not previously explained to the patient
- Where alternative treatments become available
- If new risks associated with the treatment are identified.

2.3 Patient identification

Health services must have systems in place to ensure correct patient identification and procedure verification for transfusion-related activities.

Correct patient identification procedure from the collection of specimens, to the transfusion of blood products, is vital to ensure that all patients receive the correct blood product, for the appropriate indication.

Failure to correctly identify the patient at any stage can lead to serious adverse outcomes.

2.3.1 Pre-Transfusion testing and specimen labelling

Pre-transfusion specimen collection and specimen labelling requirements and related procedures must comply with:

- ANZSBT Guidelines for Transfusion and Immunohaematology Laboratory Practice or any subsequent versions
- NSW Health Pathology NSWHP_PD_009 Minimum Patient Identification requirements for Pre-Transfusion Testing10 (or other accredited pathology provider policy and procedures, see 3.2.2)
- Principles for patient identification, and pre and post procedure matching for level 1 procedures, as outlined in the NSW Health Policy Directive PD2017_032 *Clinical Procedure Safety* or any subsequent versions.

2.3.2 Transfusion verification procedure

Transfusion related patient identification procedures must be implemented for transfusion related activities including:

- The collection of blood products from the transfusion service or appropriate storage (e.g. satellite blood fridge)
- Delivery to the clinical environment
- Administration to the patient.

The purpose of transfusion related patient identification procedures is to ensure the correct blood product is administered to the correct patient. To minimise the risk of error at the final administration check, the administering and checking clinicians must check the required information independently, a process called “double independent checking”.

Procedures must comply with:

- Principles for patient identification and procedure matching as outlined in the NSW Health Policy Directive *Clinical Procedure Safety* or any subsequent versions
- ANZSBT Guidelines for the Administration of Blood Products or any subsequent versions.

2.4 Appropriate use

Health services must have processes in place to support clinicians in their obligations to provide safe, effective and appropriate use of blood products when clinically indicated.

10 NSW Health Pathology NSWHP Policy Minimum Patient Identification requirements for Pre-Transfusion Testing available at https://intranet.pathology.health.nsw.gov.au/tools---resources-/policies-and-procedures/policies

Decisions on whether to prescribe blood products, and the dose or number of units to order should take into account:

- The presence or absence of proven benefit
- Risks associated with the use of blood products
- Other treatment options, including appropriate management of reversible causes of deficiencies[10].

Procedures for appropriate use of blood products must comply with the current and any subsequent versions of:

- National Patient Blood Management Guidelines
- Blood Service Component Information
- ANZSBT Guidelines for Transfusion and Immunohaematology Laboratory Practice including for the selection of modified blood products and:
    - Rh D negative
    - CMV negative
    - Irradiated products

2.5 Safe administration

Health services must have processes in place to support clinicians to safely administer blood products when clinically indicated.

Successful and safe transfusion practice depends on the administration of a quality blood component of the right type, for the right indication, in the right quantity or dose, via the right route, at the right time to the right patient.

Procedures for safe administration of blood products must comply with the current and any subsequent versions of:

- ANZSBT Guidelines for the Administration of Blood Products
- Blood Service Component Information.

2.6 Adverse events

Health services are to have systems and processes in place to support the appropriate identification, management, notification, and follow up of adverse outcomes of transfusion, transfusion reactions, and incidents relating to transfusion activities.

2.6.1 Transfusion reactions

Transfusion reactions are adverse pathophysiological complications associated with the use of blood products. Management of patients who are suspected of having a transfusion reaction should include:

- The initiation of patient assessment and first aid including basic life support and the appropriate escalation as per *Recognition and Management of Patients who are Deteriorating* or any subsequent versions, including obtaining further appropriate clinical consultation if required (e.g. Haematology)
- Notification to the pathology provider responsible for providing the blood product as well as following instructions on follow up investigations and clinical consultation as required
- All adverse reactions are to be entered into the incident management system (see 2.6.3)
- Resources for clinical management of transfusion reactions include:
    - ANZSBT Guidelines for the Administration of Blood Products or any subsequent versions
    - The Blood Service: Adverse Events overview or any subsequent versions.

2.6.2 Transfusion incidents

Transfusion incidents are errors in activities related to the use of blood products including specimen collection, storage, handling, ordering, prescribing, administration and documentation.

Transfusion incidents may cause severe, potentially fatal complications including ABO Haemolytic Transfusion reaction (HTR), and Transfusion Associated Circulatory Overload (TACO). Such complications should be managed as per 2.6.1 in the first instance.

2.6.3 Notification and management of transfusion reactions and incidents

All health services providing transfusion therapy are to have systems in place for the notification and management of transfusion related incidents (including transfusion reactions).

- For NSW Health services, all incidents are to be entered into the incident management system
- Notification and management must comply with NSW Health policy on *Incident Management* or any subsequent versions, including appropriate allocation of a severity assessment code (SAC) and follow up investigation and management
- A Haemolytic Transfusion Reaction (HTR) as a result of ABO (Blood Group) incompatibility, and causing serious harm or death, is a sentinel event, and is a reportable incident requiring a Reportable Incident Brief (RIB)11
- Appropriate open disclosure must occur in compliance with NSW Health policy on *Open Disclosure* or any subsequent versions
- **All** suspected Transfusion Transmitted Infections (bacterial, viral, parasitic or other) must be reported to the Blood Service:
  - 24 hour customer service line: **1300 478 348**
- **All** suspected Transfusion Related Acute Lung Injury reactions must be reported to the Blood Service:
  - 24 hour customer service line: **1300 478 348**
- Consider seeking advice from the Blood Service for the following transfusion reactions where expert advice and/or alternative component or product support may be required. These include:
  - Post transfusion purpura (PTP)
  - Transfusion associated graft-vs-host disease (TA-GVHD)
  - Severe allergic reactions
  - Immediate and delayed haemolytic and serological transfusion reactions
  - Reactions to plasma-derived recombinant products.
- Reactions associated with the use of plasma derived blood products should also be reported to the Blood Service, the product manufacturer, and to the Australian Adverse Drug Reaction Reporting System (AADRS)12.
- The NSW Clinical Excellence Commission, via the Blood Watch Program is responsible for collating and reporting haemovigilance activities in NSW for the National Haemovigilance Program (NBA)13.

2.7 Documentation and medical records

Health services must have in place processes for all models of documentation and management of health care records in compliance with NSW Health policy *Health Care Records – Documentation and Management* or any subsequent versions.

11 NSW Health Incident Management Policy section 3.1 RIB reporting requirements and 3.1.1 The sentinel events
12 Australian Adverse Drug reaction Reporting System (AADRS) as per the Advisory Committee on the Safety of Medicines (ACSOM)
13 NBA, National Haemovigilance Program

NSW Health facilities must comply with the General Retention and Disposal Authority - Public Health Services: Patient / Client Records (GDA 17) 200414.

It is a requirement that there is documentation in place to ensure the traceability (fate) of the blood product is recorded as either transfused, transferred (to another health service) or discarded. This is achieved through accurate documentation in the patient health care record **and** the laboratory information system.

2.7.1 Patient health care record

Documentation of transfusion related activity should be available to all clinical staff and include:

- Transfusion history (including previous complications) if available
- Indication for the use of blood product
- Consent
- Prescription
- Blood product compatibility information or product batch number as applicable
- Administration and completion times
- Patient observations as applicable to the type of blood product
- Outcome of the transfusion
- Occurrence and management of any adverse events or reactions.

2.7.2 Laboratory

Transfusion laboratories must comply with the documentation requirements for blood products, immunohaematology specimens, and patient information as described in the ANZSBT Guidelines for Transfusion and Immunohaematology Laboratory Practice or any subsequent versions.

The fate of fresh blood products, either transfused, transferred or discarded, must be documented in the BloodNet Fate module. If discarded, the reason must be entered, as per the definitions provided.

3 GOVERNANCE

3.1 Blood Management Committee

Health services that provide transfusion therapy must have a process in place for the review of blood product issues. This may be through a Blood Management Committee (BMC) or an equivalent quality or patient safety management committee as relevant to the size and function of the service.

The BMC (or equivalent) responsibilities should include:

- Development and monitoring of local policy, procedures and safe work practices
- Monitoring the clinical use of blood products
- Monitoring wastage of blood products
- Haemovigilance activities, i.e. monitoring, reporting, investigation and analysis of adverse events related to blood product transfusion
- Escalating any concerns or risks associated with transfusion related activities to the relevant authority
- Contingency planning in the event of notified shortages of blood products
- Monitoring education in transfusion related activities to all relevant staff groups.

14 NSW State Records Authority, General Retention and Disposal Authority - Public Health Services: Patient /Client Records (GDA 17) 2004

3.2 Education

Staff involved in transfusion related activities must complete the BloodSafe eLearning Course Clinical Transfusion Practice.

Transfusion related activities include (but are not limited to):

- Pre transfusion laboratory testing and product issuing
- Administration of blood products
- Monitoring and patient assessment
- Prescribing and ordering blood products – Intern medical officers only (Postgraduate Year 1/2) are required to complete Clinical Transfusion Practice
- Health care workers involved in non-clinical handling of blood products, such as hospital porters and orderlies, are required to complete the separate Transporting Blood module only.
- Health care workers employed only to perform phlebotomy or venepuncture are required to complete the separate Collecting Blood Specimens module only.

This mandated requirement to complete these BloodSafe eLearning courses applies only to a one-off completion, Local Health Districts and Special Health Networks may determine to repeat completion and assessment at a frequency deemed by them to meet local needs.

3.3 Roles and responsibilities

3.3.1 Local Health Districts / Special Health Networks

The Local Health District/Special Health Network must monitor compliance with this Policy Directive and ensure that all facilities that provide transfusion therapy (and related activities) are able to report to a BMC (or equivalent), and that all staff are appropriately trained as relevant to their role.

All facilities that provide transfusion therapy must achieve and maintain accreditation to the relevant NSQHS Standard.

3.3.2 NSW Health Pathology

NSW Health Pathology is responsible for the provision of transfusion laboratory services for NSW Health. As required by NSW Health Policy Directive *Accreditation of Pathology Laboratories in NSW Health* (or any subsequent versions) transfusion laboratory services are required to maintain accreditation to the standards developed by the National Pathology Accreditation Advisory Council.

Transfusion laboratory service providers, other than NSW Health Pathology, may be utilised by NSW Health services. Where such agreements are in place, the requirements of this policy apply.

For transfusion laboratories the relevant standard is the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Transfusion Laboratory Practice (3rd Ed) 201715, or any subsequent versions.

3.3.3 Blood Service

The Blood Service is responsible for the collection, manufacture and distribution of blood products to NSW.

The Blood Service operates a 24 hour, 7 day a week phone line for clinical advice and consultation on fresh components, plasma-derived products and recombinant products and on urgent clinical matters including significant transfusion reactions (see 2.6.3 Notification and management of transfusion reaction and incidents).

The contact number is: 24 hour customer service line: **1300 478 348**

15 The Department of Health, NPAAC Requirements for Transfusion Laboratory Practice (3rd Ed) 2017

4 RELATED NSW HEALTH POLICY DIRECTIVES, GUIDELINES AND INFORMATION BULLETINS

- Management of Haemophilia and Related Bleeding Disorders
- National Policy – Access to Government Funded Immunoglobulin Products in Australia
- Maternity – Rh (D) Immunoglobulin (Anti D)
- Maternity – Prevention, Detection, Escalation and Management of Postpartum Haemorrhage (PPH)

5 ATTACHMENTS

5.1 AHMAC stewardship statement

5.2 Implementation checklist

5.1 AHMAC Stewardship Statement

AUSTRALIAN HEALTH MINISTERS' CONFERENCE STATEMENT ON NATIONAL STEWARDSHIP EXPECTATIONS FOR THE SUPPLY OF BLOOD AND BLOOD PRODUCTS

The Australian Health Ministers' Conference (AHMC) has determined that a clear statement is needed on governments' stewardship expectations for the providers of blood and blood products within the health sector. Stewardship, in this context, means responsible, sustainable and appropriate use of blood and blood products.

Blood and blood products are provided under the *National Blood Agreement* 2003 to which all Commonwealth, State and Territory Governments are signatories. Achieving a blood supply that can meet the growing needs of an ageing population at an affordable cost requires the commitment from blood donors to be matched by an equal commitment from other parties in the supply chain.

All governments are committed to:

- Providing an adequate, safe, secure and affordable supply of blood products, blood related products and blood related services; and
- Promoting safe, high quality management and use of blood products, blood related products and blood related services in Australia.

A key component of the blood sector and one which plays an invaluable part is that of the health providers of blood and blood products. Hospitals, doctors, laboratories and other health providers serve a vital role in ensuring these key resources reach the patients in need.

In fulfilling this role, Ministers expect that these health providers will contribute to the sustainability of the blood supply by adopting these stewardship measures for their own organisation and requiring their adoption by any other party to whom they supply blood.

Blood Stewardship Principles

Blood should be managed in ways that ensure:

- All blood products are used in a clinically appropriate manner in accord with relevant professional guidelines and standards;
- Informed patient consent procedures are implemented for all patients;
- Processes, programs and facilities are in place to minimise the wastage of blood products;
- Facilities are accredited with the appropriate bodies to meet all quality and safety obligations; and
- Transfusion related adverse event information is collected and managed according to jurisdictional requirements.

National blood product planning, management and governance are supported by:

- Health providers having an ordering and receipt verification process in place which provides adequate financial accountability as required by governments; and
- Inventory data is provided on a regular and timely basis to assist in supply and demand planning, especially in times of national shortages.

Governments and the National Blood Authority will continue to manage the Australian blood supply to meet the needs of the community. Health providers play a vital role in making sure that products are available to meet clinical need, when and where required. The contribution of these health providers to safe and appropriate use, including minimisation of cost and wastage in the supply, is equally important. Ministers look to health providers to increase their efforts in these areas to ensure that Australia has a sustainable and affordable blood supply into the future.

Statement Approved by the Australian Health Ministers' Conference, 12 November 2010.

5.2 Implementation checklist

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. There are procedures and processes in place for blood management activities as outlined in section 2 of this Policy Directive. This includes: a) Transport and storage b) Consent c) Patient identification d) Appropriate use e) Safe administration f) Adverse event management g) Documentation	❑	❑	❑
	Notes:		
2. Procedures and processes are reviewed to ensure they are inclusive of both fresh and fractionated blood products.	❑	❑	❑
	Notes:		
3. Procedures and processes are in place to comply with the requirements for double independent checking.	❑	❑	❑
	Notes:		
4. There is governance in place including a blood management committee and processes for ensuring appropriate and safe use of blood products	❑	❑	❑
	Notes:		
5. There are procedures and processes in place to evaluate compliance with this policy, including: a) Clinical practice or patient blood management audit b) Adverse event reporting c) Haemovigilance analysis and strategies	❑	❑	❑

CORD BLOOD - PUBLIC AND PRIVATE CORD BLOOD BANKING (PD2015_048)

PD2015_048 rescinds PD2005_394

PURPOSE

Collection, storage and processing of cord blood in NSW is governed by the NSW *Human Tissue Act 1983* and regulated by the requirements of the Therapeutic Goods Administration.

This document provides direction to health services regarding public and private cord blood banking. It outlines the procedures to be followed by NSW Health staff for obtaining a woman's consent for and collection of cord blood for either donation to a public cord blood bank, directed donation to a family member requiring a haemopoietic stem cell transplant or for private storage for future personal use.

Failure to comply with the requirements of the NSW *Human Tissue Act 1983* may constitute an offence.

There are a number of options for cord blood banking available to women in NSW. It is important that women have access to relevant information on these options preferably in the antenatal period so that an informed choice can be made.

MANDATORY REQUIREMENTS

1. All consents to the donation of cord blood for its use in transplantation or other medical, scientific or therapeutic purposes (including research) must meet the requirements of the NSW *Human Tissue Act 1983.*
2. The collection of cord blood must not interfere with the delivery of the baby or placenta or any emergency procedure required.
3. If public or private patients in public hospitals wish to utilise a private cord blood bank, they must make their own arrangements for the collection of cord blood.
4. As a condition of permitting a private cord blood bank to undertake the collection of cord blood in a Public Health Organisation's premises, a mother is required to sign the request form provided at Attachment 1.
5. No employee of a Public Health Organisation may be involved in the collection of cord blood for private blood banking. Public Health Organisations must not be involved in the collection, storage or transplantation of cord blood for private blood banks.

IMPLEMENTATION

Chief Executives of Local Health Districts are responsible for:

- Ensuring that the contents of this policy are brought to the attention of relevant staff.

Cord blood bank collection staff (both public and private) must:

- Obtain consent to the collection and / or donation of cord blood by the woman (preferably in the antenatal period) and provide a copy to be placed on the woman's medical record at the commencement of labour
- Make their presence known to hospital staff when attending for collection and satisfy the Public Health Organisation's (PHO's) security requirements by presenting their company employee identification on arrival and

- Await the instruction of the doctor / midwife conducting the delivery for an indication that cord blood collection can proceed.

Individual patients who wish to have private collection of cord blood are responsible for:

- Making arrangements for the collection, storage and transfer of cord blood, with a collector from the private cord blood bank, a private obstetrician with visiting practitioner appointment to the hospital or another suitably qualified person and
- Ensuring that the private cord blood bank collection staff are notified of the commencement of labour.

Individual medical practitioners exercising their rights of private practice:

- May make arrangements with a private cord blood bank for the collection of cord blood at the request of their patients.

Private cord blood bank staff are responsible for:

- Ensuring that women complete the Request for Private Cord Blood Banking form (Attachment 1) antenatally and providing a copy to be included in the woman's medical record before the commencement of labour.

1 BACKGROUND

1.1 About this document

This document relates to cord blood banking. Cord blood is the blood remaining in the umbilical cord vessels and placenta after the umbilical cord has been cut after the birth of a baby. Normally, the umbilical cord and placenta, together with the approximately 100 millilitres of cord blood, are disposed of after birth. Cord blood collection is the collection of cord blood from the umbilical vein after birth. Cord blood is rich in stem cells and can be frozen and banked for many years and subsequently used as an alternate source of stem cells to bone marrow.

Requests for cord blood collection and / or banking are not routine but are becoming more common. Currently, in NSW, there are three circumstances in which cord blood collection may take place:

1. Public donation

2. Family donation or

3. Private collection and use / banking.

1.2 Key definitions

Public cord blood donation: the collection of cord blood for anonymous donation through the Sydney Cord Blood Bank (SCBB) at one of its collection centres. The SCBB has collection centres at a number of hospitals in NSW including Royal Hospital for Women Randwick and Royal Prince Alfred Mothers and Babies Hospital, Camperdown.

Family cord blood donation: the collection of cord blood for donation and use where there is a family member (e.g. a biological sibling) with a disease such as leukaemia who is in immediate need of a bone marrow transplant.

Private use cord blood banking: the collection of cord blood for storage for private use either for the child following whose birth the cord was collected or for another family member in case there is ever a medical need in the future.

1.3 Legal and legislative framework

The *Human Tissue Act 1983* regulates the process by which consent can be given to the donation of human tissue such as cord blood for the purpose of its transplantation into the body of another person or for medical, therapeutic or scientific purposes.

The *Human Tissue Act 1983* expressly prohibits trade in donated human tissue. This includes any agreement or offer to enter into any agreement for any valuable consideration to the sale or supply of tissue from a person's body.

Failure to comply with the requirements of the *Human Tissue Act 1983* may constitute an offence.

All public and private cord blood banks must meet TGA regulatory and / or manufacturing licensing requirements to operate as cord blood banks.

2 PUBLIC CORD BLOOD DONATION

2.1 The Sydney Cord Blood Bank (SCBB)

In NSW public donation of cord blood is managed through the SCBB located at the Sydney Children's Hospital Randwick. The SCBB is part of a national network of public cord blood banks. NSW Health supports the activities of the SCBB which collects and stores cord blood for the use of all patients, free of charge, on the basis of need.

This network collects and banks cord blood from voluntary donors for anonymous use by patients needing a stem cell transplant. Donating mothers give informed consent and are screened for blood borne viruses and for any historical risk of transmitting genetic disorders.

Collected cord blood that meets strict acceptance criteria is processed, frozen, stored and distributed for transplant and is identified only by a unit number so that the donor remains anonymous.

The SCBB arranges for cord blood to be collected by its own staff, or obstetricians and midwives who have been trained and accredited by the SCBB.

Public cord blood donations can only be collected in facilities licensed by the Therapeutic Goods Administration. Information on current collection sites for public cord blood donation is available at www.abmdr.org.au

2.6.1 Information on Public Cord Blood Collection and Banking

Public and private patients attending maternity units in hospitals with public bank collection sites should be informed that public cord blood donation is available. Information should be made available to expectant parents in the antenatal period about the option to collect and donate their cord to the public cord blood bank. If parents wish to donate the woman should be encouraged to discuss this intention with her midwife or obstetrician in the antenatal period.

2.3 Procedures for Public Cord Blood Banking in NSW Public Health Organisations

The following procedures apply for public cord blood collection and banking:

2.3.1 Informed consent to the collection of cord blood for the purpose of public cord blood banking should be obtained preferably during the antenatal period. The consent is archived by the SCBB and a copy of the consent will be provided to the public health facility. A copy of the consent is also given to the woman intending to donate.

2.3.2 It is important to confirm that the woman understands she is consenting to public cord blood donation for anonymous use by anyone in need of a stem cell transplant and that the cord will not be available and / or released for uses other than for purposes for which it has been banked (stem cell transplantation).

2.3.3 All SCBB staff employed to collect cord blood at designated collection sites must satisfy the PHO's requirements for identification and must be clearly identifiable and make their presence known to hospital staff. SCBB visitors will act in accordance with the PHO's work health and safety policies at all times whilst present.

2.3.4 Obstetricians and midwives of the public health organisation may be involved in the collection of cord blood for public cord blood banks upon voluntary completion of training and accreditation offered by the SCBB.

2.3.5 Facilities of public health organisations (i.e. materials, documents or staff) may be provided as part of a contractual arrangement with the SCBB for the purpose of cord blood collection and temporary storage.

2.3.6 The collection of cord blood must not interfere with the delivery of the baby or placenta or any emergency procedure required. The doctor / midwife conducting the delivery will indicate if the collection can proceed.

3 FAMILY CORD BLOOD COLLECTION AND DONATION

A family cord blood donation (also known as directed cord blood donation) is the donation of cord blood for use where there is an identified sibling with a disease that may require a bone marrow transplant. In NSW directed cord blood donation is only available through the Sydney Children's Hospitals Network.

A decision to use a directed donation of cord blood for transplantation will be made by the treating doctor of the family member needing a transplant.

As with all cord blood donation the consent of the mother to the donation, collection, screening and testing of the cord blood unit will be required.

If the decision is to proceed with directed donation, the donating mother will be responsible for the making the arrangements for the collection and transportation of the cord blood in collaboration with her obstetric team.

For further information on family (directed) cord blood donation contact the Sydney Children's Hospital Bone Marrow Transplant Unit.

4 PRIVATE USE CORD BLOOD BANKING

The following procedures apply for private cord blood collection and banking:

4.1.1 If a patient (either a public patient or a private patient in a public hospital) wishes to utilise a private cord blood bank for the collection of cord blood, they must make their own arrangements with a private cord blood bank representative for the collection.

4.1.2 Informed consent to the collection of cord blood for the purpose of private cord blood banking must be obtained by the private cord blood representative during the mother's antenatal period. A copy of this consent should be provided to the hospital where the woman plans to give birth and should be placed on the woman's medical record prior to the commencement of labour.

4.1.3 The mother must make a private arrangement for the collection, storage and transfer of cord blood with a collector from the private cord bank, a private obstetrician holding a visiting practitioner appointment to the hospital or another suitably qualified person.

4.1.4 No employee of the public health organisation may be involved in the collection of cord blood for private blood banks.

4.1.5 It is a matter for individual medical practitioners, exercising their rights of private practice, as to whether they make arrangements with a private cord blood bank for the collection of cord blood at the request of their patients.

4.1.6 Facilities (i.e. materials, documents or staff) of public health organisations are not to be used for the collection, storage or transplantation of cord blood for private blood banks.

4.1.7 As a condition of permitting a private blood bank to undertake the collection of cord blood in a public health organisation's premises, a mother is required to sign a request form (Attachment 1) in the ante-natal period. The form is to be placed on the medical record prior to the commencement of labour. This form confirms that she understands that the cord blood service is not provided by the public health organisation or its employees and that the hospital is not responsible for the collection, transport and storage of the cord blood.

4.1.8 The woman seeking private cord blood banking services is responsible for ensuring that the private cord blood banking service is notified when she commences labour.

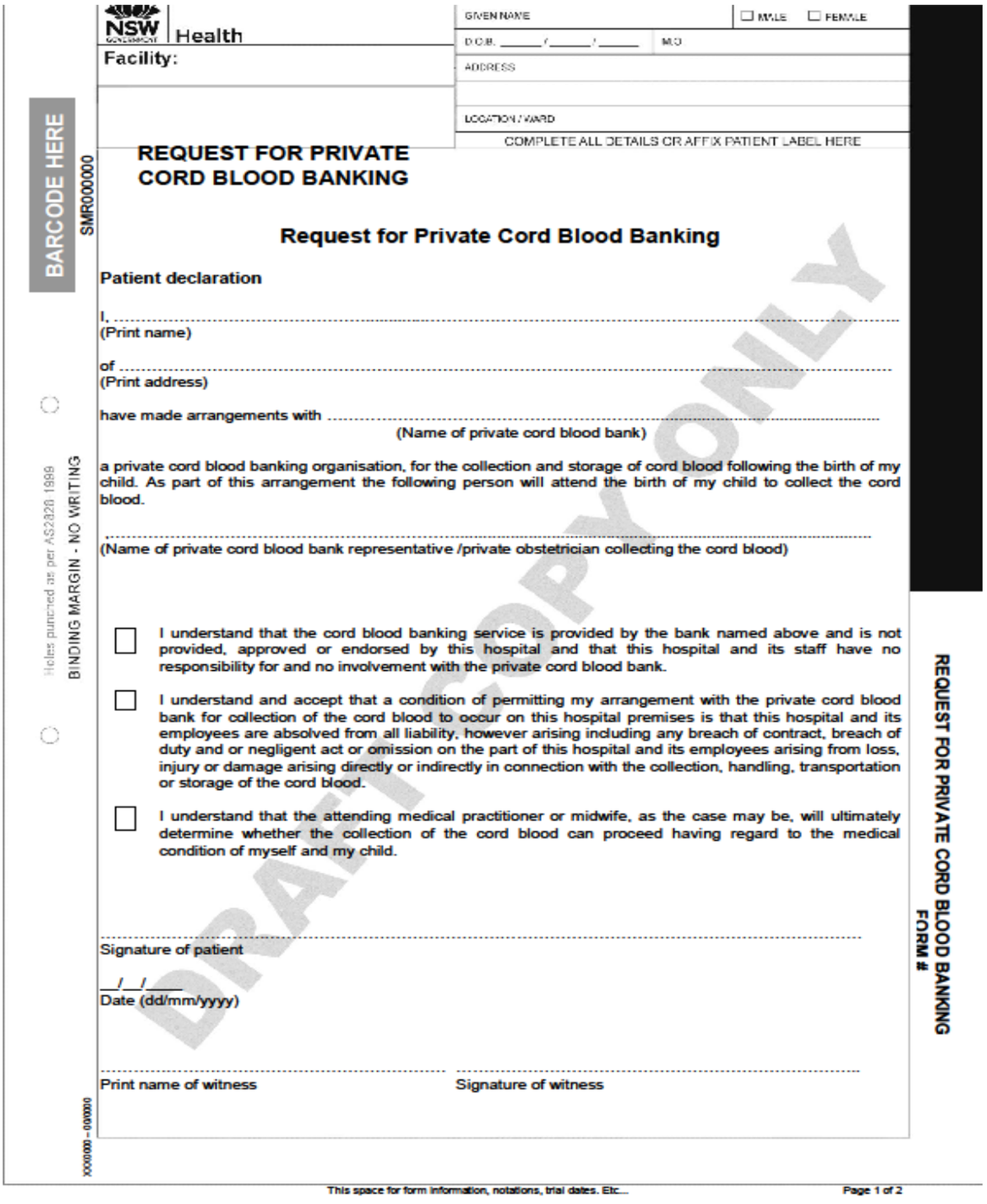
4.1.9 Private Cord Blood Bank visitors to the delivery suite involved in cord blood collection must satisfy the PHO's requirements for identification and must be clearly identifiable and make their presence known to hospital staff. Private Cord Blood Bank visitors will act in accordance with directions by PHO staff and otherwise in accordance with the PHO's work health and safety policies at all times whilst present.

4.1.10 The doctor / midwife conducting the delivery will indicate if and when the cord blood collection can proceed. Cord blood collections undertaken by private cord blood bank collectors must take place after the delivery of the baby and placenta (ex-utero).

5 LIST OF ATTACHMENTS

Request and Release for Private Cord Blood Banking

Attachment 1: Request and Release for Private Cord Blood Donation



NSW Health

Facility:

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ M.O

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BARCODE HERE

SMR000000

REQUEST FOR PRIVATE CORD BLOOD BANKING

Request for Private Cord Blood Banking

Patient declaration

I, ...
(Print name)

of .....
(Print address)

have made arrangements with .....
(Name of private cord blood bank)

a private cord blood banking organisation, for the collection and storage of cord blood following the birth of my child. As part of this arrangement the following person will attend the birth of my child to collect the cord blood.

.....
(Name of private cord blood bank representative /private obstetrician collecting the cord blood)

☐ I understand that the cord blood banking service is provided by the bank named above and is not provided, approved or endorsed by this hospital and that this hospital and its staff have no responsibility for and no involvement with the private cord blood bank.

☐ I understand and accept that a condition of permitting my arrangement with the private cord blood bank for collection of the cord blood to occur on this hospital premises is that this hospital and its employees are absolved from all liability, however arising including any breach of contract, breach of duty and or negligent act or omission on the part of this hospital and its employees arising from loss, injury or damage arising directly or indirectly in connection with the collection, handling, transportation or storage of the cord blood.

☐ I understand that the attending medical practitioner or midwife, as the case may be, will ultimately determine whether the collection of the cord blood can proceed having regard to the medical condition of myself and my child.

.....
Signature of patient

__/__/____
Date (dd/mm/yyyy)

.....
Print name of witness

.....
Signature of witness

DRAFT COPY ONLY

REQUEST FOR PRIVATE CORD BLOOD BANKING FORM #

Holes punched as per AS2828 1988 BINDING MARGIN - NO WRITING

XXXXXX – XXXXXX

This space for form information, notations, trial dates. Etc...

Page 1 of 2

RESPONSIBILITIES OF MEDICAL OFFICERS WITH REGARD TO DRIVERS
(IB2013_059)

IB2013_059 rescinds PD2005_028.

PURPOSE

This information bulletin summarises the responsibilities of medical practitioners working in NSW Health with regard to drivers, and outlines the relevant legislation that permits reporting by medical officers of concerns about drivers directly to Roads and Maritime Services (RMS).

This information bulletin replaces PD2005_028 *Drivers – Medical Officers Responsibilities with Regard to Drivers.*

KEY INFORMATION

The Ministry of Health's policy, based on common law and ethical principles, is that the duty of confidentiality owed by medical practitioners to their patients must be preserved except where disclosure of health information occurs with the consent of the patient or where there is a lawful justification for disclosing the information without the consent of the patient.

One context in which disclosure of health information to third parties arises is medical assessment of patients for fitness to hold a licence to drive. This is generally done to assist the relevant licensing authority (Roads and Maritime Services in NSW) to determine whether or not a patient is fit to hold a licence or to hold a conditional licence.

Information regarding this process can be found on the RMS website, which includes a standard "Medical Condition Notification Form". This form can be completed by the medical practitioner in consultation with the patient, and submitted to RMS.

There may be circumstances in which a medical practitioner may hold concerns about a patient's fitness to drive and/or that the patient is a potential danger to the public if permitted to drive in any circumstances, or is permitted to drive without being subject to conditions. In this event where possible medical practitioners should encourage patients to either self-notify the medical condition to RMS or to consent to the medical practitioner notifying RMS of the practitioner's concerns via the submission of a completed "Medical Condition Notification Form".

Where the patient does not comply with the medical practitioner's advice, legislation in NSW provides protections for medical practitioners who directly report the matter to RMS.

Section 275(4) of the *Road Transport Act* 2013 (NSW) provides as follows:

> *An individual does not incur civil or criminal liability for reporting to the Authority [ie RMS], in good faith, information that discloses or suggests that:*
>
> *(a) Another person is or may be unfit to drive*
>
> *(b) It may be dangerous to allow another person to hold, to be issued or to have renewed, a driver licence or a variation of a driver licence.*

The above provisions are **discretionary** reporting requirements only. There is no mandatory reporting requirement for medical practitioners in relation to drivers who may present a risk to the public. In considering whether to make report directly to RMS, medical practitioners should ensure that:

- They are acting in good faith – that is, they are acting out of a bona fide concern for safety concerns regarding the driver concerned.
- The health information they disclose to RMS is limited to information that is relevant to the issue of the driver's fitness to drive or that allowing the person to hold a licence may be dangerous.

Situations that may result in a medical practitioner reporting a patient to the RMS include where the patient is:

- Unable to appreciate the impact of their condition.
- Unable to take notice of the health professional's recommendations due to cognitive impairment.
- Continues driving despite appropriate advice and is considered likely to endanger the public.

In the event that the medical practitioner decides to directly report a patient to RMS, it is good practice to advise the patient that the practitioner is doing so.

Medical practitioners may, if they wish, when directly reporting a patient to RMS, use a copy of the approved "Medical Condition Notification Form". A copy of the form, and more information from RMS, can be found at: http://www.rms.nsw.gov.au/licensing/healthmedicals/health_professionals.html

FORENSIC DRUG AND ALCOHOL SAMPLING IN EMERGENCY DEPARTMENTS (PD2021_010)

PD2021_010 rescinds PD2021_005

POLICY STATEMENT

NSW hospitals are required by the Road Transport Act 2013 (Schedule 3), Marine Safety Act 1998 (Schedule 1), the Rail Safety (Adoption of National Law) Regulation and the Law Enforcement (Powers and Responsibilities) Act 2002 No 103 to provide a service 24 hours per day/7 days per week for the collection of forensic blood and urine samples for drug and alcohol testing. Currently this service is provided in emergency departments (EDs).

This Policy Directive provides additional information for authorised sample takers to assist them to meet the obligations of the stated legislation. Forensic sampling for legislation outside of this (for example sexual assault or drink spiking) is out of scope for this Policy.

SUMMARY OF POLICY REQUIREMENTS

This Policy **does not** replace the requirement for authorised sample takers (please refer to section 1.2 Key Definitions) to ensure they have a detailed understanding of their obligations and comply with legislative requirements.

Two different sampling kits are to be available in all NSW EDs to facilitate sampling– the blood testing for alcohol kit and the blood/urine testing for drugs kit (also known as the 'D' kit as the serial number on the certificate starts with a 'D'). NSW Police will bring an additional kit (also known as/referred to by Police as the 'B' or BAS kit) with them if that is required for sampling.

Authorised sample takers are to ensure the correct sampling kit is used to allow the samples and test results to be used as evidence.

Detailed instructions are available within each sampling kit and must be adhered to. The serial number of the kit is to be documented in the patient's health care record and the sample put immediately in the blue NSW Police security box located in the ED (unless sample is being taken in accordance with Rail legislation please refer to section 6 Rail Legislation).

Circumstances where taking a sample is not required are detailed in the attached procedure document in section 7.1

Appendix 1 provides a quick reference guide for hospitals/EDs in acknowledgement of the complexities of the various pieces of Legislation, sampling kits and sampling requirements.

The complete policy directive is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2021_010

MANAGEMENT OF SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)
(PD2019_035)

PURPOSE
This Policy Directive outlines the mandatory requirements for management of Sudden Unexpected Death in Infancy (SUDI) in NSW Health facilities. It also outlines the role of NSW Health in the context of the NSW Government response to SUDI which includes the NSW Coroner and Police.

MANDATORY REQUIREMENTS
SUDI is a reportable death under the Coroners Act 2009.1 Most SUDI deaths occur in the community and are brought to their local emergency department, however SUDI can also occur in hospital. NSW Health's role in management of SUDI includes that local health districts and specialty health networks must:

- Ensure that local policies that guide management of SUDI are easily accessible for staff. This includes emergency departments as well as other areas that SUDI may occur such as maternity, paediatrics and intensive care. Information for staff on how to access locally networked paediatric services should be included.
- Ensure that adequate resources and education are provided so that staff can meet the needs of the infant and the parents/carers, and that parents/carers have access to expert medical advice, nursing care and social work. If necessary, these can be accessed via locally networked paediatric services. In some instances the situation may warrant transfer of the infant to a higher level facility.
- Nominate a hospital contact who will coordinate the SUDI response for example a social worker or nurse. This health professional will provide support to the parents/carers and coordinate completion of documentation required by NSW Health. A list of roles and responsibilities of agencies and staff involved in the SUDI response is at Section 6.1 Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities.
- Ensure that the infant's medical history is completed by a senior medical staff member and documented in the health care record. A checklist to support this is at Section 6.2 Medical History Guide – Sudden Unexpected Death in Infancy. A copy of the infant's health care record must be forwarded to Forensic Medicine (NSW Health Pathology) within 24 hours of the infant's death.
- Ensure that support is available for staff who provide care to infants and parents/carers who have experienced SUDI. If necessary, this can be accessed via locally networked paediatric services.
- Ensure there are processes to maintain the quality of care and patient experience of SUDI cases. This includes incident notification, documentation, case discussion that includes the perspective of parents/carers and staff and implementation of any identified improvement opportunities.

IMPLEMENTATION
Local health district chief executives are responsible for:

- Assigning responsibility, personnel and resources to implement this policy.
- Establishing mechanisms to ensure the mandatory requirements are applied, achieved and sustained as usual processes in the instance of a SUDI. This should include nomination of an executive sponsor.
- Ensuring that any local policy reflects the requirements of this policy and is written in consultation with the hospital executive, clinical governance unit and clinical staff.

The complete policy directive is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2019_035

NON-CORONIAL POST MORTEMS (PD2013_051)

PD2013_051 rescinds PD2005_008.

PURPOSE

Non-coronial post-mortems are governed by the *Human Tissue Act 1983* (the Act) which makes specific provisions for obtaining consent and authorisation for the conduct of a non-coronial post mortem and the subsequent use of organs and tissues removed at post mortem and retained for other purposes (eg. for scientific research or teaching purposes).

This Policy Directive provides guidance for Local Health Districts (LHDs) Speciality networks and NSW Health Pathology Services on the procedures that must be in place to support families and clinicians in:

- Providing information to families regarding non-coronial post mortems.
- Obtaining written consent and the authorisation of a designated officer for a non-coronial post mortem and the retention and subsequent use of organs and tissue removed at post mortem for other purposes.
- Disposing of, or returning tissue removed at post mortem to the next of kin for disposal.
- Determining attribution of the costs of post mortems.
- Meeting the requirements relating to the post mortem report including the retention periods for post mortem records.

MANDATORY REQUIREMENTS

Facilities where non-coronial post mortems are undertaken must ensure:

- Compliance with the requirements of the Act in relation to obtaining consent and authorisation prior to post mortem being undertaken and in relation to using tissue taken at post mortem for other purposes (such as scientific research or teaching).

One or more designated officers are available for authorising the post mortem and/or the subsequent use of tissues removed.

- That staff who approach families for consent for the above procedures have appropriate knowledge about the post mortem process and the training to provide that information in a clear and sensitive manner.
- That the standard state-wide forms attached to this policy directive are used wherever indicated by this policy directive.

IMPLEMENTATION

Chief Executives of LHDs and Specialty Networks must ensure that:

- All relevant staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive.

Staff involved with non-coronial post mortems:

- Must comply with this policy statement as it relates to the work they undertake.

Non-Coronial Post Mortems Procedures

1. BACKGROUND

1.1 About this document

Non-coronial post mortems are performed in a hospital or a forensic pathology facility[16] at the request of a treating clinician, or occasionally at the request of the deceased person's family, when the cause of death is known but there is an interest in determining, for example, the extent of the condition/ disease that caused the death, the effects of therapy or whether any undiagnosed disease of interest might have contributed to the death. These post mortems must not be performed on a person who has, or is suspected of having a prescribed infectious disease as defined in Clause 53 of the *Public Health Regulation 2012*.

Non-coronial post mortems and the use of tissues removed for the purposes of a post mortem examination, are governed by Part 5 *Human Tissue Act 1983* and the principles set out in the Australian Health Ministers' Advisory Council *National Code of Ethical Autopsy Practice and Guidelines* 2002 and the Royal College of Pathologists of Australasia 2011 Policy*: Autopsies and the Use of Tissues Removed from Autopsies*.

Unlike coronial post mortems, a non-coronial post mortem can only be conducted if the deceased or his/her senior available next of kin has consented to it and it has been authorised by a designated officer. The Policy Directive outlines the legal requirements relating to consent and authorization, together with the principles applicable to obtaining consent. It should be read in conjunction with the NSW Ministry of Health PD2013_002 *Designated Officer Policy and Procedures.* The Policy also addresses a number of administrative matters relating to hospital post mortems.

For information about post mortem following stillbirth, see the NSW Ministry of Health's Policy Directive PD2007_025 *Stillbirth - Management and Investigation.*

1.2 Definitions

Authorised/Delegated person: A person who has been authorised in writing by a deceased person's senior available next of kin to exercise his/her functions under the *Human Tissue Act 1983*.

Child: A person who has not attained the age of 18 years and who is not married.

Designated officer means:
(a) In relation to a hospital, a person appointed under s5 (1) (a) of the *Human Tissue Act 1983,* to be a Designated Officer for the hospital.
(b) In relation to a forensic institution, a person appointed under s*5 (1)(a) of the Human Tissue Act 1983,* to be a Designated Officer for the forensic institution.
(c) In relation to a private hospital within the meaning of the *Private Health Facilities Act 2007* a person appointed by the governing body (defined in the Human Tissue Act as the licensee) of the hospital.

Post mortem (non-coronial): A non-coronial post mortem is a medical examination of the body performed after death to:
(a) Confirm the nature of the illness and/or the extent of the disease.
(b) Identify other conditions that may not have been diagnosed.
(c) Assess the effects of treatments and drugs, and identify any complications or side-effects.

[16] In this PD, the term forensic institutions means the Department of Forensic Medicine, Glebe, Sydney, the Department of Forensic Medicine at Wollongong and the Departments of Forensic Medicine, Northern Hub at Newcastle.

Full post mortem: A full post mortem entails a detailed external examination of the body and a gross and histological examination of organs and tissues contained in the abdominal, thoracic and cranial body cavities.

Limited post mortem: A limited post mortem is one in which restrictions are placed on the examination for example, limited to an external examination only with X-rays, computed tomography or magnetic resonance imaging or restricted to an examination of the tissues in only one or two body cavities.

Records: The term record includes consent forms, registers of tissue/organ sources and their disposal. Records may include cards/charts, registers, files, microfilm and microfiche, electronic records including electronic media and photographs, x-rays, scans, film, video, audio and audio-visual recordings. It is expected that the medium or format in which the record is stored will support its retention and maintenance for as long as the record is required.

Senior available next of kin: The order of senior available next of kin is defined in the *Human Tissue Act 1983* in relation to a deceased child as:
(a) Parent of the child.
(b) Sibling of child who is 18 years of age or over where a parent is not available.
(c) Guardian of the child at the time of death where none of the above is available.

and in relation to **any other deceased person** as:
(a) Spouse (which can include a de facto spouse and same sex partner).
(b) Son or daughter of the deceased person (18 years of age or over) where above is not available.
(c) Parent where none of the above is available.
(d) Sibling of the deceased person (18 years of age or over), where none of the above is available.

It should be noted that the list of senior available next of kin for both adults and children is exhaustive and cannot be extended to include other people.

Tissue: In this Policy Directive, the term tissue refers to an organ or part of a human body and any substance extracted from a human body or from part of a human body.

Valid consent: For consent to be valid the following conditions must be met:
(a) The consent must be in writing.
(b) The person giving the consent must be fully informed of the procedures to be undertaken.
(c) The person giving consent must have the capacity to do so.
(d) Consent must be given freely.
(e) Consent must be specific to the procedure.
(see NSW PD2005_406 *Consent to Medical Treatment - Patient Information*).

1.3 Legal, Ethical and Policy Framework

Legislation
Human Tissue Act 1983 (NSW)
Public Health Regulation 2012 (NSW)

National Guidelines and Standards
The Australian Health Ministers Advisory Council (AHMAC) *National Code of Ethical Post Mortem Practice and Guidelines* (2002).
The Royal College of Pathologists of Australasia (RCPA) *Policy on Autopsies and the Use of Tissues Removed from Autopsies* (2011).
National Pathology Accreditation Advisory Council (NPAAC) *Guidelines for Approved Pathology Collection Centres* (2nd Edition, 2012).
Requirements for the Packaging and Transport of Pathology Specimens and Associated Materials (2007 Edition); and
NPAAC Standard: *Requirement for the Retention of Laboratory Records and Diagnostic Material* (Fifth Edition 2009).

NSW Policy and Guidelines
NSW Ministry of Health PD2005_406 *Consent to Medical Treatment - Patient Information.*
NSW Ministry of Health PD2013_002: *Designated Officer Policy and Procedures.*
NSW Ministry of Health PD2006_053 *Interpreters – Standard Procedures for Working with Health Care Interpreters.*
NSW Ministry of Health PD2007_025 *Stillbirth - Management and Investigation.*
State Records Authority of NSW *General Retention and Disposal Authority for Public Health Services: Patient/Client Records (GDA 17) (2004)*

2. CONSENT

Valid consents are required for (1) the conduct of a non-coronial post mortem and (2) the retention of tissue taken at post mortem for subsequent use for research or education and training purposes i.e. purposes that are unrelated to the post mortem examination. Consent must be informed and in writing. If the tissue is to be used for research purposes, the proposed research project must have the approval of a properly constituted Human Research Ethics Committee.

2.1 Who can provide consent?

2.1.1 Where the deceased is an adult

Consent may be given by the deceased during his/her lifetime or posthumously by the deceased's senior available next of kin or their delegate.

2.1.2 Where the deceased is a child

The child's senior available next of kin (usually a parent of the child) is required to provide the consent. *The Human Tissue Act 1983* only requires the written consent of one parent; however, if both parents are alive and one refuses to give consent or objects to a post mortem being conducted, a designated officer must not authorise the post mortem (see NSW Ministry of Health PD2013_002 *Designated Officer Policy and Procedures*).

2.2 Delegation of responsibilities of the senior available next of kin

In some cultures and communities, for example, Aboriginal and Torres Strait Islander cultures, it is usual for responsibilities relating to death to be undertaken by a person who is not the deceased's senior available next of kin. The *Human Tissue Act 1983* provides for this situation by allowing the deceased's senior available next of kin to authorise another person (known as a delegate), to exercise their functions. Authorisation must be in writing. The form "Authorisation to delegate responsibilities of next of kin" must be used for this purpose (Appendix 2).

If responsibilities of the senior available next of kin have been delegated, it is the delegate who is included in discussions in which consent is being sought.

2.3 The consent process

The overarching principle for consent for post mortem is that the family of the deceased must be consulted. In relation to non-coronial post mortems the deceased's family has the right to:

- Refuse a post mortem being performed.
- Limit both the extent of the examination and the organs and tissues retained for diagnostic purposes, understanding that such limitations may compromise the information obtained at post mortem.
- Determine the method of disposal of retained tissues.
- Agree or refuse to tissues taken during the post mortem for being subsequently used for therapeutic, medical or scientific purposes.

In hospitals, consent to perform a post mortem should be sought by a senior clinician supported by a staff member with appropriate skills in grief and bereavement counselling. An interpreter should be present, if required. If not readily available, an interpreter can be accessed over the telephone (see NSW Ministry for Health PD2006_053 *Interpreters – Standard Procedures for Working with Health Care Interpreters).*

If the consent of Aboriginal and Torres Strait Islander families is being sought, it is useful to have an Aboriginal Liaison Officer or Aboriginal Health Care Worker present to assist with the discussions.

The consent seeking process should involve an initial discussion about the reason for wanting to perform a post mortem. If the deceased's family raises no objection to a post mortem the discussion should be broadened to include information about:

- Who will perform the post mortem.
- What it involves.
- The option of a limited post mortem.
- The option to agree to tissues removed for the purpose of the post mortem being subsequently used for research purposes.
- Information about costs.
- Viewing arrangements.
- Information about the post mortem report.

The senior next of kin/delegate should also be advised that:

(1) **small pieces of tissue** taken during the post mortem and prepared as blocks and slides for microscopic examination will be retained.

(2) **whole organs** removed from the body during the course of the examination will be returned to the body unless further diagnostic testing is required. In the latter case the family have the option, once the tests are completed, of having the organ(s):

- Returned to the body prior to the funeral (which may result in the funeral being delayed).
- Returned to them after the funeral for separate burial/cremation as required by the family.
- Disposed by the institution.

At the end of the discussions the senior available next of kin or the delegate should be provided with an information sheet (see example provided in Appendix 5) in an appropriate language outlining all the matters discussed and an opportunity to ask questions before signing the consent form (Appendix 1 Consent and Authorisation Form).

2.4 Refusal to have a post mortem conducted

If a deceased's senior available next of kin/delegate refuses to give consent to a post mortem, the requesting clinician must not instead refer the case to the Coroner.

In cases where a post mortem is requested for the purpose of determining compensation entitlement, as in the case of persons who contract dust diseases as a result of their employment, not conducting a post mortem may result in the lack of essential medical evidence required to make a compensation award to dependents of the deceased.

3. AUTHORISATION

Once consent has been obtained, a post mortem **MUST NOT** be carried out until it has been authorised in writing by a designated officer of the facility in which the body is located ie. hospital or forensic institution. The designated officer can only authorise what was consented.

Prior to authorizing a post mortem, a designated officer must be satisfied as to the following:

3.1 In relation to Adults

Where an adult consented during their lifetime, the designated officer must be satisfied that

- Written consent had been given **and**
- The deceased person had not withdrawn their consent before he/she died.

Where the senior available next of kin of a deceased adult has consented, the designated officer must be satisfied that:

- Written consent had been given **and**
- While the deceased was alive he/she had never expressed an objection to having a post mortem or tissue being used for non-diagnostic purposes (if applicable) when they died **and**
- No next of kin of the same or higher order than the senior available next of kin has objected to a post mortem being carried out or tissue used for non-diagnostic purposes.

3.2 In relation to Children

Before a designated officer can authorise a post mortem on a child or a neonate and, where applicable, the use of tissue for subsequent non-diagnostic purposes, they must be satisfied that:

- The child had not during their lifetime expressed an objection to having an post mortem when they died or their tissue being used for non-diagnostic purposes such as teaching and research **and**
- The child's senior available next of kin has given written consent **and**
- No next of kin of the same or a higher class than the child's senior available next of kin objects to the post mortem or, where applicable, the use of tissue for research or teaching purposes.

4. DISPOSAL OF TISSUE

Disposal of tissue removed for the purposes of the post mortem examination must be carried out in accordance with what was consented.

4.1 Procedure to follow where a request had been made for return of tissue for burial/ cremation

If a senior available next of kin or their delegate requests that tissue/body parts be returned to them for cremation or burial[17], the deceased persons clinician or a senior health officer must establish the grounds for the request and explain the relevant public health requirements (see *Public Health Regulation 2012*), the safe handling of human tissue including the requirement that it must not be packed on dry ice, and any of the facility's policy requirements that they must comply with. The hospital should obtain a signed statement from the senior available next of kin/delegate stating that they have had the requirements explained to them and that they have understood the requirements and agree to them. If the request is made for the return of a fetus, the meeting should include a staff member with skills in grief and bereavement counselling and an interpreter if required consistent with the principles outlined in section 2.3.

Once a decision has been made to allow release of the human tissue for disposal, the hospital authorities should provide written instructions for the senior available next of kin/delegate specifying the conditions under which release of the tissue is permitted (including the agreed method of final disposal) and waiving the responsibility of the organisation and its employees if the tissue is subsequently managed in an unauthorised manner. It should be made clear to the person who signs the Tissue Release Form (see Appendix 5) for the receipt of the tissue that they are responsible for the safe and secure storage of the transferred tissue.

The senior available next of kin/delegate should be provided with a copy of a Tissue Release Form (Appendix 5) and a letter (see example Appendix 6) should be given to the person collecting the tissue certifying that they are travelling with human tissue in their possession by the authority of the organisation (in case of accidents etc.).

Tissue that is returned to the senior next of kin or their delegate for separate burial/cremation should be triple packed as required by the National Pathology Accreditation Advisory Council *Guidelines for Approved Pathology Collection Centres (2012).*

4.2 Disposal of the tissue by the institution

If the senior available next of kin or delegate requests that retained organs be disposed of by the institution, the *National Code of Ethical Autopsy Practice 2002* states that the organs must be disposed of by cremation rather than incinerated with surgical waste. Co-cremation of retained organs requires approval from the Director-General, NSW Ministry of Health (*Public Health Regulation 2012).*

5. GENERAL ADMINISTRATIVE MATTERS RELATING TO POST MORTEM EXAMINATIONS

5.1 General matters

Once a post mortem has been authorised, all reasonable efforts should be made to minimise delays in proceeding with it.

At the completion of the post mortem examination, the senior available next of kin/delegate should be contacted and provided with information about the outcome of the post mortem and any associated investigations.

[17] In some cultures tissues expelled from the body such as placentas or tissue removed during treatment such as limbs are similarly required to be returned for cremation or burial and the same principles that apply to tissues returned following post mortem apply in these cases.

If the post mortem shows a different outcome to that listed on the initial certificate as to cause of death, the clinician who provided the initial certificate should prepare a new one and send it to the NSW Registry of Births, Deaths and Marriages together with an explanatory letter.

5.2 Forms

In NSW standardised State Forms must be used for recording of the consent and authority for non-coronial post mortem examination and the delegation of authority of the senior available next of kin. All forms required by this policy may be obtained from Fuji Xerox (previously SALMAT) Electronic Print on Demand (ePOD) at fujixerox.com.au.

5.3 Costs associated with a post mortem

The costs of a post mortem performed at the request of a treating clinician will be borne by the relevant Local Health District. Where a post mortem is requested by the deceased's family, the full costs associated with the post mortem are borne by the deceased's estate. These costs include transport, the post mortem examination and the costs of any tests conducted.

If a post mortem has been requested by the NSW Workers Compensation Dust Diseases Board, the Board will bear the full costs associated with the post mortem.

The full cost of a post mortem on a deceased person who has, or is suspected of having Creutzfeldt-Jakob Disease is borne by the Department of Forensic Medicine, Glebe**.**

5.4 The post mortem report

In the case of non-coronial post mortems the senior available next of kin/delegate has a right to receive a copy of the post mortem report. During the initial consent discussions, the senior available next of kin/delegate should be advised of this together with an explanation that the report is a technical document which they should discuss with the deceased's GP, a GP of their choice or the deceased's hospital treating clinician. Once the post mortem report is available the health facility should post a copy of the report to the address provided by the senior available next of kin/delegate.

In the event that the senior available next of kin/delegate initially declined to have a copy of the report and subsequently changed his/her mind, they should contact the Clinical Information Department of the hospital or facility where the post mortem was conducted to seek a copy.

5.5 Post mortem records

The following documents should be placed on the deceased's medical record file and where relevant or requested a copy given to the senior next of kin/delegate:

- Records of the original discussions that took place between the senior available next of kin/ delegate and family members.
- The post mortem report.
- Signed consent and authorisation forms for the post mortem and any subsequent use of tissue for purposes other than diagnostic purposes.
- A copy of the Delegation of Authority form (if relevant).
- Details of any tissues retained and records relating to method of disposal of tissue including date(s) on which disposed.
- Copies of correspondence, statements and tissue release forms relating to the release of tissue to the senior available next of kin/delegate if applicable (see section 6.1).

5.6 Retention period for tissues and records

The National Pathology Accreditation Advisory Council (NPAAC) *Requirements for the Retention of Laboratory Records and Diagnostic Materials (Fifth Edition2009)* represent the minimum standards for the retention of tissues. Paraffin blocks and slides prepared from adult tissue should be kept for a minimum of 10 years. In the case of children, the retention time of paraffin blocks and slides is the age of majority (18 years) PLUS 7 years. There are specific retention times for samples used for genetic tests/investigations and the *NPAAC guidelines* should be consulted in relation to these.

The NPAAC guidelines and the State Records Authority of NSW *General Retention and Disposal Authority for Public Health Services: Patient/Client Records* require that records of post mortem examinations should be retained for a minimum of 20 years and that genetic reports/records should be kept for a minimum of 100 years. If tissue is retained at post mortem, the records should be kept for a period of 20 years from the date the tissue was disposed of/returned to the senior available next of kin/delegate.

Facilities that maintain integrated patient records should keep the complete record for the longest period required for any part of the record. Electronic records must be accessible for the relevant period (see above) so it is important that the records are migrated across systems if they are changed during that period.

Facilities that keep electronic records rather than hard copy records should ensure that the records are protected so that data cannot be amended without creating an audit trail.

6. ATTACHMENTS

Appendix 1: Consent and Authorisation Form.
Appendix 2: Authorisation to Delegate Responsibilities of Senior Available Next of Kin.
Appendix 3: Authorisation of the Release of Human Tissue Form.
Appendix 4: Example of letter to be issued to a person travelling with human tissue in their possession.
Appendix 5: Information for families about non-coronial post mortems (to print as a folded brochure printer settings should be set to double sided and flipped on short edge).

Appendix 1, 2, and 3 should be obtained from Fuji Xerox (previously SALMAT) Electronic Print on Demand (ePOD) at fujixerox.com.au

APPENDIX 1 - CONSENT AND AUTHORISATION FORM

NSW Health

Facility:

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020032

[Note: This form should be used to obtain consent for the conduct of a non-Coronial post mortem. A copy of the completed form must be (1) retained as part of the post mortem record; (2) placed in the deceased person's notes; and (3) given to the person who provided consent i.e. the senior available next of kin or their delegate].

SECTION 1

DETAILS OF PERSON OBTAINING CONSENT

Family name _____ Given name _____

Institution/Hospital: _____

Person's Position: _____

Contact: Phone _____ Pager _____

ADDITIONAL DETAILS OF THE DECEASED

Date of death of the deceased _____/_____/_____

Optional: Is the deceased an Aboriginal person or Torres Strait Islander? *[Tick as appropriate]*

- ☐ **YES**
- ☐ **NO**
- ☐ **UNKNOWN**

SECTION 2: PERSON GIVING THE CONSENT

[Tick relevant box and complete as appropriate]

☐ **PERSON GIVING THEIR CONSENT DURING THEIR LIFE TIME TO A POST MORTEM EXAMINATION OF THEIR BODY AFTER DEATH**

I_____ (insert name) consent to a post mortem examination of my body after I have died as detailed in Section 3.

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

SMR020.032

111213

NO WRITING

Page 1 of 4

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION FORM_111213.indd 1 11-12-2013 1:13:44 PM

NSW Health

Facility:

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

☐ **SENIOR AVAILABLE NEXT OF KIN**

DETAILS OF SENIOR AVAILABLE NEXT OF KIN

Family name _____ Given name _____

of: _____ *[Insert address]*

Post code: _____

Relationship of senior available next of kin to deceased: _____

☐ **A DELEGATE OF THE SENIOR AVAILABLE NEXT OF KIN**

DETAILS OF DELEGATE OF THE SENIOR AVAILABLE NEXT OF KIN

Family name _____ Given name _____

of: _____ *[Insert address and postcode]*

Telephone Number: _____

Attach written authorisation of delegate

SECTION 3: THE CONSENT

I CONSENT TO THE FOLLOWING BEING CARRIED OUT ON THE ABOVE NAMED DECEASED: *[Tick appropriate box]*

☐ a full post mortem examination of the deceased

☐ a post mortem examination of the deceased **LIMITED** to the following organs, body parts or body cavities:

_____

_____

_____

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR020032

NO WRITING

NSW Health

Facility:

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020032

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

I ALSO CONSENT TO: *[Tick where applicable]*

☐ The retention of organs and other body parts for diagnostic testing.

The following organs or body parts **CAN** be retained: _____

_____

☐ The retention of organs and other body parts for scientific, therapeutic and medical purposes

The following organs or body parts **CAN** be retained: _____

_____

☐ The retention of _____ *[Specify organs or body parts]*

for _____ *[Specify research study]*

I REQUEST that any organs and other body parts be: *[tick as applicable]*

☐ Reunited with the body prior to burial/cremation;

☐ Returned to me or the person nominated by me, if practicable

Name of nominated person: _____

Address of nominated person: _____

Relationship to nominated person: _____

☐ Disposed of in a lawful manner by the hospital

I ALSO REQUEST that:

☐ a copy of the post mortem report be sent to: _____

Address: _____

☐ The body is ready for the funeral which takes place: Date: ___/___/___ Time _____

I HAVE NO REASON TO BELIEVE that the deceased had expressed any objection to this post mortem examination or any use of tissue noted above.

THE NATURE OF THE POST MORTEM EXAMINATION and the way in which the tissue from the deceased's body will be dealt with have been explained to me.

111213

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

SMR020.032

NO WRITING

Page 3 of 4

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION FORM_111213.indd 3 11-12-2013 1:13:44 PM

NSW Health

Facility:

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

SIGNATURE of the person giving consent in their lifetime _____

SIGNATURE of the senior available next of kin or authorised delegate _____

SIGNATURE of doctor/health professional _____ **Date:** _____/_____/_____

INTERPRETER present: NO/ YES **SIGNATURE** of Interpreter: _____

AUTHORISATION BY A DESIGNATED OFFICER

I, _____ hereby authorise: *[tick where applicable]*
[Full name of Designated Officer]

- ☐ the full post mortem examination of the deceased's body
- ☐ the limited post mortem examination of the deceased's body
- ☐ the retention of organs or other body parts for diagnostic testing
- ☐ the retention of tissue, organs and body parts removed for the purposes of the post-mortem examination for scientific, therapeutic, and medical purposes as set out in the above consent.

I _____ declare that I do not have a personal interest in the deceased and I have not had a clinical involvement with the deceased.
[Name of the Designated Officer]

SIGNATURE of the Designated Officer: _____

DATE: ____/____ / ____

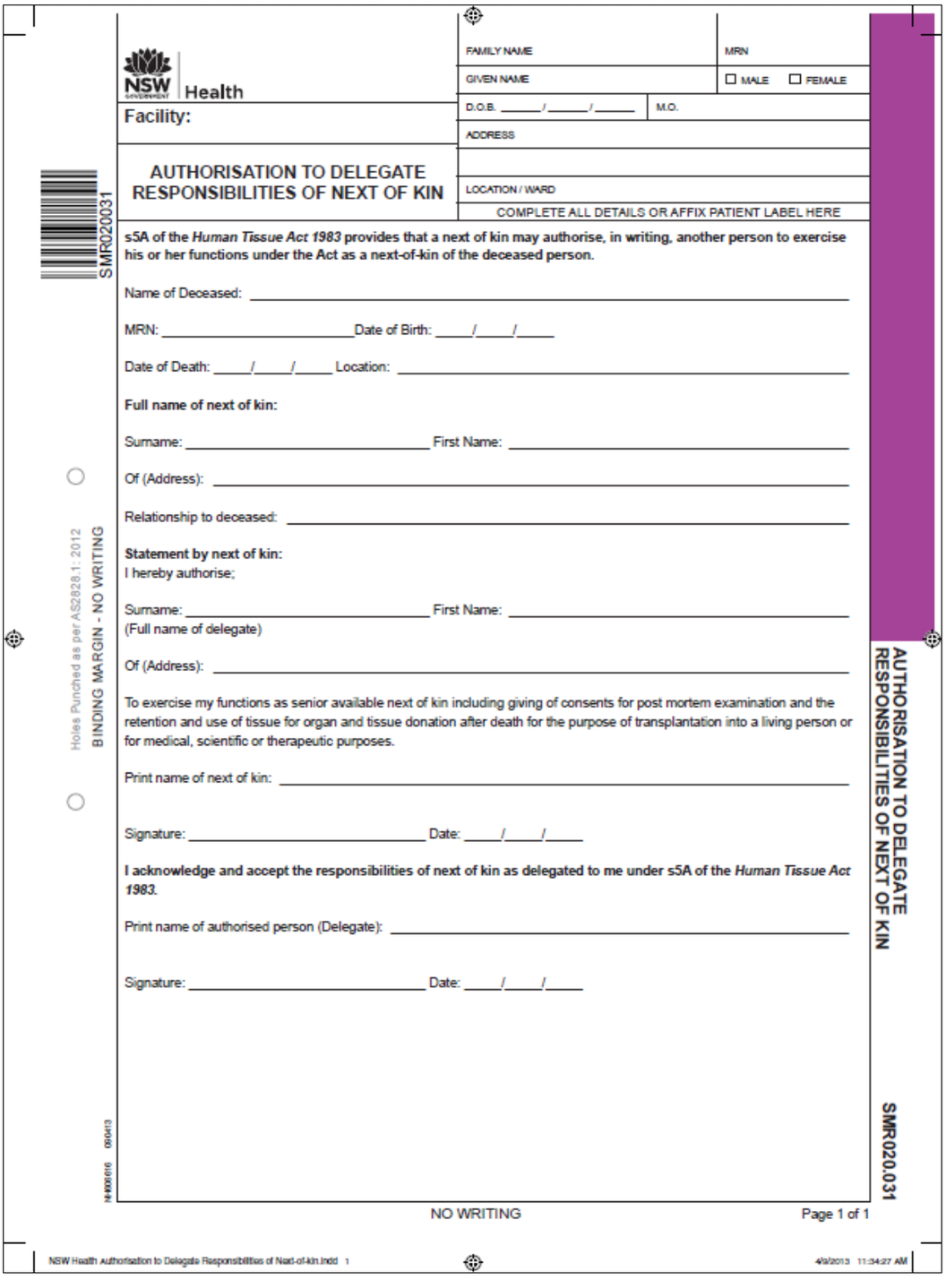
Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR020032

Page 4 of 4 NO WRITING

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION FORM_111213.indd 4 11-12-2013 1:13:46 PM

APPENDIX 2 - AUTHORISATION TO DELEGATE RESPONSIBILITIES OF NEXT OF KIN



NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020031

AUTHORISATION TO DELEGATE RESPONSIBILITIES OF NEXT OF KIN

s5A of the *Human Tissue Act 1983* provides that a next of kin may authorise, in writing, another person to exercise his or her functions under the Act as a next-of-kin of the deceased person.

Name of Deceased: _____

MRN: _____ Date of Birth: ____/____/____

Date of Death: ____/____/____ Location: _____

Full name of next of kin:

Surname: _____ First Name: _____

Of (Address): _____

Relationship to deceased: _____

Statement by next of kin:
I hereby authorise;

Surname: _____ First Name: _____
(Full name of delegate)

Of (Address): _____

To exercise my functions as senior available next of kin including giving of consents for post mortem examination and the retention and use of tissue for organ and tissue donation after death for the purpose of transplantation into a living person or for medical, scientific or therapeutic purposes.

Print name of next of kin: _____

Signature: _____ Date: ____/____/____

I acknowledge and accept the responsibilities of next of kin as delegated to me under s5A of the *Human Tissue Act 1983*.

Print name of authorised person (Delegate): _____

Signature: _____ Date: ____/____/____

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

AUTHORISATION TO DELEGATE RESPONSIBILITIES OF NEXT OF KIN

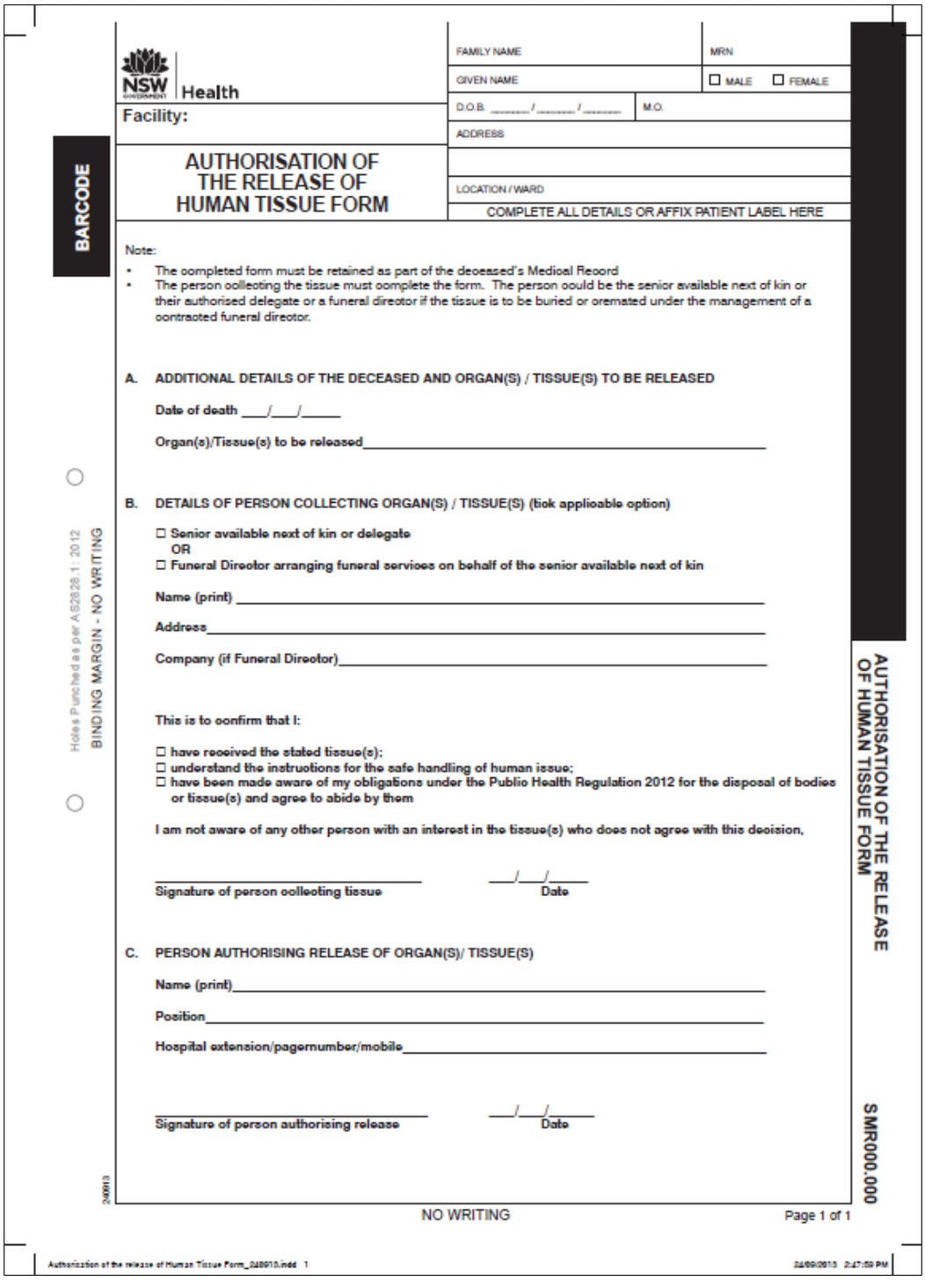
SMR020.031

NO WRITING

Page 1 of 1

NSW Health Authorisation to Delegate Responsibilities of Next-of-kin.indd 1 4/9/2013 11:34:27 AM

APPENDIX 3 - AUTHORISATION OF THE RELEASE OF HUMAN TISSUE FORM



NSW GOVERNMENT Health

Facility:

AUTHORISATION OF THE RELEASE OF HUMAN TISSUE FORM

BARCODE

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Note:

- The completed form must be retained as part of the deceased's Medical Record
- The person collecting the tissue must complete the form. The person could be the senior available next of kin or their authorised delegate or a funeral director if the tissue is to be buried or cremated under the management of a contracted funeral director.

A. ADDITIONAL DETAILS OF THE DECEASED AND ORGAN(S) / TISSUE(S) TO BE RELEASED

Date of death ___/___/_____

Organ(s)/Tissue(s) to be released_____

B. DETAILS OF PERSON COLLECTING ORGAN(S) / TISSUE(S) (tick applicable option)

☐ Senior available next of kin or delegate
OR
☐ Funeral Director arranging funeral services on behalf of the senior available next of kin

Name (print) _____

Address_____

Company (if Funeral Director)_____

This is to confirm that I:

☐ have received the stated tissue(s);
☐ understand the instructions for the safe handling of human issue;
☐ have been made aware of my obligations under the Public Health Regulation 2012 for the disposal of bodies or tissue(s) and agree to abide by them

I am not aware of any other person with an interest in the tissue(s) who does not agree with this decision.

_____ ___/___/_____
Signature of person collecting tissue Date

C. PERSON AUTHORISING RELEASE OF ORGAN(S)/ TISSUE(S)

Name (print)_____

Position_____

Hospital extension/pagernumber/mobile_____

_____ ___/___/_____
Signature of person authorising release Date

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

AUTHORISATION OF THE RELEASE OF HUMAN TISSUE FORM

SMR000.000

240913

NO WRITING Page 1 of 1

Authorisation of the release of Human Tissue Form_240913.indd 1 24/09/2013 2:47:59 PM

APPENDIX 4 - EXAMPLE OF LETTER TO BE ISSUED TO PERSON TRAVELLING WITH HUMAN TISSUE IN THEIR POSSESSION

To whom it may concern,

This is to certify that _____
(Name of person authorised to travel with human tissue in their possession)

Is travelling with human tissue in their possession.

The tissue is hermetically sealed inside a container and there is no risk associated with transporting the tissue stored in this manner.

Person certifying the packaging of the tissue:

Name: _____

Designation: _____

Institution/Hospital: _____

Contact: _____

Signature of authorising person: _____
Date: ____/_____/_____

Can I consent to retaining organs for use for other (therapeutic, medical and scientific) purposes?
When you are asked to give consent for a post mortem, you may also be asked to consider allowing the use of your deceased relative's organs or tissue for other purposes that are not an essential part of the post mortem examination. This includes research and teaching.

You do not have to consent to the use of organs or tissue for these other purposes. A post mortem can still be carried out.

What about training?
Medical students and specialists in training need to attend and sometimes assist in performing post mortems as part of their ongoing medical education. In these circumstances the post mortem is always supervised by a fully qualified pathologist.

Will I have to pay for a post mortem examination?
There may be costs associated with the post mortem examination. It is important you discuss this with your doctor or hospital representative before you give consent.

What happens after consent is given for a post mortem?
The post mortem will be carried out as soon as possible after consent has been given. If you wish to see the body prior to the post mortem, let the doctor know and arrangements will be made.

When and how will I find out the results of the post mortem?
A preliminary post mortem report will be available within a few days of the examination but the final report will be prepared only after all test results are returned and may take some months. You can decide whether you want the report to be sent to you, your family doctor or the doctor(s) who cared for your loved one. As the report contains technical language, you should make a time with one of these doctors to discuss the report and any implications it may have for you or your family.
If you have any further questions please contact:
Name……
Phone……..Pager…….
INFORMATION FOR FAMILIES ABOUT

NON-CORONIAL POST MORTEMS
Deciding about a post mortem for your deceased family member can be very difficult. After reading this information, you may find it helpful to discuss the examination with a doctor who has cared for your relative or hospital social worker.

What issues should be considered?
It is important that you make the decision that is right for you and your family. It can be helpful to consider what the deceased person would have wished in the circumstances. It may also help to think about whether a post mortem would help you and your family understand and come to terms with your loved one's death.

What is a post mortem?
A post mortem (also known as an autopsy) is a medical examination of a body after death by a doctor who is a pathologist or by a doctor training in pathology under the supervision of a pathologist. Pathologists are doctors who specialise in the study of disease.

A post mortem can be a full or limited post mortem.

A full post mortem will involve:
- an external and internal examination of the organs and tissues within the head, abdomen and chest cavities
- taking of small samples of tissues from the major organs for later testing
- possible retention of some specific organs for more detailed analysis

A limited post mortem means that you, as the next of kin, may set limits on the extent of the post mortem examination, for example:
- an external examination only;
- an external examination and some testing on small samples of tissue or
- an internal examination limited to certain areas of the body.

A post mortem examination does not always provide all the answers about a person's death.

What information can a post mortem provide?
- More information about the medical conditions that may have caused or contributed to your relative's death

- Information that may confirm or rule out a suspected or unsuspected medical condition. This may be important for you or other members of your family, for example, if the condition might be inherited; and
- Information that may help improve care of people in the future

When is consent needed for a post mortem?
A non coronial post mortem is a post mortem that is not legally required by the Coroner. It is either recommended to you by a doctor or sometimes requested by the family in order to find out, for example, the extent of the condition that caused the death or whether any undiagnosed disease might have contributed to the death. These are **non-coronial or hospital** post mortems and they require written consent from either the deceased (given when they were alive) or from the deceased's senior available next of kin (which is determined by the *Human Tissue Act 1983)* after death.

Who can consent to a post mortem?
As the senior available next of kin, you may be approached by a health care worker and asked for your consent to the post mortem examination. You are free to choose whether or not to give your consent for the post mortem examination. Your consent must be given in writing.

I am the senior next of kin but in my culture it is not my role to make these decisions. Can someone else do it for me?
It is recognised that in some cultures arrangements around the death of a person may traditionally be performed by someone other than the senior available next of kin. The *Human Tissue Act* allows a senior available next of kin to authorise another person, in writing, to exercise their functions. This 'authorised person' also known as a 'Delegate' can then give written consent for a non-coronial post mortem. There is a form you will be asked to complete if you wish to authorise someone to be your delegate.

What happens at a post mortem?
The pathologist who will be performing or supervising the post mortem will review the deceased's medical records before undertaking a thorough examination of the body. A full post mortem will include:

- an examination of the outside of the person's body looking for marks or other abnormalities that might indicate injury or disease;
- an **internal** examination which is a surgical procedure like a large operation. The pathologist will usually make two incisions, one across the back of the head and another on the front of the body. This allows the pathologist to examine all the major organs including the brain if necessary. Small samples of tissue or body fluids will usually be taken for later microscopic examination.
- a **laboratory** examination, which may involve microscopic examination of the tissue samples taken during the internal examination or other testing looking for evidence of disease.

What happens after the post mortem?
Once the examination is complete the incisions are closed like a surgical operation and the body cleaned. In most cases, once the body has been clothed, the effects of the post mortem are not very noticeable. Normally, you will be able to see the body after the post mortem.

Why would the Pathologist need to retain organs?
It is often important for the pathologist to retain an organ (usually the brain or heart) in order to test for signs of disease or injury that are not immediately apparent. Usually this will be discussed as part of the consent but the need to retain a particular organ may not be known until the post mortem has begun.

If the pathologist does need to retain organs you may be able to delay the funeral arrangements for a short time so these organs can be returned to the body before it is released for burial or cremation. If this is not possible, you can decide whether you would like the organs returned to you or your funeral director for separate burial or cremation or disposed of by the facility where the post mortem was conducted (usually by cremation). Small samples of tissue and fluids taken during the internal examination will not be returned to the body.

DESTITUTE PERSONS - CREMATION OR BURIAL (PD2008_012)

PD2008_012 rescinds PD2007_051.

1. Introduction

This policy directive rescinds Policy Directive PD2007_051 due to the inclusion in that Policy Directive of Police forms, and references to them, which are no longer to be used. This Policy Directive deals with the cremation or burial of the bodies of deceased destitute persons in the State of New South Wales for services as set out in this document.

Definitions:

For the purposes of this policy directive the following terms mean:

"Destitute Persons" - deceased persons with no money or assets and whose relatives and friends are unable to pay the costs of cremation or burial.

"Still Birth" - means the birth of a child that exhibits no sign of respiration or heartbeat, or other signs of life, after birth and that:

a) is at least 20 weeks' gestation; or
b) if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, has a body mass of at least 400 grams at birth.

"Public Health Unit" - please see the attached list (attachment I).

2. Cremation/Burial generally

Funeral procedures and rites are helpful for the resolution of grief and the bereavement process. This is no less true for the families and friends of people who are destitute when they die. The conditions for the cremation or burial of deceased destitute persons should take equal account of the emotional needs of any relatives or friends of the deceased.

Cremation will generally be the preferred method of disposal, provided that:

- there is no objection set out in the Will of the deceased;
- there is a written agreement of any known relatives or friends;
- it is not contrary to the direction of the State Coroner;
- all necessary cremation certificates have been completed.

In all Areas Health Services and Public health facilities it should be noted that only the contracted funeral director will be contacted to provide the service. A list of these can be obtained from the Department of Commerce, Office of Government Business and Procurement.

3. Responsibility for Burial or Cremation of Destitute Persons

Public Health Units are responsible for the administration of the process related to the cremation and burial of destitute persons within their Area Health Service boundaries and are to provide assistance and advice to interested parties to ensure all requirements are adhered to.

The cost of cremation or burial of deceased destitute persons is the responsibility of the Area Health Service.

4. Procedure for Burial or Cremation

4.1 Where the death occurs in a public hospital, State Government nursing home, or other facility under the control of a public health organisation under the *Health Services Act* (in this policy referred to as a 'public health facility') and a medical practitioner has issued a death certificate:

- The social worker at that facility shall make all reasonable inquiries to locate any relatives, friends or members of organisations that may wish to arrange for a cremation or burial of the body at their own expense.
- Where no one is able to pay for the cremation or burial of the body:
  1. issue an order to the contracted funeral director for a funeral and cremation or burial to be conducted in accordance with the contract requirements;
  2. arrange for an officer of the public health facility to attend the service;
  3. forward the duly certified invoice to the Area Health Service for payment.

The assistance of the Police may be obtained if the facility's own enquiries fail to locate any relatives, friends, or others who may wish to arrange a cremation or burial at their own expense. This will help to avoid causing unnecessary distress to people who may have wished to make other funeral arrangements and been willing to pay the funeral costs.

4.2 Where the death of a destitute person occurs outside of a public health facility, does not fall within the Coroner's jurisdiction, a medical certificate as to the cause of death has been issued, and the Police have determined that the State is ultimately responsible for the burial or cremation then:

- Police will complete forms P372 (attachment 2);
- the form is then forwarded to the Director of the Public Health Unit for the relevant Area Health Service;
- an Environmental Health Officer will complete form HEALTH373 (attachment 3) and contact the contracted funeral director to arrange for the burial or cremation; and
- after the burial or cremation, the contracted funeral director will forward the invoice to the Public Health Unit to arrange payment by the appropriate Area Health Service.

4.3 Where the death of a person comes within the Coroner's jurisdiction, or when a medical certificate as to the cause of death has been not been issued, and the Police have determined that the State is ultimately responsible for the burial or cremation then:

- Police will complete form P372 (attachment 2) and forward it to the Coroner;
- in all cases the Coroner will issue an Order for Disposal of a Destitute Person;
- the Coroner will forward the form to the Director of the appropriate Public Health Unit and request the burial or cremation to be conducted; and
- an Environmental Health Officer will complete Form HEALTH 373 (attachment 3), contact the contracted funeral director and request to arrange the burial or cremation.

5. Contracts for Destitute Cremation and Burial

Contracts for the cremation or burial of deceased destitute persons are under the control of the Department of Commerce, Office of Government Business and Procurement. Contract details and information about them may be obtained from the Office of Business and Procurement. Such contracts are generally reviewed every three years.

Each contract may cover one or more police regions/local areas/towns, and includes services to all public health facilities in that police region/local area/town. Public health facilities and Area Health Services **must** use the contracted funeral director for all funerals, cremations or burials paid for by Area Health Service under these arrangements.

Contracts generally provide for separate rates of payment, whether it is a burial or cremation, for:

- adult - burial including ground fee and burial rites and relevant certificates;
- child under 1.1 metres - burial including ground fee and burial rites and relevant certificates;
- still-born neo-nate (not less than 20 weeks gestation or 400 grams in weight) - burial including ground fee and burial rites and relevant certificates;
- adult - cremation including cremation fee and relevant certificates;
- child under 1.1 metres - cremation including cremation fee and relevant certificates; and
- still-born neo-nate - cremation including cremation fee and relevant certificates.

6. Complaints about Contractors

Any complaints by family or friends about the performance of a contracted funeral director should be taken up in the first instance with the Department of Commerce, Office of Business and Procurement which has the primary responsibility for contracted funeral directors.

7. Responsibility of the Police

The Police are responsible in all cases for:

- determining whether a death is reportable to the Coroner and whether any person is able to pay for the cost of the burial or cremation;
- determining whether the deceased has any assets or estate.
- completion of Forms P372 (attachment 2) and forwarding the form to the Public Health Unit (or to the Coroner in coroner's cases) as is appropriate and required in the particular case.

8. Records of Burial or Cremation

Under the Public Health (Disposal of Bodies) Regulation the cemetery or cremation authority is required to maintain records of the name, date, location of the grave, section and record number, or the location of the ashes, of the deceased. The ultimate burial/cremation site location details will generally also form part of the information recorded by the Registrar of Births, Deaths and Marriages. Public Health Units are also required to keep records of the name of the deceased, and place of burial/ cremation and the contracted funeral director used.

9. Assistance to Relatives and Friends of the Deceased

Appropriate staff in the public health facilities should be made aware of this policy to enable information to be supplied to relatives of destitute persons where there is an obvious need of assistance with funeral expenses. Family members should be directed to the social worker who will assess the situation and provide appropriate advice.

A register is to be maintained at the Public Health Unit and notation made in that register in the event that relatives, after being provided details of destitute burial/cremation, decline the service. Any subsequent ex gratia request for contribution to the funeral arrangements for that particular person will then not be accepted (see Section 12 for ex gratia payments generally).

Where an ex gratia claim is made from non-family members the hospital is to examine carefully the bona fides of the claim as generally the full cost of the funeral is the responsibility of those persons.

Bereaved relatives and friends of a destitute person should, regardless of their inability to meet the cost of cremation or burial, be informed of funeral arrangements by the contracted funeral director and encouraged to attend the funeral service. They will, however, be entirely responsible for their own transportation to and from the service.

10. Death in a Hospital Remote from Residence

When the deceased destitute person has been transported from their normal area of residence to a "remote hospital" for treatment not available at their local hospital, and has died at the remote hospital, the reasonable costs of returning the body to the area of residence may be paid if:

- the burial/cremation in their local area is requested by relatives of the deceased; and
- approval was arranged prior to the transfer of the body.

In these cases, the cost of transport back to the local area will be met by the remote hospital where the person dies. The costs of the actual destitute funeral will be met by the local Area Health Service covering the deceased's normal place of residence.

11. Australian Ex-Service Man or Woman

The Department of Veterans' Affairs will pay a certain amount towards the funeral expenses of an Australian ex-service man or woman who dies in destitute circumstances. The Department of Veteran Affairs should be contacted for the current details of the benefit payable in a particular case.

12. Requests for Financial Assistance after the Funeral has been performed

Where the funeral service has already been conducted, and persons otherwise responsible for the funeral arrangements claim financial difficulty, a petition may be submitted to the relevant Area Health Service for an ex gratia contribution to that cost. Chief Executives have limited delegation to approve the provision of financial aid to impoverished families to assist with already incurred burial costs of relatives. All other ex gratia payments are to be referred to the Department of Health.

The petition should take the form of a covering letter requesting assistance and the circumstances for the request. In addition all petitioners must supply a signed statutory declaration witnessed by a Justice of the Peace, which states:

- a complete listing of the assets of the deceased;
- a complete listing of assets, income, expenditure of the remaining relatives;
- a copy of the funeral director's invoice. If the invoice has been fully paid, it would be in very exceptional circumstances that any assistance would be offered;
- a copy of the death certificate;
- details of any financial assistance provided by charities, Centrelink or any other source; and
- details of any arrangement made with the funeral director to pay off the debt.

It should be noted, as per the Combined Delegations Manual (Delegation F91), that the Chief Executives of all Area Health Services are authorised to approve of ex gratia payments under this delegation within specified limits. Chief Executives are required to submit an annual return each financial year of the actual payments made to the Chief Financial Officer, Department of Health. The return for each year must include the following details;

- recipient;
- value of ex gratia payment;
- full cost of funeral as claimed by recipient; and
- number of claims rejected without any ex gratia payment made.

The Department will therefore no longer have primary administrative and financial liabilities associated with destitute burials and ex gratia payments. To facilitate the management by Area Health Services of all future claims for destitute burials and ex gratia payments the Department is providing annualised budget supplementation to Area Health Services from 1 July 2007 based on average annual costs over the previous 3 years.

Attachment 1

Public Health Unit	Mailing Address	Phone contact (work hours)	Fax contact (work hours)	After hours contacts
Greater Southern AHS	**Goulburn Office**	02 4824 1837	02 4824 1831	02 6021 4799 (diverts to Albury Base Hospital) - ask for the Environmental Health Officer on call
Public Health Unit	Locked Bag 11 Goulburn 2580		02 4824 1838 (secure)	
	Queanbeyan Office	02 6124 9934	02 6124 9946	02 6021 4799 (diverts to Albury Base Hospital) - ask for the Environmental Health Officer on call
	PO Box 1845 Queanbeyan 2620			
	Albury Office PO Box 3095 Albury 2640	02 6021 4799	02 6021 4899	02 6021 4799 (diverts to Albury Base Hospital) - ask the Environmental Health Officer on call
	Wagga Wagga			02 6021 4799 (diverts to Albury Base Hospital) - ask the Environmental Health Officer on call
	PO Box 201 Wagga Wagga 2650	02 6923 5755	03 6923 5751	
Greater Western AHS	**Broken Hill Office**	08 8080 1499	08 8080 1683	08 8080 1333 (Broken Hill Base Hospital) - ask for the Senior Environmental Health Officer on call
Centre for Population Health	PO Box 457 Broken Hill 2880		08 8080 1196 (secure)	or on call mobile 0417 685 259
	Dubbo Office	02 6841 5569	02 6841 5571 (secure)	02 6885 8666 (Dubbo Base Hospital) - ask for the Senior Environmental Health Officer on call
	PO Box 739 Dubbo 2830			or call 0418 866 397 - ask for the Senior Environmental Health Officer on call
	Bathurst Office	02 6339 5601	02 6339 5173 (secure)	0428 400 526 - ask for the Senior Environmental Health Officer on call
	PO Box 143 Bathurst 2795			
Hunter/New England AHS	**Newcastle Office**	02 4924 6477	02 4924 6490 (secure)	02 4924 6477 (diverts to John Hunter Hospital) - ask for Public Health Officer on call
Hunter Population Health	Locked Bag 10 Wallsend 2287			if no answer, phone 016301965 and ask for Public Health Physician on call
	Tamworth Office	02 6767 8630	02 6766 3003	02 6767 8630 (diverts to Tamworth Base Hospital) - ask for Public Health Officer on call
	PO Box 597 Tamworth 2340			if no answer, phone 016301965 and ask for Public Health Physician on call
Justice Health Service	PO Box 150 Matraville 2036	02 9214 6229	02 9289 2494 (secure)	02 9311 2707 - ask for Nurse Manager
Public Health Unit		(Public Health coordinator/CNC)		
North Coast AHS	**Port Macquarie Office**	02 6588 2750	02 6588 2837	0407 271 498 - ask for Public Health Officer on call
Public Health Unit	PO Box 126 Port Macquarie 2444			if no answer, phone 0417 244 966
	Lismore Office	02 6620 7500	02 6622 2151	132222 pager number 397635
	PO Box 498 Lismore 2480		02 6620 2252 (secure)	if no answer, phone 0417 244 966

Northern Sydney/Central Coast AHS	**Hornsby Office**	02 9477 9400	02 9482 1650	02 9477 9123 (Hornsby Hospital) - ask for the Environmental Health Officer on call
Public Health Unit	c/- Hornsby Hospital Palmerston Rd Hornsby 2077		02 9482 1358 (secure)	
	Gosford Office	02 4349 4845	02 4349 4850 (secure)	02 4320 2111 (Gosford Hospital) - ask for the Environmental Health Officer on call
	PO Box 361 Gosford 2250			
South Eastern Sydney/ Illawarra AHS	**Randwick Office**	02 9382 8333	02 9382 8334	02 9382 2222 (Prince of Wales Hospital) - ask for Public Health Nurse on call
Public Health Unit	Locked Bag 88 Randwick 2031		02 9382 8314 (secure)	
	Wollongong Office	02 4221 6700	02 4221 6722	02 4222 5000 (Wollongong Hospital) - ask for Public Health Officer on call
	Locked Bag 9 Unanderra 2526		02 4221 6759 (secure)	
Sydney South West AHS	**Eastern Zone**	02 9515 9420	02 9515 9440	02 9515 6111 (Royal Prince Alfred Hospital) - ask Public Health Officer on call
Public Health Unit	(Camperdown Office)		02 9515 9467 (secure)	
	PO Box 374 Camperdown 2050			
	Western Zone	02 9828 5944	02 9828 5955	02 9828 3000 (Liverpool Hospital) - ask for Public Health Officer on call
	(Liverpool Office)			
	Locked Mail Bag 7017 Liverpool BC 1871			
Sydney West AHS	**Penrith Office**	02 4734 2022	02 4734 3300	02 9845 5555 (Westmead Hospital) - ask for Public Health Officer on call
Centre for Population Health	PO Box 63 Penrith 2751		02 4734 3444 (secure)	
	Parramatta Office	02 9840 3603	02 9840 3608	02 9845 5555 (Westmead Hospital) - ask for Public Health Officer on call
	Locked Bag 7118 Parramatta BC 2150		02 9840 3591 (secure)	

Attachment 2

P. 372

BURIAL/CREMATION OF A DECEASED DESTITUTE PERSON

_____Police Station

_____20__

Full name of deceased _____ _____
(Surname) (Christian or given name/s

Address _____

Age _____ Date of Birth _____ Native of _____

Date of Death _____Time am/pm _____ Place _____

Circumstances of death _____

_____

Death certificate issued by Dr _____

Was the deceased -

(a) a pensioner/ ** YES/NO. If yes, type of pension _____
(Repatriation, Invalid,Age, etc)

(b) a returned or an ex-serviceman or woman? ** YES/NO

(c) a member of any trade union, friendly society or other organisation Interested in defraying burial expenses? **YES/NO

(d) insured? **YES/NO

Did the deceased have any -

(e) money? **YES/NO Details _____

(f) property? ** YES/NO Details _____
(If insufficient space attach report)

Religion of deceased _____

Name and address of next of kin _____

_____Relationship to deceased _____

Next of kin notified of the death by _____

Will the next of kin or other person defray burial expenses? **YES/NO

Does the next of kin desire -

(g) a religious ceremony? *YES/NO If yes, details _____

(h) the body to be interred or cremated? * INTERRED/CREMATED

_____Signature

_____ Name

_____ Rank

THIS FORM IS TO BE COMPLETED IN DUPLICATE AND SUBMITTED TO THE PUBLIC HEALTH UNIT, OR THE CORONER (IF A CORONER CASE)

*CROSS OUT WORDS WHICH DO NOT APPLY
** CROSS OUT WORDS WHICH DO NOT APPLY. IF ANSWER TO ANY QUESTIONIS 'YES' ATTACH A REPORT GIVING DETAILS

67(5/08)

Attachment 3
HEALTH 373

AUTHORITY FOR BURIAL/CREMATION
OF DECEASED DESTITUTE PERSON

Public Health Unit: ……..…… Phone No …….

Report Date: …….……..

Police Officer: …….…... Morgue Register/Book No: …….

The Authority given for Cremation/Burial indicated below is based on Information received by the NSW Police Service.

To: ……..…….(Undertaker's Name)

You are hereby requested to provide a coffin and conveyance of the body of a ……(sex)

person, named ……..…… lying dead at ….……..(morgue),

and to arrange for …….……..(Cremation/Interment) without delay.

The account for the Department of Health is to be delivered to …….

(Director, Public Health Unit) of ……...

…….(Area Health Service).

Authorised: …….……..…….(Signature)

(Senior Environmental Health Officer)

Payment of Account No: ……

Approved: ……..…….. Not Approved: ……..……..

Note: This Authority must be returned to the Director, Public Health Unit as shown above.

I hereby certify that the remains of the late ……

were buried/cremated on …….(date) and place in Grave No: ……...

OR ……(other).

Signature: …….. Date: …….……

Address: ……..

CORONER'S CASES AND THE *CORONERS ACT 2009* (PD2010_054)

PD2010_054 rescinds PD2009_083.

PURPOSE

To provide:

- medical practitioners, health care workers and managers in the public health system with specific information about the *Coroners Act 2009*; and
- medical practitioners, nurses and midwives, health care workers and administrators with direction and guidance about reportable deaths to the NSW Coroner.

MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place to report deaths to the Coroner in accordance with the *Coroners Act 2009* and this Policy Directive.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure that:

- the principles and requirements of this policy are applied, achieved and sustained;
- all staff are made aware of their obligations regarding this Policy Directive;
- documented procedures are in place supporting the Policy Directive;
- there are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive.

Hospital Managers and Staff have responsibility to:

- report Anaesthetic deaths to the Director-General via the Report of Death Associated with Anaesthesia/Sedation form (section 7.1);
- provide copies of medical records to the pathologist or medical officer conducting a post mortem (section 9.3);
- provide the Coroner's Office with a completed "Report of Death of a Patient to the Coroner" (form A) along with original or copies of medical records (sections 6; 9.3).

1. BACKGROUND

1.1 About this document

The policy directive *Coroner's Cases and the Coroner's Act 2009* provides specific information about *Coroners Act 2009* (the Act) and the implications for medical practitioners, health care workers and managers in the public health system.

A number of key changes have been enacted in the *Coroners Act 2009* which are relevant to health care workers. These include changes in the categories of cases which must be reported to the Coroner, and changes to coronial autopsy procedures.

Current versions of the *Coroners Act 2009* and the *Coroners Regulation 2010* are accessible at www.legislation.nsw.gov.au

2. DEFINITIONS

The *Coroners Act 2009* defines the following terms that are used in this Policy Directive as follows:

Child: means a person who is less than 18 years old.

Child in care means a child or young person who is less than 18 years old:
(a) who is under the parental responsibility of the Minister administering the *Children and Young Persons (Care and Protection) Act 1998*, or
(b) for whom the Director-General of the Department of Community Services or a designated agency has the care responsibility under section 49 of the *Children and Young Persons (Care and Protection) Act 1998*, or
(c) who is a protected person within the meaning of section 135 of the *Children and Young Persons (Care and Protection) Act 1998*, or
(d) who is the subject of a out-of-home care arrangement under the *Children and Young Persons (Care and Protection) Act 1998*, or
(e) who is the subject of a sole parental responsibility order under section 149 of the *Children and Young Persons (Care and Protection) Act 1998*, or
(f) who is otherwise in the care of a service provider.

parental responsibility, in relation to a child or young person, means all the duties, powers, responsibilities and authority that, by law, parents have in relation to their children.

service provider has the same meaning as it has in the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

Coronial proceedings: Defined in the Act as any proceedings conducted by a Coroner or assistant Coroner for the purposes of the *Coroner's Act 2009* concerning the investigation of a death, suspected death, fire or explosion. Without limiting the definition, coronial proceedings include the following:
(a) the holding of an inquest or inquiry
(b) proceedings to determine whether or not to hold, or to continue to hold, an inquest or inquiry,
(c) proceedings of an interlocutory or similar nature (including proceedings to deal with evidential matters or case management issues).

Health related procedures see section 5.3, 5.3.1 & 5.3.2.

Reportable deaths see section 5.1.

Senior next of kin: This is defined in section 4 of the *Coroners Act* to mean:
(a) the deceased's person spouse; or
(b) if (a) is not available, any of the deceased's adult children; or
(c) if (a) and (b) are not available, either of the deceased's parents; or
(d) if non of (a), (b) or (c) are available, the deceased person's adult brothers or sisters; or
(e) if none of the above are available, the executor named in the deceased's will or the deceased's legal representative immediately prior to death.

Remains: of a deceased person means the body or remains of the body (or any part of the body) of the person.

Tissue: includes an organ, or part, of a human body, including bodily fluids.

Whole organ: of a deceased person means the whole or a substantial part of a visibly recognisable structural unit of the person's body.

In the context of this Policy Directive the terms Nursing Unit Manager (NUM) is interchangeable between Director of Nursing, Midwifery Unit Manager or any other nursing and midwifery position that is responsible for the management of a service or unit.

3. LEGAL AND LEGISLATIVE FRAMEWORK

Births, Deaths and Marriages Registration Act 1995
Children (Detention Centres) Act 1987
Children and Young Persons (Care and Protection) Act 1998
Community Services (Complaints, Reviews and Monitoring) Act 1993
Coroners Act 2009
Coroners Regulation 2005
Crimes (Administration of Sentences) Act 1999
Disability Services Act 1993
Human Tissue Act 1983 (part 7)
Mental Health Act 2007
Public Health (Disposal of Bodies) Regulation 2002
Public Health Act 1991

4. JURISDICTION OF THE CORONER

A Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that:

(a) the person's death is (or there is reasonable cause to suspect that the person's death is) a reportable death, or
(b) a medical practitioner has not given (or there is reasonable cause to suspect that a medical practitioner has not given) a certificate as to the cause of death.

5. CIRCUMSTANCES IN WHICH A MEDICAL PRACTITIONER SHOULD NOT ISSUE A CERTIFICATE AS TO CAUSE OF DEATH

A medical practitioner must not issue a certificate as to the cause of the death under the *Births, Deaths and Marriages Registration Act 1995* if the death is a **REPORTABLE** death (s6 *Coroners Act 2009*), i.e.

(a) the person died a violent or unnatural death;
(b) the person died a sudden death the cause of which is unknown;
(c) the person died under suspicious or unusual circumstances;
(d) the person died in circumstances where the person had not been attended by a medical practitioner during the period of six months immediately before the person's death;
(e) the person died in circumstances where the person's death was not the reasonably expected outcome of a health related procedure carried out in relation to the person (see below);
(f) the person died while in or temporarily absent from a declared mental health facility within the meaning of the *Mental Health Act 2007* and while the person was a resident at the facility for the purpose of receiving care, treatment or assistance.

OR

if the death is a death under s23 *Coroners Act 2009*, i.e. a death in custody case where the person died:

(a) while in the custody of a police officer or in other lawful custody; or
(b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody;or
(c) as a result of, or in the course of police operations; or
(d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
  (i) a detention centre within the meaning of the *Children (Detention Centres) Act, 1987*
  (ii) a correction centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*
  (iii) a lock-up; or
(e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

OR

if the death is a death under s24 *Coroners Act*, i.e.

(1) the death of a child who was:
  (a) a child in care; or
  (b) a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death; or
  (c) a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death; or
  (d) a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances.

OR

(2) the death of a disabled person

(a) a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or a residential centre for disabled persons, or

(b) a person (other than a child in care) who is in a target group within the meaning of the *Disability Services Act 1993* who receives from a service provider assistance (of a kind prescribed by the regulations) to enable the person to live independently in the community.

5.2 Changes to the categories of cases that were previously reportable in the *Coroners Act 1980*

(a) Deaths during, within 24 hours, or as a result of anaesthesia are no longer reportable to the Coroner unless they are captured under one of the other sections of the Act listed above. For example, if death occurred following anaesthesia and this was not a reasonable expected outcome of the procedure, the death is still reportable. (See also S7.1)
(b) The period where the person had not been attended by a medical practitioner for three months prior to death has been increased to six months.
(c) The limitation whereby a death need be reported only if it occurred within a year and a day of an accident has been removed.

(d) A death is not reportable if it follows an accident attributable to old age, if the person is older than 72 years (as opposed to 65 years in the previous legislation). The provision covers accidents that occur in a nursing home, hospital or at home. The medical practitioner **MUST STATE** on the certificate that it is given in pursuance of S38(2) of the *Coroners Act 2009*. Note that if a relative of the deceased person objects to a medical practitioner issuing a death certificate in these circumstances, the death must be reported to the Coroner (s38(3) of the Act).

5.3 NSW DEPARTMENT OF HEALTH GUIDELINES FOR DETERMINING WHETHER A DEATH IS A REASONABLY EXPECTED OUTCOME OF A HEALTH-RELATED PROCEDURE

5.3.1 What is a health-related procedure?

For the purposes of this section, the *Coroner's Act* defines a health-related procedure as a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug). Procedure in this circumstance is taken to mean health care provided to a patient.

5.3.2 What is meant by the term 'reasonably expected outcome'?

The *Coroners Act 2009* does not define the term '*reasonably expected outcome*'. This is a matter for medical practitioners to decide based upon the facts of the case. Guidelines to assist the medical practitioner determine whether or not the death should be reported to the Coroner are below (however, the examples are not exhaustive and factors individual to each case must be considered).

In determining whether the death is a reportable death?

Consider:

- did the health related procedure cause the death, and
- was the death an unexpected outcome of the procedure?

IF THE ANSWER TO BOTH OF THESE QUESTIONS IS YES, THEN THE DEATH IS REPORTABLE.

In determining whether the health procedure caused the death consider:

- was the health related procedure necessary to improve the patient's medical condition, rather than an elective or optional procedure; and
- with regards to the death, would your peers consider the health related procedures performed to be consistent with competent professional practice?

IF THE ANSWER TO BOTH OF THESE QUESTIONS IS *YES,* THEN *THE DEATH MAY NOT BE REPORTABLE.*

In determining whether the death was an unexpected outcome of the health related procedure consider:

- whether the patient's condition (factoring in their age and co-morbidities) at the time they underwent the health or health related procedure was such that death was likely to occur if they did not undergo the procedure;
- was death recognised as being a significant risk of the procedure given the patient's medical condition, but the patient, family and/or medical practitioner believed the potential benefits of the procedure outweighed the risk;
- with regards to the death, would your peers consider the health related procedures performed to be consistent with competent professional practice?

IF THE ANSWER TO EACH OF THESE QUESTIONS IS YES THEN THE DEATH MAY NOT BE REPORTABLE.

The factors to consider in each particular case will be different and doctors should use their professional judgement to determine whether the death is reportable. If the medical practitioner is uncertain about whether the death is reportable then s/he should contact the NSW State Coroner's Office on the numbers located at the end of this Policy Directive.

6. OBLIGATION TO REPORT DEATHS OR SUSPECTED DEATHS THAT ARE EXAMINABLE BY THE CORONER

Under the Act, hospitals and medical practitioners *or* any other person, who has reasonable grounds for believing that a death or a suspected death would be examinable by the Coroner must report the death or suspected death to the police (who will then report it to the Coroner) or a Coroner or assistant Coroner as soon as possible (ss35 and 38 of the Act).

All reports by medical practitioners and hospitals to the Coroner should be on the prescribed Form "*Report of Death of a Patient to the Coroner*" annexed to this Policy Directive. Reports on this form should be prepared in triplicate; the original and a duplicate copy should be handed to the police (a copy for the police and a copy for the police to give to the Coroner), the third copy should be retained by the hospital in the medical record of the deceased patient.

Medical, nursing and midwifery staff requiring further advice

If there is doubt as to whether the death is reportable, contact **must** be made with a senior medical team member or senior nurse manager or in their absence the NSW Police or the Office of the NSW State Coroner on 02 8584 7777 (business hours).

7 NSW DEPARTMENT OF HEALTH REQUIREMENT TO REPORT OTHER KINDS OF DEATHS

7.1 Anaesthetic deaths

The *Coroners Act 2009* does not specifically identify anaesthesia related deaths as being reportable to the Coroner. The requirement of the 1980 *Coroners Act* to report to the Coroner deaths occurring while under, or as a result of, or within 24 hours after the administration of anaesthesia enabled these deaths to be reviewed by the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) who then ensured that policies and practices were put in place to help reduce the number of such deaths.
In order to ensure the continued monitoring of anaesthetic related deaths, the *Public Health Act* and Regulation have been amended to make a death occurring 'while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature (other than a local anaesthetic administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death)' ("Anaesthesia Related Deaths") a Category 1 Scheduled Medical Condition.

Category 1 Scheduled Medical Conditions must be reported to the Director-General in accordance with the *Public Health Act* and Regulation. In relation to Anaesthesia Related Deaths, medical practitioners are required to notify SCIDUA via the "Report of Death Associated with Anaesthesia/ Sedation" ("SCIDUA Notification Form").

The SCIDUA Notification Form is annexed to this Policy Directive. Copies of the SCIDUA Notification Form are available from the Department of Anaesthesia at each hospital. The form can also be downloaded from the NSW Clinical Excellence Commission's website: http://www.cec.health.nsw.gov.au/programs/scidua

The completed Notification Forms are to be mailed to:

Secretary NSW Health,
C/o Special Committee Investigating Deaths Under Anaesthesia
Clinical Excellence Commission
Locked Bag 8
HAYMARKET NSW 1240

It should be noted that it is possible that a death might require notification to both the Coroner and SCIDUA, for example, if death occurred following anaesthesia and this was not a reasonable expected outcome of the procedure. In such cases Form A should be completed and sent to the Coroner and SCIDUA should be notified using the notification form "Report of a Death Associated with Anaesthesia/Sedation".

7.2 Certain other deaths

The NSW Department of Health has other Policy Directives for reporting deaths that may not be part of the *Coroner's Act*, such as reporting to:

- NSW Reportable Incident Review Committee
- NSW Maternal and Perinatal Committee, and
- Collaborating Hospitals Audit of Surgical Mortality (formally known as the Special Committee Investigating Deaths Associated with Surgery).

Staff should be familiar with these Policy Directives and note that they have a responsibility to report to these Committees.

8 GUIDELINES FOR MEDICAL, NURSING AND MIDWIFERY STAFF ON CORONERS' CASES DYING IN HOSPITAL

8.1 General considerations

The guidelines should be followed by medical, nursing and midwifery staff in dealing with Coroners' cases dying in hospital. In general nothing should be done to a body after death if it is a Coroner's case.

All intra-venous cannulae, needles, endotracheal and intragastric tubes, all drains and airways should be left in situ. Attached drip bags, bottles and feed lines must accompany the body. All sharps or items of equipment left in situ should be firmly taped or secured to the body in such a way that the risk of sharps injury or leakage is minimised. The immediate area should be checked and any sharps or equipment not required to remain in situ should be removed for disposal or reprocessing.

The body should be placed only in a plastic body bag. The body should not be washed even if the surface is soiled so that all surface contamination can be observed by the forensic pathologist and duly assessed. For instance, when death occurs shortly after injury by impact with a vehicle or by violent assault, washing may remove vital trace evidence such as an offender's blood and hairs or such things as paint flakes, glass chips or other finely divided material, which may be matched later against similar material obtained from another source.

Limbs and jaws must not be tied and orifices should not be plugged with cotton wool as these activities can leave marks, which cause problems especially about the face and neck.

Any material sucked from the stomach and/or any vomitus from suspected poisoning cases, should be retained and placed in screw-capped container(s), appropriately labelled and forwarded with the body for chemical analysis.

8.2 Removal of surgical apparatus

Generally, surgical and other apparatus are removed from the body during an autopsy. Such apparatus will be returned to the hospital if requested. However, not all deaths reported to the Coroner undergo an autopsy and in these circumstances surgical apparatus and similar equipment will not necessarily be removed from the body. If the hospital would like the surgical and other apparatus returned, written application should be made to the Coroner so that the equipment can be removed from the body.

8.3 Infectious diseases

Prior to death, if the deceased had or may have had one of the infectious diseases listed under "List A" or "List B" in section 3 of the *Public Health (Disposal of Bodies) Regulation 2002*, then a label stating clearly and indelibly only either "Infectious Disease List A - Handle With Care" or "Infectious Disease List B - Handle With Care" should be attached to the body and the body should be placed only in a plastic body bag. The body should then be placed in a second plastic body bag with a second label with the same information affixed outside. Neither label should specify the condition. The body should **not** be washed with antiseptic solution.

Infectious Diseases:
List A

- Creutzfeldt-Jakob disease
- Hepatitis C, and
- Human Immunodeficiency Virus Infection (HIV)

List B

- Diphtheria
- Plague
- Respiratory Anthrax
- Smallpox
- Tuberculosis
- Any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Congo-Crimean fevers)

8.4 Custody of body

The hospital in whose care the body of the deceased is, is responsible for the safe custody of the body until a Coroner's order for burial has been issued or, when directed by the Coroner, it is removed by members of the Police Force. This implies safe custody of the correct body in the same condition as when death occurred, i.e.no interference with incisions, dressings, equipment in situ etc. and orifices must not be plugged.

8.5 Education purposes

Occasionally, medical staff of a teaching hospital might have a coronial case that they would like to use for the specific purpose of informing clinical staff or teaching students. For example, they might wish to conduct the post mortem at the teaching hospital in order that students can attend; alternatively, they might wish to take photographs of the body for future teaching purposes. In these cases, a senior medical practitioner or hospital administrator must first obtain the written consent of the deceased person's senior next of kin and then obtain the approval of the Coroner.

8.6 Relatives

Relatives are at times caused distress because they are questioned by police and asked to carry out the necessary identification formalities without having been advised in advance of the reason for police enquiries. Where deaths are reported to the Coroner, whether immediately after death or at anytime thereafter, a senior Hospital Officer should make all reasonable efforts to contact and, where possible, to interview relatives to explain to them the formalities required by the *Coroner's Act*.

- Access to bodies for identification purposes should be appropriately authorised and supervised by the police.
- Access to bodies for any other reason including compassionate reasons should be appropriately authorised and supervised by a staff member such as a Nursing/Midwifery Unit Manager or Acting Nursing/Midwifery Unit in the ward or manager or social worker employed by the Area Health Service.
- In any death considered suspicious or where criminal charges relating to the death are possible, any access to the body should be appropriately authorised and supervised by the police.

9 CORONIAL POST MORTEMS

9.1 Power to dispense with a post mortem

The Coroner has powers to dispense with a post mortem if after obtaining advice from police officers and medical practitioners, s/he is satisfied that the person died from natural causes and the senior next of kin (see Definitions section of PD) indicates the family does not wish to have a post mortem conducted to ascertain the precise cause of the person's death.

9.2 Dignity of deceased person to be respected

Under the terms of the 2009 Act the dignity of the deceased person is to be respected.

Medical practitioners undertaking post mortems are to endeavour to use the least invasive procedures that are appropriate in the circumstances. Examples of procedures that are less invasive than a full post mortem examination of the remains of a deceased person include (but are not limited to) the following:

(a) an external examination of the remains;
(b) a radiological examination of the remains;
(c) blood and tissue sampling; and
(d) a partial post mortem examination.

9.3 Transfer of medical records to forensic pathologists for post mortem

Where a post mortem is to be conducted under the direction of the Coroner, the pathologist or medical officer conducting the post mortem must have access to a copy of the medical records. The hospital is responsible for providing a copy of the medical records. The following procedure is recommended for the handling of records:

(a) the release of all medical records should be handled by the Medical Records Section or designated responsible officer of the hospital. All hospitals must maintain a Register of Deceased Persons. It is recommended that the movement of medical records of deceased persons be recorded either in a specific register or in the Register of Deceased Persons. If a separate register is kept it should contain the following information:
    - **Area Health Service Unique Patient Identifier (medical record number)**. This is a registered number given to the patient.
    - **Patient's full name**
    - **Date of death**
    - **Hospital autopsy**. This column should be notated if the medical staff of the hospital are seeking to conduct a post mortem within the hospital.

- **Report to Coroner complete.** This column should be notated to signify that the statutory form A "*Report of Death of a Patient to the Coroner*" has been completed.
- **Report to SCIDUA.** This column should be notated to signify that the form "*Notification of Death Associated with Anaesthesia/Sedation*" has been sent to the Clinical Excellence Commission, if relevant.

(b) Medical records may be sent with the deceased but should be collated and packaged prior to dispatch. The records should be forwarded in a sealed envelope to the Coroner. (If the original documents are forwarded to the Coroner, the hospital must retain a copy of the medical records.)

(c) A signed receipt should be obtained for all records from the Coroner's Court. The receipt may be a simple card bearing the following:

Received from.....Hospital

Package Number:.....

.....signed

.....date
The Coroner, Coroner's Court

(d) Records should be forwarded within 24 hours of the death.
(e) Records should be forwarded and collected by the hospital courier where practical.

Records will generally be available for collection within seven (7) days of delivery to the Coroner's Court.

Police requesting information and/or medical records from frontline staff should be advised to make a formal request to the Area Health Service Chief Executive.

9.4 Discharge type summaries for coronial cases in hospitals

For coronial cases involving deaths in hospitals, it is the responsibility of hospitals to provide the Coroner's Office with originals or copies of the deceased person's medical records and completed Form A.

Hospitals should provide a discharge type summary upon the written request of the Coroner. This summary should outline the care and treatment received by the deceased person at the hospital and specifically answers the questions raised by the Coroner's Office in its request. This will enable any issues of concern to be addressed in the first instance without the intervention of the police.

9.5 Information for relatives of a deceased person whose death has been referred to the Coroner

This section provides information that should be given to the relatives of a deceased person, irrespective of whether that person was a public or private patient, whose death has been referred to the Coroner.

9.5.1 The right to object to the exercise of post mortem investigative function

The senior next of kin of a deceased person whose death has been referred to a Coroner may object in writing to the conduct of a post mortem investigation including the retention of whole organs during the conduct of such investigations. If the Coroner decides that a post mortem examination is necessary or desirable in the public interest, the Coroner must notify the senior next of kin in writing of this decision. The senior next of kin may apply to the Supreme Court within 48 hours of receiving the notice for an Order that the post mortem examination not be conducted or a whole organ not be retained.

9.5.2 Coronial Information and Support Program - Objections

The Coronial Information and Support Program (CISP) at the Office of the NSW State Coroner manages all objections throughout New South Wales. The CISP staff are trained to deal with acutely bereaved families and will speak to the senior next of kin regarding any objection to the autopsy. Tel. 02 8584 7777.

The website for the Office of the NSW State Coroner contains important information and links to other supportive information. The address is: http://www.coroners.justice.nsw.gov.au/.

In addition the State Coroner's Court and the Department of Forensic Medicine, Glebe has produced an information leaflet. The leaflet provides information about the coronial system and informs next of kin of their right to object to a post mortem examination. Copies of the leaflet can be obtained from the State Coroner's Court at Glebe on (02) 8584 7777 or the Department of Forensic Medicine, Glebe on (02) 8584 7800.

9.5.3 The availability of Grief Counselling

Forensic grief counsellors are employed on a full-time basis at the NSW Department of Forensic Medicine, Glebe on (02) 8584 7800 and at the Department of Forensic Medicine at Newcastle on (02) 49223700.

The counsellors are available to assist relatives of the deceased person (who are coronial cases). They provide the bereaved with information, support and counselling.

10. CORONIAL INVESTIGATIONS

10.1 Power to obtain documents and things for purposes of coronial investigation.

For the purposes of assisting a Coroner in her/his investigation, s53 of the Act gives the coroner the power to direct a person to produce a document or other thing. The power to give direction includes:

(a) power to direct that a document be produced relating to the medical care or treatment of a person;
(b) the power to direct a person to provide any tissue in the person's possession or under the person's control that was taken from the deceased before his or her death.

However, the Coroner must withdraw a direction if it appears to the Coroner that:

(a) any person would be entitled on the grounds of privilege to refuse to produce the document or other thing in a court of law; and
(b) the person does not consent to compliance with the direction.

The production of a copy of a document is taken to be sufficient compliance with the direction unless the direction expressly requires the production of the original document.

10.2 Cross border coronial assistance

Under the Act (s102) the State Coroner may request in writing that the person holding a corresponding office in another State or Territory provide assistance in relation to a matter that is the subject of an investigation. Likewise the State Coroner, at the written request of a person holding a corresponding office in another State or Territory, provide assistance in relation to that person or a Coroner of that State or Territory in connection with the exercise of power under the law of that State or Territory.

In practice this section allows the NSW State Coroner to request assistance from an Area Health Service (AHS) (this could be a request for clinical records or statements from staff) in relation to an Inquest that is been held in another State, at the request of a Coroner from another State.

11. CORONERS RECOMMENDATIONS

The role of the State Coroner in New South Wales is to ensure all deaths, suspected deaths, fires and explosions, which come under the Coroner's jurisdiction are properly investigated and concluded.

Where an inquest or inquiry is held, the *Coroners Act* allows NSW Coroners to make any recommendation that they consider necessary or desirable in relation to a death, suspected death, fire or explosion.

When a Coroner addresses a recommendation to the Minister for Health or to NSW Health, the Department's Corporate Governance and Risk Management Branch is responsible for ensuring a response is provided to the Coroner. Corporate Governance and Risk Management Branch liaise with relevant areas within the NSW Health System, particularly those areas responsible for implementing recommendations, to prepare the response.

The Department's Corporate Governance and Risk Management Branch is also responsible for reporting to the Department of Attorney-General as referred in the Department of Premier and Cabinet memorandum M2009-12 Responding to Coronial Recommendations.

The Department's Corporate Governance and Risk Management Branch can be contacted on telephone 9391 9654.

Form - "Report of Death of a Patient to the Coroner" and SCIDUA Notification form "Report of Death Associated with Anaesthesia/Sedation: can be downloaded from http://www.health.nsw.gov.au/policies/pd/2010/PD2010_054.html

102(02/09/10)

CORONIAL CHECKLIST (IB2010_058)

PURPOSE

To advise the NSW Health system of a checklist that has been drawn up for use in determining whether a death should be reported to the coroner.

KEY INFORMATION

The NSW Health Department has recently issued Policy Directive PD2010_054 Coroners Cases and the *Coroners Act 2009*. A Coronial Checklist has been developed for optional use as an aid in determining whether a death should be reported to the coroner. All forms (those annexed to the Policy Directive PD2010_054 and the Coronial Checklist) can be obtained from SALMAT either by Electronic Print On Demand (ePOD) or by purchase order from Health Support Services, Better Health Centre.

Please go to http://www.health.nsw.gov.au/policies/ib/2010/IB2010_058.html to view the Coronial Checklist forms.

113(02/12/10)

ACCREDITATION OF PATHOLOGY LABORATORIES IN NSW HEALTH
(PD2017_011)

PD2017_011 rescinds PD2006_064

PURPOSE
NSW Health Pathology is required to ensure that the accreditation of pathology laboratories is maintained. By maintaining accreditation it is expected that laboratories will meet uniform standards of practice, competently perform tests / examinations and produce accurate and reliable results for the tests for which they are accredited.

MANDATORY REQUIREMENTS
The Commonwealth requires that for a pathology service to attract Medicare benefits the pathology laboratory is to be accredited for the kinds of services that are being provided.

The standards used to assess accreditation for pathology laboratories are Standards for Pathology Laboratories developed by the National Pathology Accreditation Advisory Council ("NPAAC"). These set out the minimum standards acceptable for good pathology practice in Australia. It should be noted that the NPAAC Standards also require the laboratory to be certified to *AS ISO 15189: Medical laboratories – Requirements for quality and competence* and other Australian and International Standards.

The Commonwealth has chosen the National Association of Testing Authorities (NATA) to act on its behalf to undertake the accreditation and certification of laboratories.

Full information on the Commonwealth's requirements for obtaining accreditation are in the Medical Benefits Schedule Category 6 – Pathology Services which can be obtained from http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201605

IMPLEMENTATION
- The NSW Health Pathology Chief Executive is responsible for ensuring pathology laboratories in NSW Health are accredited.
- The Sydney Children's Hospitals Network Chief Executive is responsible for ensuring pathology laboratories at The Children's Hospital at Westmead are accredited.

MANAGED POINT OF CARE TESTING (POCT) SERVICE (PD2018_028)

PD2018_028 rescinds PD2015_028

PURPOSE

The purpose of the Managed Point of Care Testing (PoCT) Service Policy Directive is to describe the requirements for a quality assured pathology service using devices located near the patient.

More rapid access to test results provided through the use of PoCT devices can increase clinical effectiveness and contribute to improved patient outcomes. However the result provided by the devices must be accurate, reliable and relevant.

This Policy Directive outlines the requirements for the safe and effective management and use of PoCT. Devices must be fit for their intended purpose and be used by competent individuals on the correct patient. Results become part of the patient record.

The expected outcomes for this Policy Directive are to ensure that:

- PoCT pathology testing is deployed in NSW Health facilities in an accurate, effective and clinically reliable manner supporting safe and optimal care for patients.
- clear standards for the introduction and management of PoCT that maximise patient care and patient safety are provided.
- any associated medico-legal and financial risks are minimised by supporting all operators in implementing PoCT appropriately including those without a laboratory background.
- patients and staff do not suffer avoidable harm or loss.
- staff using PoCT are trained, competent and use safe work practices.
- equipment including facilities and environmental conditions are safe for users.
- compliance with International Standards ISO 15189 and ISO 22870 and any other relevant regulatory requirements so that supervising laboratories achieve and maintain National Association of Testing Authorities Australia (NATA) accreditation for PoCT.
- principles of quality management and continuous improvement for PoCT are applied.

MANDATORY REQUIREMENTS

The mandatory requirements are described in the Procedures at Attachment 1.

IMPLEMENTATION

Effective clinical governance is an essential component of PoCT. This Policy Directive describes a co-operative framework involving both NSW Health Pathology services and local healthcare facility staff.

The multidisciplinary PoCT Clinical Advisory Committee provides governance oversight.

The NSW Health Pathology Operational Team where the PoCT device is situated provides operational oversight of the PoCT Service including laboratory assigned supervision. The local healthcare facility performs testing at the point of care.

Customer Service Charters must specify:

- appropriate use of devices.
- roles and responsibilities for managing the PoCT service.
- measures for compliance with the requirements of this Policy Directive and any other relevant requirements.

NSW Health Pathology provides an electronic management solution for PoCT devices to support clinical governance and accreditation objectives by:

- electronically transmitting a patient result to the Laboratory Information System (LIS) in which they then become part of that patient medical record.
- monitoring both operator and device performance.
- allowing for remote management of devices including preventing device operation if the competency of the operator has not been assessed or reassessed within appropriate intervals.
- supporting e-learning for ongoing competency assessment.

Public Health Organisations (PHOs) and NSW Health Pathology must ensure that all relevant staff comply with this Policy Directive.

Managed Point of Care Testing (PoCT) Service: Procedures

1 BACKGROUND

The driving forces increasing the demand for PoCT include clinician demand for best practice treatments, the need for more rapid results and advances in technology resulting in new devices.

PoCT is performed in many locations throughout NSW Health facilities including Emergency and ICU departments and clinics and other settings.

Advantages of PoCT include:

- improved equity of access
- greater satisfaction for patients who require care in rural and remote communities or who are unable to travel from home
- improved patient compliance with testing due to the convenience of PoCT and, in some instances, more simple sample collection
- more rapid provision of test results particularly the reduced time between collection and analysis.

This ensures more timely treatment reducing the risk of harm and increasing the likelihood of more effective healthcare outcomes.

1.1 About this document

This document applies to all approved PoCT services and equipment incorporated into the NSW Health Pathology's Managed PoCT Service and covers the management and use of these devices irrespective of who performs the test.

The process for approval of devices is detailed in the PoCT Device Commissioning Flowchart (Attachment 1).

1.2 Key definitions

Point of Care Testing (PoCT) is defined as pathology testing performed in close proximity to a patient by a healthcare worker and usually outside the precincts of a traditional laboratory. Other terms commonly used to describe PoCT include:

a) Near patient testing (NPT)

b) Bedside testing

c) Physician office testing

d) Extra-laboratory testing

e) Disseminated laboratory testing.

Managed PoCT Service is defined as an organisational framework that delivers an integrated PoCT service according to defined standards to provide results in a short period of time because of clinical urgency.

Operator refers to registered medical practitioners, nurses, midwives, and other healthcare workers including laboratory staff.

Quality Assurance is the process of assuring that diagnostic services have been performed in an appropriate and approved manner adequate to meet an agreed standard of medical care.

1.1 Abbreviations

APA	Approved Pathology Authority
APP	Approved Pathology Provider
ARTG	Australian Register of Therapeutic Goods
eMR	Electronic Medical Record
EQA	External Quality Assurance
ISO	International Organization for Standardization
ISO 15189	International Standard -Medical Laboratories – Requirements for quality and competence - Requirements for quality and competence
ISO 22870	International Standard - Point-of-care testing (POCT) - Requirements for quality and competence
IT	Information Technology
KPI	Key Performance Indicator
LIS	Laboratory Information System
NATA	National Association of Testing Authorities,Australia
NPAAC	National Pathology Accreditation Advisory Council
NPT	Near Patient Testing
NSWHP	New South Wales Health Pathology
PHO	Public Health Organisation
PoCT	Point of Care Testing
QA	Quality Assurance
QC	Quality Control
RCPA	Royal College of Pathologists of Australasia
SLA	Service Level Agreement
TGA	Therapeutic Goods Administration
WH&S	Workplace Health and Safety

1.2 Regulatory Framework

NSW Ministry of Health requires that NSW Health staff comply with all approved jurisdictional policies and legislation regulating and assuring the quality of pathology results.

The Accreditation of Pathology Laboratories in NSW Health Policy Directive PD2017_011 states that accreditation of NSW Health Pathology laboratories is required by the Commonwealth to meet uniform standards of practice, competently perform tests and examinations, and produce accurate and reliable results in order to attract Medicare benefits.

2 MANDATORY REQUIREMENTS FOR A MANAGED PoCT SERVICE

2.1 General

2.1.1 Pathology testing that is performed on approved PoCT devices must conform to this Policy Directive.

2.1.2 PoCT will only be approved for use as an alternative to a laboratory based service if there is a significant demonstrable benefit to patient care or clinical outcomes.

2.1.3 The Managed PoCT Service must comply with all relevant NPAAC Standards and International Organization for Standardization (ISO) Standards ISO 15189 Medical laboratories – Requirements for quality and competence and ISO 22870 Point-of-care testing (POCT) Requirements for quality and competence.

2.1.4 The service must review all requests to establish PoCT and must approve all such services and the devices to be used before PoCT is implemented.

2.1.5 Testing locations performing PoCT must be authorised to provide PoCT testing by the Local Health District (LHD).

2.1.6 Each staff member performing PoCT tests must be trained and assessed as competent. This training and assessment must occur before commencing testing.

2.1.7 PoCT devices must be periodically evaluated for their ongoing suitability.

2.1.8 PoCT devices may be withdrawn and PoCT services suspended if:

- PoCT service testing locations fail to comply with this Policy Directive
- a significant safety issue has occurred
- the instrumentation is misused or operator accreditation or certification is deficient
- there are concerns in relation to accuracy of results
- there is a lack of clinical effectiveness
- the expected benefits for using PoCT are not realised.

Services may be reinstated if evidence of remediation or resolution is provided.

2.2 Service Introduction

2.2.1 Applications to introduce, modify or change POCT services or devices must be submitted on the Application Form for PoCT Service Form.

2.2.2 Implementation of PoCT by NSW Health Pathology must be in collaboration with the LHD or relevant clinical service team and the supporting NSW Health Pathology Operational Team and must be integrated into the clinical framework of the health service.

2.2.3 The application must:

a) identify if PoCT will replace, or will be in addition to, laboratory testing

b) identify how PoCT will be integrated in to clinical pathways and guidelines

c) address the benefits to clinical need and effectiveness

d) define quality key performance indicators (KPIs).

2.2.4 Only approved devices will be endorsed and supported by this policy and procedure, irrespective of how the devices are financed, for example, purchased, loaned, gifted, leased, etc.

2.2.5 Devices will be commissioned once adequate numbers of competent operators have been trained, assessed and accredited. 'Adequate numbers' of operators will be determined by the management at the requesting test location.

2.2.6 A Customer Service Charter must be agreed and signed before implementation of PoCT services.

2.3 Accreditation

2.3.1 All PoCT services must be accredited by National Association of Testing Authorities, Australia (NATA).

2.3.2 Under Commonwealth legislation, all PoCT devices must be approved for use by the Therapeutic Goods Administration.

2.4 Patient Results

2.4.1 All patient results must be entered into, or transferred to, the appropriate LIS so they become part of the electronic medical record (eMR).

2.4.2 Results from PoCT devices must be clearly distinguishable in the LIS and eMR from results derived from laboratory analysers.

2.5 Networking

2.5.1 All new PoCT devices included in the Managed PoCT service must be:

a) capable of transferring patient results electronically to the LIS.

b) linked to NSW Health Pathology's PoCT Management System.

2.6 Supporting Documentation

2.6.1 A copy of the operational procedure for each device must be readily available near the PoCT instrument. Electronic copies are available from the NSW Health Pathology internet.

2.6.2 The procedure must contain:

- principle of examination
- sample requirements
- reagent storage
- calibration procedure (if appropriate)
- testing procedure and use of all related equipment

- maintenance and troubleshooting procedures including device error messages
- result interpretation including critical alert limits and reference ranges
- competency assessment criteria
- response to abnormal or unexpected results
- limitations of procedure including known interferences and limits of detection
- Quality Control (QC) and External Quality Assurance (EQA) procedures and Quality Control Record Sheets
- safe work practice and infection control information
- requirements and processes for recording results
- storage of documentation relating to testing ie printed test results.

2.7 Safety

2.7.1 Only PoCT devices and associated equipment that have satisfied Workplace Health & Safety requirements may be commissioned.

2.7.2 Specimens, reagents and other consumable supplies must be handled and disposed of according to safe work practices.

2.7.3 Devices and associated equipment must be located/stored, used and managed according to safe work practices.

2.8 Quality Control and External Quality Assurance

2.8.1 Prescribed quality control and quality assurance must be performed on all devices for all analytes as specified by the Managed PoCT Service to achieve compliance with the NATA Medical Testing Field Application Document Requirements for Accreditation (2013).

2.8.2 All devices must be enrolled in an EQA program for every analyte/test performed. If a commercial EQA is not available, an internal "interlab" program is mandatory.

2.8.3 Quality control and external quality assurance must be performed by certified operators. It is recommended that a representative sample of staff who use the device participate in the EQA program. All results must be recorded and retained for a period according to NPAAC Requirements.

2.9 Device Maintenance

2.9.1 Maintenance of devices is the responsibility of staff employed at the testing location performing PoCT.

2.10 Training and Competency Assessment

2.10.1 Initial training for devices must include 'face-to-face' training.

2.10.2 Training must be undertaken by an approved trainer. Knowledge/skill training requirements must include:

- the ability to demonstrate appropriate use of the device.
- pre-analytical requirements such as sample collection, reagent storage requirements, safety and infection control practices.
- the ability to identify results that fall outside of reference ranges.
- device maintenance.
- an understanding of Quality Control (QC) and Quality Assurance Program (QAP).

2.10.3 All staff performing PoCT must be initially assessed for competence by an approved trainer, for all devices they use.

2.10.4 All staff performing PoCT must be reassessed for competence periodically. The interval between All staff performing PoCT must be reassessed for competence periodically. The interval between re-certification of competency will be dependent on the device type, testing frequency and may be varied if there is any deficiency in performance of PoCT at the testing location. Minimum intervals for re-certification are to be specified in service level agreements.

2.10.5 All training will be followed by competency assessment.

2.10.6 Competency assessment records must be stored on site and retained in accordance with NPAAC Requirements.

2.11 Incident Reporting

2.11.1 Any incident involving PoCT devices must be reported in the NSW Health Incident Information Management System (IIMS) in accordance with the Incident Management Policy.

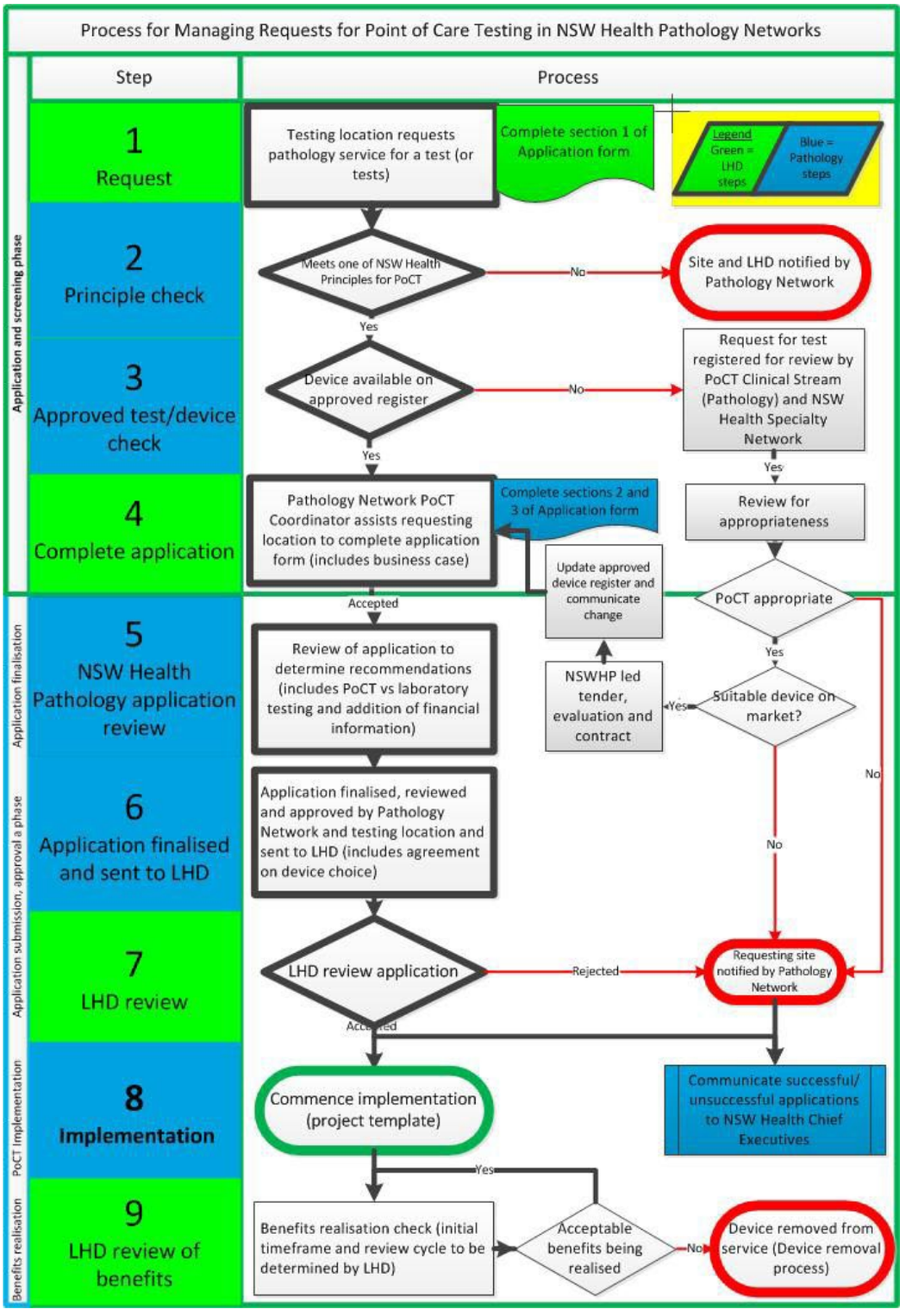
2.11.2 Any non-clinical issue relating to reagents, devices, quality control, EQA must be reported to the management at the testing location and be made the subject of a corrective action report in accordance with current standards.

2.12 Internal and External Audit

2.12.1 PoCT Services are subject to internal and external audits to assure quality and compliance with accreditation requirements**.**

3 APPENDIX

Attachment 1: PoCT Device Commissioning Flowchart



TRANSPORT OF PATHOLOGY SPECIMENS TO LABORATORIES (PD2023_001)

PD2023_001 replaced PD2018_020

POLICY STATEMENT

NSW Heath Pathology provides specialist pathology services for NSW Health organisations, NSW Police, private pathology providers, community based medical practitioners and private hospitals. It ensures a consistent state-wide approach to the safe and timely transport of all pathology and forensic specimens in compliance with relevant regulatory requirements.

SUMMARY OF POLICY REQUIREMENTS

Pathology specimens must be transported by the NSW Health Pathology Transport Service to NSW Health Pathology's on-site laboratory or to the appropriate laboratory providing the required diagnostic testing.

Other transport services can only be used to transport specimens to the appropriate laboratory providing the required diagnostic analysis in the following circumstances:

- Where the NSW Health Pathology Service is not operating
- Where there is no on-site NSW Health Pathology laboratory
- When the NSW Health Pathology laboratory is closed.

To ensure the integrity of specimens and the safety of staff and transport personnel, specimens must be appropriately handled, prepared, stored, packaged, labelled and transported in compliance with all legislative and regulatory requirements and this Policy.

To download the full Transport of Pathology Specimens to Laboratories policy to to:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_001

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters

CHAPTER 20 - PHARMACEUTICAL MATTERS

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Pharmacy Department Reimbursement and Data Collection During PBS-Subsidised Naloxone Pilot	IB2020_005
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MEDICATION HANDLING (PD2022_032)

PD2022_032 resinded PD2013_043, IB2013_064, IB2017_045, IB2019_041.

POLICY STATEMENT

NSW Health organisations must have appropriate processes in place to ensure the appropriate, safe, efficient and cost-effective use of medications in NSW public health facilities.

SUMMARY OF POLICY REQUIREMENTS

The Chief Executive is responsible for establishing a Drug and Therapeutics Committee for the governance of medication management.

Each Drug and Therapeutics Committee will be responsible for the governance of quality and safe medication procurement, storage, prescribing, supply, administration and recording protocols and procedures at the facilities assigned to the Committee. The Drug and Therapeutics Committee also has oversight of facility procedures for medication safety alerts, recalls, shortages and incident management.

Facility procedures for the procurement, storage, labelling, prescribing, dispensing, supplying, administering and recording of medications must be in accordance with *the Poisons and Therapeutic Goods Act 1966*, *Poisons and Therapeutic Goods Regulation 2008* and applicable NSW policies and guidelines.

Each facility must establish a High-Risk Medicines Program with a High-risk Medicines Register in accordance with NSW Health Policy Directive *High-Risk Medicines Management* (PD2020_045). Facility procedures must be developed for all high-risk medicines specified on this register.

Authorised prescriber requirements under the *Poisons and Therapeutic Goods Regulation 2008* to direct the administration of medication and issue prescriptions for pharmacist dispensing are in section 4 of the Policy procedures. The Regulation restricts the prescribing of specific medications to certain authorised prescribers and/or under the Authority of the NSW Health Secretary. Authorised prescribers may also supply medications for patient take home use from health facility stocks when the Pharmacy Service is not available.

Medications at the Pharmacy Service are under the governance of the director of pharmacy, or authorised pharmacist delegate where there is no director of pharmacy. At a facility where there is no employed/contracted pharmacist the medication supply service is managed by the director of nursing or medical superintendent authorised by the Chief Executive. Schedule 8 medications are to be stored in a safe or vault apart from all other medications and accounted for in a drug register.

Pharmaceuticals prepared for by, or on behalf of, a public health facility, must be managed in accordance with the Policy Directive *Pharmaceuticals – Preparation in NSW Public Health Facility Pharmacy Services* (PD2015_007).

Medications stored and used within a patient care area are under the governance of the registered nurse or midwife in charge. Specific storage requirements apply for Schedule 4 Appendix D and Schedule 8 medications as they are vulnerable to diversion. Schedule 8 medication transactions are to be recorded in a drug register.

Authorised staff administer and supply medications under facility procedures, such as:

- on a medication chart order, or
- on a verbal (face to face), telephone or video call, email or facsimile order, or
- under a Standing Order, or

- under a nurse-initiated medication protocol, or
- under a Schedule 4 medication clinical protocol.

Certain medications require a second person check in specified circumstances.

TheMedication Handling policy in full is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_032

343(11/08/22)

TENECTEPLASE REPLACEMENT IN PUBLIC HOSPITALS FOR AMBULANCE PARAMEDICS (IB2013_063)

PURPOSE

This Information Bulletin is to provide guidance on tenecteplase replacement in public hospitals for NSW Ambulance Paramedics.

KEY INFORMATION

The Pre-Hospital Thrombolysis (PHT) program is part of the State Cardiac Reperfusion Strategy (SCRS) that is being progressively implemented by the Local Health Districts (LHD) with support from the Agency for Clinical Innovation (ACI) in collaboration with NSW Ambulance.

As part of the PHT program, NSW Ambulance paramedics administer intravenous tenecteplase to eligible patients with ST Elevation Myocardial Infarction (STEMI) prior to the patient arriving at the hospital.

In accordance with an Authority issued under the *Poisons and Therapeutic Goods Regulation 2008* (NSW), a registered nurse in charge (or his/her delegate) of the Emergency Department (ED) of a public hospital that receives a patient following pre-hospital administration of thrombolytic therapy, is permitted to supply a NSW Ambulance paramedic with one vial of tenecteplase 50mg from ED stock, at the time of patient handover (i.e. 1:1 replacement) to restock the Ambulance Medication kit.

A record of the supply of tenecteplase from the ED, signed and dated by the nurse in charge of the ED (or his/her delegate) and the NSW Ambulance paramedic, must be kept for accountability over the movement of prescription medicines and audit purposes.

The replacement vial must be unused and in its original packaging and should have at least six (6) months shelf life prior to the expiry date.

Replacement should occur even if the hospital only holds one vial of tenecteplase 50mg in stock. In such cases, the Local Health District (LHD) and hospitals will determine how the hospital stock will be replaced according to their local pharmaceutical supply policies.

Processes to facilitate the replacement of tenecteplase provided to paramedics by the ED will be established locally.

In most cases, the patient receiving the pre-hospital tenecteplase would have received tenecteplase at that hospital if the PHT program was not in place (or at another hospital within the same LHD).

These replacement arrangements apply only to tenecteplase that has been used for a patient. Expired stock will not be replaced, nor will any other medication used by paramedics.

The procurement, storage, recording, handling and supply of tenecteplase by a hospital must be in accordance with the NSW Ministry of Health Policy Directive PD2013_043 Medication Handling in NSW Public Health Facilities.

196(12/12/13)

APPROVAL PROCESS FOR MEDICINES AND THEIR USE (PD2022_056)

PD2022_056 rescinds PD2016_033

POLICY STATEMENT

NSW Health is committed to establishing a standard process for the approval of medicines for use within NSW public hospitals and health services in accordance with the NSW Medicines Formulary, or for approval of medicines for individual patient use (IPU).

SUMMARY OF POLICY REQUIREMENTS

All NSW public hospitals and health services are to have the process in place for:

Submissions for addition, amendment, or removal of a medicine on the NSW Medicines Formulary. All medicines under consideration for addition, or for variation to an existing listing, need to undergo a thorough evaluation process. The NSW Medicine Formulary Committee's approval is required for all formulary listings of medicines that are for initiation within NSW public health facilities, including any prescribing restrictions associated with it.

Approval of specific medicines for Individual Patient Use when a therapeutic need exists for a medicine or an indication which is not listed on the NSW Medicines Formulary. The Drug and Therapeutics Committee is responsible for management of Individual Patient Use and needs to have a standard process to guide their decision-making when evaluating a medicine for Individual Patient Use

Use of off-label or unregistered medicines. Prescribers considering use of a specific medicine for an off-label indication, or use of an unregistered medicine, need to follow a systematic evaluation process to assist with the assessment of whether such use is clinically justified.

1. BACKGROUND

This Policy Directive describes governance structures and standard procedures for approval of medicines for use within NSW public hospitals and health services. It includes procedures to support adoption and compliance with the Statewide NSW Medicines Formulary.

The NSW Medicines Formulary aims to reduce unnecessary clinical variation, increase equity of access to medicines, and improve both patient safety and quality use of medicines.

1.1 About this document

This Policy applies to all clinical staff working within NSW public hospitals and health services, involved in the prescribing, dispensing and administering of medicines, as well as those involved in the approval process for medicines.

All NSW public hospitals and health services are to have the process in place for:

- Medicines listed on the NSW Medicines Formulary
- Medicines that are registered or listed on the Australian Register of Therapeutic Goods that have not yet been added to the NSW Medicines Formulary
- Use of registered or listed medicines in a manner that is not included in the approved product information for that medicine
- Use of medicines that are not registered or listed on the Australian Register of Therapeutic Goods.

The process set out in this Policy, does **not** apply to:

- Medicines supplied through Medicines Access Programs (refer to the Council of Therapeutic Advisory Groups (CATAG) document on *Managing Medicines Access Programs: Guiding Principles for the governance of Medicines Access Programs in Australian hospitals*)
- The approval of medicine use for research refer to NSW Health Guideline Human *Research Ethics Committees: Standard Operating Procedures for NSW Health Public Health Organisations* (GL2013_099).

All public hospitals and health services in NSW are to adopt and comply with the NSW Medicines Formulary.

Drug and Therapeutics Committees (DTC) are to support local adoption of the NSW Medicines Formulary and provide oversight of the use of all medicines in local facilities.

Prescribers working within public hospitals and health services can only initiate medicines that are listed on the NSW Medicines Formulary or in accordance with this Policy.

1.2 Key definitions

Conditional Use	Refers to off-label use of medicines where [1]: • The quality of evidence is low to moderate; however, there is reasonable justification for use in certain types of patients • A Drug and Therapeutics Committee (DTC)-approved protocol, NSW Health Policy or Statewide/national Clinical Guideline guides the therapy • Evidence development is required with systematic reporting of effectiveness and safety outcomes to the Drug and Therapeutics Committee and relevant clinicians • There is regular review of continued therapy for an individual and group of patients. Approval applies to a specific group of patients.
Drug and Therapeutics Committee (DTC)	The Committee with delegated responsibility for the governance and quality of the medication management system and for ensuring the appropriate, safe, effective, and cost-effective use of medicines in the health facility, Local Health District or Speciality Health Network under their jurisdiction [2]. For further information on the role and operation of Drug and Therapeutics Committees, refer to the: • NSW Health Policy Directive *Medication Handling* (PD2022_032) • Council of Australian Therapeutic Advisory Groups' (CATAG) *Achieving effective medicines governance: Guiding Principles for the roles and responsibilities of Drug and Therapeutics Committees in Australian public hospitals*. Some health facilities may have an equivalent committee (such as a Quality Use of Medicines Committee) that governs such quality use of medicine functions. For this Policy, equivalent committees are considered to have the same roles and responsibilities as Drug and Therapeutics Committees, and the same governance and quality responsibilities apply.
Exceptional Use	Refers to off-label use of medicines where [1]: • There is low or very low-quality evidence • The potential benefits may be greater than the potential harms for the specific individual circumstances that meet pre-specified criteria (such as a serious or rare condition and/or no other effective or safe alternative therapy). Approval is patient specific.

Health Service	Any hospital, clinic, institution, health service, or health support service controlled by a Local Health District, Statutory Health Corporation or Affiliated Health Organisation, as specified in *Health Services Act 1997* (NSW).
Hospital	A hospital designated as such by a Local Health District, a Statutory Health Corporation or an Affiliated Health Organisation, as specified in *Health Services Act 1997* (NSW).
Individual Patient Use (IPU)	A request to or approval by the Drug and Therapeutics Committee for the use of a medicine by a patient, where the requested medicine or indication is not available on the NSW Medicines Formulary.
Medicine	Used singularly throughout this Policy to describe a drug, medicine, pharmaceutical preparation (including an extemporaneously compounded preparation), therapeutic substance, complementary and alternative medicine, vaccine, diagnostic agent for patient administration, medicated dressing, device containing a medicine, and a fluid for intravenous use. Includes Scheduled medication and unscheduled medication.
Medicines Use Evaluation	A cyclical process involving a structured review of medicines use within and across healthcare organisations. The review determines whether medicines use is appropriate according to pre-determined standards, thereby targeting areas for interventions [3]. This process was previously referred to as Drug Use Evaluation (DUE).
NSW Medicines Formulary	A state-wide, continually updated list of medicines and other therapeutic agents that have been approved for use within NSW public hospitals and health services. It includes the generic medicine name, strength, indication(s) where appropriate, dosage form(s), and any prescribing restrictions, if applicable.
NSW Medicines Formulary Committee	The peak NSW governance committee for medicines and therapeutic agents approved for use within NSW public hospitals and health services. The committee oversees the maintenance of the NSW Medicines Formulary.
Off-label medicine use	Use of a medicine for a therapeutic purpose other than that specified in the Therapeutic Goods Administration (TGA)-approved Product Information. This may include when the medicine is prescribed or administered: • For another indication • At a different dose or frequency of administration • Via an alternate route of administration • For a patient of an age or gender outside the registered use [1].
Routine Use	Refers to medicines routinely used off-label where [1] high quality evidence supports such use, for example, once daily dosing of intravenous gentamicin. There is a favourable benefit/harm ratio for the intended off-label use.
Special Access Scheme	Arrangements which provide for the import and/or supply of a non-TGA approved therapeutic good for individual patient use [4].
Unregistered medicine	An unregistered medicine is a medicine or dosage form that is not currently approved for use in Australia and hence is not in the Australian Register of Therapeutic Goods [5].

1.3 Legal and legislative framework

The *Poisons and Therapeutic Goods Act 1966* (NSW) and *Poisons and the Therapeutic Goods Regulation 2008* (NSW) regulate the procurement, storage, labelling, prescribing, supplying, administering and recording of both scheduled and unscheduled medicines at health facilities, and by health practitioners and pharmaceutical wholesalers. This is the legislation that authorised prescribers, pharmacists and nursing staff are to adhere to when prescribing, dispensing, and administering medicines.

2. APPROVAL PROCESS

All public hospitals and health services are to adopt and comply with the NSW Medicines Formulary. Medicines and their use for initiation within NSW public hospitals and health services are to be approved by the NSW Medicines Formulary Committee (see Section 2.1.1).

If a prescriber intends to initiate a medicine that is not listed on the NSW Medicines Formulary, an approval from the local Drug and Therapeutics Committee for Individual Patient Use is required prior to prescribing (see Section 2.1.2). Initiation of medicines that are out of scope of the NSW Medicines Formulary is to follow local Drug and Therapeutics Committee procedures.

If a prescriber intends to prescribe a medicine for continuation (i.e., the medicine was initiated prior to hospital admission), that is not listed on the NSW Medicines Formulary, an Individual Patient Use approval is not required. Medicines in this category may be kept in the hospital for inpatient use. The exception to this is; where the local Drug and Therapeutics Committee has specified particular products need an Individual Patient Use approval (e.g., unregistered Schedule 8 medicine).

Refer to NSW Health Policy Directive *Medication Handling* (PD2022_032) for direction on the use of patient's own medicines while an inpatient.

It is the responsibility of the Drug and Therapeutics Committee to decide which NSW Medicines Formulary medicines are to be routinely stocked in hospital, considering patient case mix, local services, and demographics. It is expected that a medicine not routinely stocked but listed on the NSW Medicines Formulary would be obtained in a timely manner, if required for initiation where no suitable alternative is available.

The Drug and Therapeutics Committee is to have a system in place for the management of non-formulary medicines regarding how they are approved, supplied during admission and on discharge, and any monitoring or reporting of outcomes requirements associated with their use.

For further information on the NSW Medicines Formulary Committee and its secretariat, please refer to the Clinical Excellence Commission (CEC) document *NSW Medicines Formulary Committee Business Processes*.

2.1 Submission processes

2.1.1 Addition, amendment or removal of a medicine

The NSW Medicine Formulary Committee's approval is required for any formulary listing of a medicine for initiation within NSW public health facilities, including any prescribing restrictions associated with it.

The approval process is outlined in Appendix 2.

All medicines under consideration by the committee for addition to the NSW Medicines Formulary, or for variation to an existing listing, need to undergo a thorough evaluation process.

The evaluation process will include some or all of the following steps (as applicable to the particular application):

- Critical evaluation of evidence supporting the inclusion in the NSW Medicines Formulary. The level of evidence required concerning effectiveness will depend on the specific medicine and the circumstances in which it is proposed to be used. Sufficient evidence regarding the safety profile of the medicine will be required to establish an acceptable risk/benefit ratio for the given clinical circumstances.
- Clear description of the objectives of formulary addition or amendment of listed indication(s) regarding the delivery of patient care, including the expected outcome(s) that the medicine will have on the medical condition being treated and the impact of this change.
- Assessment of the medicine costs (including costs associated with the use of the medicine such as the need for extra resources and associated diagnostic tests), including direct and indirect costs associated with the potential harms and benefits of the new medicine. This is in comparison with existing therapies, including non-pharmacological therapies where appropriate (known as **pharmacoeconomic analysis**).
- Assessment of ongoing cost to patient or health service for continuation of medicine outside of inpatient admission.
- Assessment of the requirement for a specific medicine protocol/guideline to standardise and guide judicious, appropriate, effective, safe and cost-effective medicine use.
- Assessment of the requirement for any specific training, qualifications, skills or competencies to prescribe, dispense or administer the medicine.
- Assessment of the equity and ease of access to the medicine, including ongoing supply after discharge from hospital.
- Assessment of medication safety impact i.e., potential risk for medication error.

The clinician(s) requesting the addition to, amendment of, or removal of a medicine from the NSW Medicines Formulary will need to complete and submit electronically the NSW Medicines Formulary Submission form to their local Drug and Therapeutics Committee (DTC) for endorsement, using the agreed mechanism determined by the NSW Medicines Formulary Committee secretariat.

The Drug and Therapeutics Committee are to have a standard process to guide decision making when endorsing a medicine for submission to the NSW Medicines Formulary.

It is recognised that depending on local governance arrangements, the process of endorsement may vary in each Local Health District/Specialty Health Network. Therefore, there is a need for a defined local process for clinicians to follow when submitting a formulary application.

The final application to the NSW Medicines Formulary Committee is to be submitted by the Executive Sponsor or delegated officer of the Drug and Therapeutics Committee from the Local Health District/Specialty Health Network.

Submissions can only be made by clinicians within NSW Health. Submissions by pharmaceutical representatives or manufacturers will not be accepted.

2.1.2 Individual Patient Use approval

Approval of specific medicines for Individual Patient Use is required when a therapeutic need exists for a medicine or an indication which is not listed on the NSW Medicines Formulary [6].

The Drug and Therapeutics Committee is responsible for management of Individual Patient Use and needs to have a standard process to guide their decision-making when evaluating a medicine for Individual Patient Use.

The clinician(s) requesting a medicine for Individual Patient Use will need to complete the relevant Individual Patient Use application form for the Drug and Therapeutics Committee.

Depending on the medicine and its use, the Drug and Therapeutics Committee may require a written clinical protocol to accompany the application that includes indication(s) and circumstances of use, expected outcomes, safe prescribing and administration details, contraindications, precautions and interactions with other therapy, common and serious adverse effects.

There are additional considerations for Individual Patient Use applications for off-label or unregistered medicines (see Section 2.5).

Multiple Individual Patient Use requests for the same medicine/indication

The Drug and Therapeutics Committees are to have a system to monitor Individual Patient Use applications and approvals. High use of a specific Individual Patient Use medicine for a specific indication may prompt an evaluation for formulary submission to the NSW Medicines Formulary Committee.

In these cases, the NSW Medicines Formulary secretariat will consult with the relevant Drug and Therapeutics Committee(s) on whether a formulary submission is required. The secretariat may also facilitate a formulary submission in consultation with a Local Health District/Specialty Health Network or multiple Local Health Districts/Specialty Health Networks.

2.2 Management of applications

All applications submitted to the NSW Medicines Formulary Committee, and the outcome of these applications, are to be recorded by the NSW Medicines Formulary secretariat. The application of a medicine to be added to the NSW Medicines Formulary is to include the active ingredient(s), strength(s), dosage form(s), proposed indication(s) (where appropriate) and any restriction(s), for example, by prescriber, indication or duration of therapy.

Once a submission is received, the NSW Medicines Formulary secretariat will liaise with the applicant regarding timeline for review at an NSW Medicines Formulary Committee meeting.

All applications for Individual Patient Use (IPU) managed locally, including urgent out of session applications and the outcome of these applications, are to be logged by the Drug and Therapeutics Committee (DTC) using the agreed mechanism determined by the NSW Medicines Formulary Committee secretariat.

Members of the NSW Medicines Formulary Committee, local Drug and Therapeutics Committee s and others who may be involved in the approval of applications are to disclose any perceived or actual conflicts of interest, as per the NSW Health Policy Directive *Conflicts of Interest and Gifts and Benefits* (PD2015_045).

There must be full disclosure of any significant relationship (financial or otherwise) between the clinician who requests NSW Medicines Formulary addition or approval of individual patient or patient group use, and the supplier of the product or other significant party.

Notification of application outcomes

Regarding applications for formulary submission or amendment, Drug and Therapeutics Committees and any other endorser of the application will be informed of the outcome of the application. A decision log, kept by the NSW Medicines Formulary secretariat, will document all NSW Medicines Formulary Committee decisions and changes, including those that are not approved. The decision log will be made available by the NSW Medicines Formulary secretariat.

The clinician who submitted the application (for formulary submission or amendment) is to be informed of the outcome of their application, together with details of approved use, including indication(s) for use, any prescribing restrictions, and any monitoring and reporting requirements.

Processes are to be in place for communication of relevant decisions to all relevant clinicians and medication related governance committees (see Section 2.4).

Appeals Process for NSW Medicines Formulary Decisions

Appeals against decisions made by the NSW Medicines Formulary Committee may be made on the grounds of:

- Decisions based on inaccurate or incomplete information.
- Procedural fairness, i.e., the published submission process has not been followed.
- Decisions which are expected to have high-cost, high-impact, require large practice change or pose significant risk to any Local Health District, Specialty Health Network or facility.

For information on how to lodge an appeal, please refer to the CEC document *NSW Medicines Formulary Committee Business Processes*.

Urgent applications

In circumstances of medicines shortages, recalls, public health responses, or unexpected discontinuation of medicines, the NSW Medicines Formulary Committee will have a process in place to facilitate rapid approval of an alternative medicine. The circumstances and details of such approvals is to be clearly documented and reported for review at the next NSW Medicines Formulary Committee meeting.

If use of a specific medicine is required urgently to prevent or minimise harm to a patient, there is to be a procedure in place that facilitates rapid assessment of the Individual Patient Use (IPU) application by a Drug and Therapeutics Committee. The circumstances and details of such approvals is to be clearly documented and reported for review at the next Drug and Therapeutics Committee meeting.

2.3 Review of NSW Medicines Formulary

The NSW Medicines Formulary Committee will have a formulary review process in place to ensure that the addition, amendment, removal and review of all medicines occur in a systematic, fair and transparent manner.

Ongoing management will include a regular review process for medicines placed on formulary. The review of medicines on the formulary will include (but not be limited to); medicine utilisation trends over time, new evidence for or changes in indications for use, evidence of inappropriate use or safety implications, and changes to Pharmaceutical Benefit Scheme (PBS) listings.

Medicines can be considered for deletion from the formulary when evidence or information emerges which identifies the medicine is no longer efficacious, is unsafe, or inferior to alternatives, or is to be discontinued in the Australian market.

Monitoring and reporting

Processes are to be in place for monitoring and reporting outcomes of medicines use to inform systems improvements, such as Medicines Use Evaluation or other clinical quality audit processes. This includes, where applicable, outcome data for Individual Patient Use (IPU) approvals, in particular where ongoing use is anticipated.

Medication incident reporting and adverse drug reaction reporting

Besides the usual reporting using the facility's incident management system and the Therapeutic Goods Administration's Adverse Event Management System, incidents associated with the use of medicines, including suspected adverse drug reactions, are to be reported to the Drug and Therapeutics Committee (DTC) for review, evaluation and action.

The evaluation is to include the review of any associated clinical protocol for use of the medicine. If deemed appropriate by the Drug and Therapeutics Committee, incidents are to be escalated to the NSW Medicines Formulary Committee or the Medication Safety Expert Advisory Committee via the secretariat (CEC-MedicineFormulary@health.nsw.gov.au, CEC-MedicationSafety@health.nsw.gov.au).

2.4 Communication of decisions

2.4.1 NSW Medicines Formulary Committee

The secretariat of the NSW Medicines Formulary Committee will facilitate communication of NSW Medicines Formulary Committee decisions to the Drug and Therapeutics Committees of NSW hospitals, Local Health Districts and Specialty Health Networks, District Director of Pharmacy and/or Director of Pharmacy.

2.4.2 Individual Patient Use

To facilitate communication of Drug and Therapeutics Committee (DTC) decisions to the Drug and Therapeutics Committee s of other NSW hospitals, Local Health Districts and Specialty Health Networks, the NSW Medicines Formulary secretariat maintains a register of Drug and Therapeutics Committee Individual Patient Use (IPU) decisions and patient outcome data for NSW public hospitals. The register will be accessible to authorised personnel, including Drug and Therapeutics Committee members.

All hospitals are to inform the secretariat of all Individual Patient Use decisions using the agreed mechanism determined by the NSW Medicines Formulary Committee secretariat.

2.5 Use of off-label or unregistered medicines

Off-label indications and unregistered medicines may be listed on the NSW Medicines Formulary for initiation and would, therefore, not require an Individual Patient Use submission.

Prescribers considering use of a specific medicine (whether listed on NSW Medicines Formulary or not) for an off-label indication, or use of an unregistered medicine, need to follow a systematic evaluation process (see Appendix 1) to assist with the assessment of whether such use is clinically justified.

See CATAG document, Rethinking medicines decision-making in Australian Hospitals: Guiding Principles for the quality use of off-label medicines, for further information on categories and conditions including for Research or Investigational Use.

The Drug and Therapeutics Committees (DTC) are to have policies and protocols for off-label use of medicines and use of unregistered medicines. Policies and protocols need to address:

- Consent and documentation requirements as outlined in Table 1
- Patient's and/or carer's involvement in any decision-making regarding off-label medicine use
- The provision of medicine information and resources for the patient and/or their carer
- The provision of product information in English, when available, for clinicians involved in the administration of the off-label or unregistered medicine when the medicine is procured from overseas, for example, Special Access Scheme (SAS) products
- Labelling of medicines that are imported from overseas to ensure generic name, strength and route of administration are clearly identifiable and are printed in English
- Monitoring and reporting of outcomes from treatment, including adverse events
- Ongoing cost considerations to the patient and hospital, and continuity of the supply of medicines following discharge from hospital or transition of care
- Other requirements for use of the unregistered medicines, including prescriber and hospital reporting requirements

- Any requirement for specific training, qualifications, skills or competencies.

Off-label medicines

Guidance may be required to support decision making by health professionals, consumers and Drug and Therapeutics Committees in their evaluation, approval and use of off-label medicines.

Unregistered medicines

All medicines under consideration for use that are unregistered are to undergo an evaluation process that first considers the use of an alternative Therapeutic goods Administration (TGA)-registered product, if available. Unregistered medicine use will only be considered when the approved use of a registered medicine does not address the clinical need(s) of the patient(s).

Drug and Therapeutics Committee s are to have processes in place that evaluate and manage the risk that may be associated with the use of unregistered medicines, such as those obtained under Schedule 5A of the *Therapeutic Goods Regulation 1990* (Commonwealth), Section 19A of the *Therapeutic Goods Act 1989* (Commonwealth) and via the Special Access Scheme.

Conditional registration of a product may occur under Section 19A of the *Therapeutic Goods Act 1989* (Commonwealth), for example, during times of medicine shortage. If a product is replacing a medicine on the NSW Medicines Formulary, the replacement product will be assessed as outlined in the NSW Policy Directive *Coordination of responses to urgent system-level medicine or medical device issues* (PD2019_019) and referred to the NSW Medicines Formulary Committee for listing.

Table 1: Patient consent and other documentation requirements for off-label and unregistered medicines

Off-label medicine	
Routine use	• Follow usual processes for patient consent to therapy with provision of information and discussion. • This is to occur as part of routine clinical care and does not require additional measures.
Exceptional use	• Approval is patient specific. • Informed patient consent is to be obtained (refer to the NSW Health *Consent to Medical and Healthcare Treatment Manual* (Consent Manual) for further details). • Reasons for use are to be documented in the medical record. • The prescriber is to conduct a detailed discussion about uncertainty of benefits and harms with use of the medicine with the patient and/or carer.
Conditional use	• Informed patient consent is to be obtained (refer to the NSW Health *Consent to Medical and Healthcare Treatment Manual* (Consent Manual) for further details). • Reasons for use need to be documented in the medical record. • Approval of use is conditional on further monitoring and assessment of effectiveness and safety. • Detailed discussion about these aspects with the patient and/or carer and the benefit/ harms of alternatives and potentially sharing information with others is required.
Unregistered (unlicensed) medicine	
Informed patient consent is to be obtained (refer to the NSW Health *Consent to Medical and Healthcare Treatment Manual* (Consent Manual) for further details). Refer to the Therapeutic Goods Administration website (Information for Health practitioners) for specific requirements.	

3. REFERENCES

1. Council of Australian Therapeutic Advisory Groups. *Rethinking medicines decision-making in Australian Hospitals: Guiding Principles for the quality use of off-label medicines*, Darlinghurst, 2013.
2. Australian Commision on Safety and Quality in Healthcare, *Safety and quality improvement guide. Standard 4: Medication safety*, Sydney 2012.
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4. Therapeutic Goods Administration. Special access scheme. Australian Government, Department of Health 2020 (accessed 6 October 2020).
5. Gazarian M, Kelly M, McPhee JR, Graudins LV, Ward RL, Campbell TJ. *Off-label use of medicines: consensus recommendations for evaluating appropriateness*. Medical Journal of Australia. 2006;185:544-8.
6. Council of Australian Therapeutic Advisory Groups. *Achieving effective medicines governance: Guiding Principles for the roles and responsibilities of Drug and Therapeutics Committees in Australian public hospitals*, Darlinghurst, 2013.

4. APPENDICES

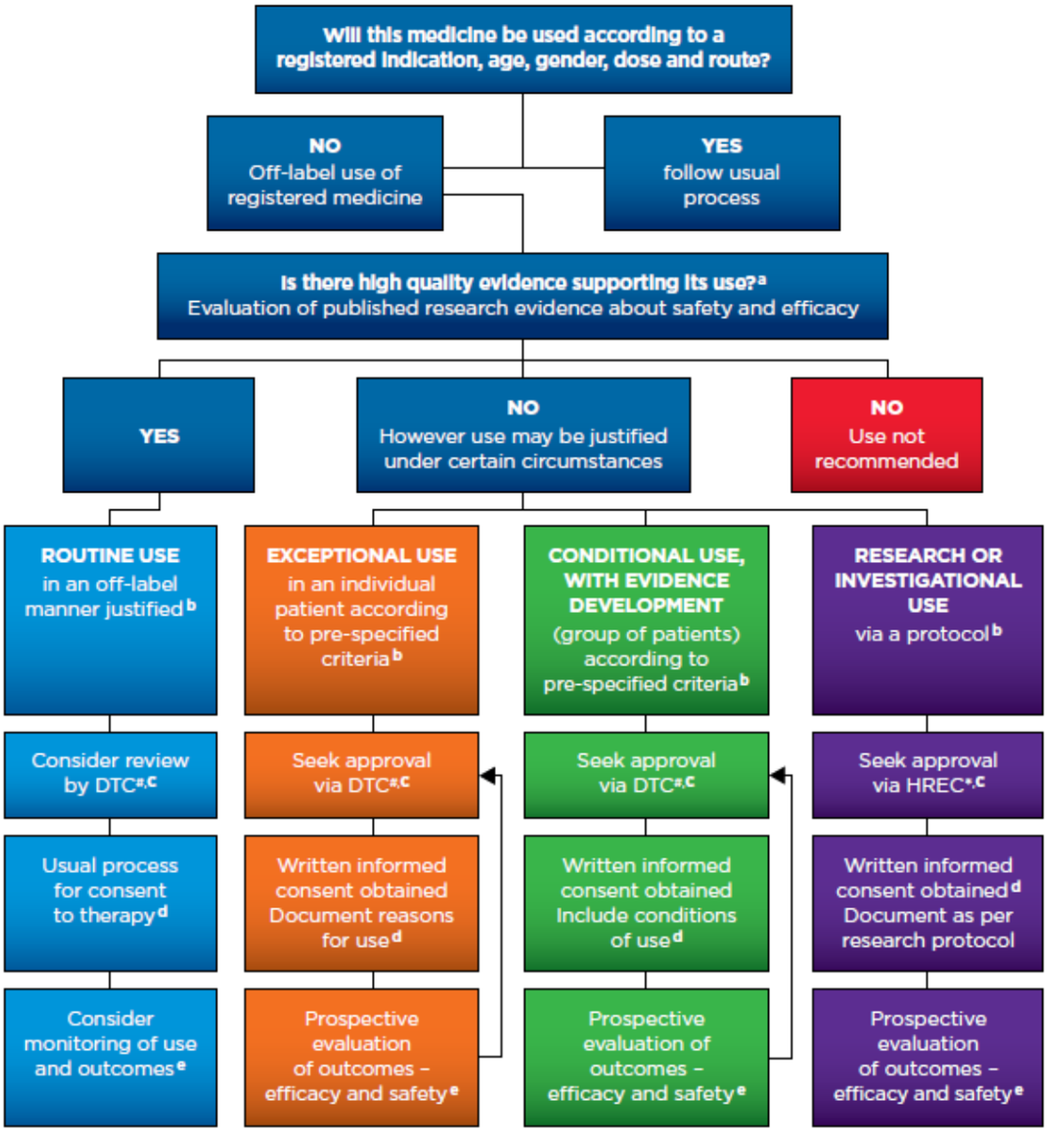
1. Assessing appropriateness of off-label medicine use
2. Submission processes for addition, amendment or removal of a medicine on the NSW Medicines Formulary

4.1 Assessing appropriateness of off-label medicine use

The figure below is adopted, with the permission of the Council of Australian Therapeutic Advisory Groups, Darlinghurst, from the document: *Rethinking medicines decision making in Australian Hospitals.Guiding principles for the quality use of off-label medicines*.

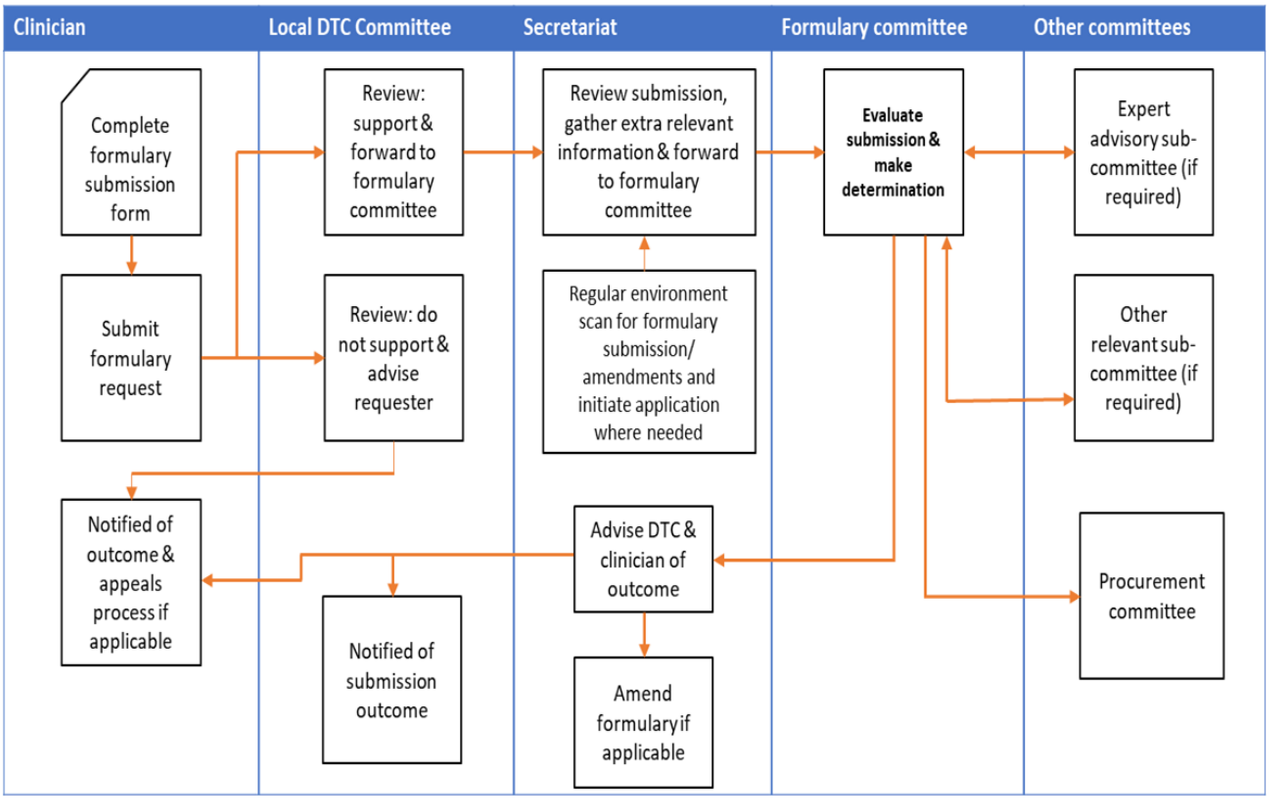
Figure 1 Assessing appropriateness of off-label medicine use and process for approval, consent and monitoring.

Note: This Policy does not cover the 'Research or Investigational Use' pathway



a See Guiding Principle 2 and Appendix 3 for detailed guidance in answering this question
b See Guiding Principle 2, point 5 for description of criteria for this category
c See Guiding Principle 4
d See Guiding Principle 3
e See Guiding Principle 6
Drug and Therapeutics Committee
* Human Research Ethics Committee

4.2 NSW Medicines Formulary submission processes



PREPARATION OF PHARMACEUTICAL AND ADVANCED THERAPEUTIC PRODUCTS (PD2023_021)

PD2023_021 replaced PD2015_007

POLICY STATEMENT

NSW Health facilities must have appropriate infrastructure, staff capabilities and processes in place relevant to the type of pharmaceutical and advanced therapeutic products being prepared to ensure the safe product preparation in the facility.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive includes the preparation, procurement, storage, transportation, waste disposal and guidance for outsourcing the preparation of pharmaceuticals, clinical trial investigational medicinal products (IMPs), genetically modified organism medicinal products, chimeric antigen receptor (CAR) T-cell products, antigen specific cell and bacteriophage products for human use.

The Chief Executive is responsible for the risk assessment of the current facilities and are to provide a plan to the NSW Ministry of Health's Chief Pharmacist Unit, of works and procedures necessary to meet the minimum facility standards for the compounding or preparation of pharmaceutical and advanced therapeutic products relevant to the scope of practice of the local health district, specialty health network or affiliated health organisation.

The Director of Pharmacy is responsible for the compounding or preparation of pharmaceutical and advanced therapeutic products, including investigational medicinal products (IMPs), at the pharmacy service in accordance with NSW Health Policy Directive Medication Handling (PD2022_032). Upon supply of the prepared product to the patient care area the nurse unit manager or delegate is responsible for the storage, handling and administration of the prepared product.

NSW Health facilities undertaking aseptic compounding or preparation of pharmaceuticals and advanced therapeutic products must be compliant with the infrastructure, personnel, documentation, processes, and quality control standards described in the Pharmaceutical Inspection Co-Operation Scheme (PIC/S) Guide to Good Practices for the Preparation of Medicinal Products in Healthcare Establishments (PE 010).

A pharmacist in a public hospital can compound a pharmaceutical product in anticipation of a medication order, under the Therapeutic Goods Regulation 1990 (Cth), when the pharmaceutical medicine is required urgently and a delay in treatment is detrimental to the outcome for the patient. Compounding in anticipation of an order must be approved by the Drug and Therapeutics Committee and for aseptically compounded or prepared products, sterility testing of each batch must be performed.

It is the responsibility of the Director of Pharmacy to ensure a risk assessment is completed prior to the compounding or preparation of each pharmaceutical or advanced therapeutic product by the pharmacy service, in accordance with the Pharmacy Board of Australia's Guidelines on Compounding of Medicines. The risk assessment must identify the containment requirements for all non-aseptically and aseptically prepared products according to the occupational exposure risk for staff handling hazardous products as per the National Institute for Occupational Safety and Health NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016.

The preparation in a pharmacy of non-aseptically compounded oral products must be undertaken within a high efficiency particulate air (HEPA) filtered powder containment cabinet or equivalent.

The preparation of non-aseptically compounded hazardous drugs must be undertaken in a negative pressure HEPA filtered powder containment cabinet in a negative or neutral pressure room.

The reconstitution of a hazardous drug oral suspension, as per the manufacturer's product information, must at a minimum be undertaken in a segregated area away from the main dispensary and the use of a negative pressure HEPA filtered powder containment cabinet or equivalent should be considered.

The application of an extended beyond use date (BUD) beyond 24-hours for aseptically prepared pharmaceutical products must be supported by a consistently high level of microbial quality control and assurance within PIC/S Guide to Good Practices for the Preparation of Medicinal Products in Healthcare Establishments (PE 010) acceptable colony forming unit limits for the duration of the BUD to be assigned. Under this Policy Directive a BUD must not exceed 7-days for aseptically prepared products.

The Director of Pharmacy is responsible for the approval of any NSW Health employee or contractor to enter a pharmacy clean room environment. They must be satisfied that any NSW Health employee entering the clean room have a thorough understanding of clean environments including; Good Manufacturing Practice (GMP), PIC/S Guide to Good Practices for the Preparation of Medicinal Products in Healthcare Establishments (PE 010), local standard operating procedures, occupational exposure, and microbiology. All external contractors entering the clean room environment must be supervised and accompanied by the senior production pharmacist or senior production pharmacy technician.

Continuous temperature logging is required for all stages of storage and transportation of prepared refrigerated or frozen pharmaceuticals and IMPs within the same public health facility and when transporting all prepared pharmaceutical and IMPs, including room temperature products, to another facility, including courier transportation.

To prepare doses of medium-risk occupational exposure therapeutic medicinal products, including monoclonal antibodies, in the patient care area, nurses and midwifes are required to have received additional training like local chemotherapy handling accreditation.

Where a pharmaceutical product is initiated in a public health facility that does not have the facilities to prepare onsite, this can be sourced from a third-party supplier. Non-aseptically prepared compounded products can be sourced from a community compounding pharmacy on prescription for an individual patient.

Aseptically prepared products intended to be sterile must only be sourced from a Therapeutic Goods Administration manufacturing licenced facility.

Clinical trial investigational products

A Drug and Therapeutics Committee (DTC) is responsible for the governance and approval of all clinical trials involving medicines and bacteriophage. The DTC is responsible for the oversight of clinical trials involving gene therapies according to the organisations accreditation under the Gene Technology Act 2000 (Cth) and for the oversight of CAR T-cell and antigen specific cell therapies.

Where the investigator at the principal trial site facility is the holder of the Clinical Trial Approval (CTA) or Clinical Trial Notification (CTN) and the approval applies to multiple satellite clinical trial sites, the pharmacy service at the principal trial site facility may prepare Schedule 2, 3 or 4 IMPs and unapproved IMPs, other than biologicals, for supply to the multiple NSW Health facilities within NSW stipulated in that approval.

The full version of the Preparation of pharmaceutical and advanced therapeutic products policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_021

MANAGEMENT OF OPIOID DEPENDENT PERSONS ADMITTED TO HOSPITALS IN NEW SOUTH WALES (PD2006_049)

PD2006_049 rescinds PD2005_049. It should be read in conjunction with PD2013_043 'Policy on the Handling of Medication in New South Wales Public Hospitals' and the New South Wales Opioid Treatment Program Guidelines.

This policy directive applies to the management of opioid dependent persons in public or private hospitals.

1 INTRODUCTION

From time to time, opioid dependent persons are admitted to hospitals for the treatment of acute or life threatening medical conditions or injuries or for the management of drug toxicity or withdrawal.

In such cases the prescribing of opioid drugs, including methadone or buprenorphine, may need to be considered. However, without prior proper investigation of the patient's history and physical condition, the immediate prescribing of an opioid drug may be contraindicated.

The policy addresses both the clinical and legal issues of prescribing drugs of dependence for opioid dependent persons and has been prepared to assist medical practitioners in dealing with this situation by outlining the procedures to be followed.

In short, the policy provides for the management of opioid dependent persons:

1. who are on an opioid treatment program and who have been admitted to a hospital for the treatment or assessment of:
   - ⇨ a medical condition and need to continue with their authorised methadone or buprenorphine dose, or
   - ⇨ a painful medical condition and need to continue with their authorised methadone or buprenorphine dose together with such opioid analgesics as are necessary to control pain. In such cases, there should be a clearly identifiable cause of pain or other strong clinical indication requiring analgesia.
2. who are **not** on an opioid treatment program and who have been admitted to a hospital for the treatment or assessment of a medical condition, and require opioid treatment where:
   - ⇨ controlling withdrawal symptoms with opioids is a necessary part of the management of a serious medical condition, and/or
   - ⇨ there is a clearly identifiable cause of pain or other strong clinical indication requiring analgesia.

This policy should be brought to the attention of all hospital staff involved in the management of inpatients who are opioid dependent persons. Additionally, each hospital should ensure that protocols or mechanisms exist for obtaining expert advice on a 24 hour basis on the clinical management of opioid dependent persons.

2 LEGAL RESTRICTIONS ON THE PRESCRIBING OF DRUGS OF ADDICTION TO DRUG DEPENDENT PERSONS

Under the provisions of Section 28 of the *Poisons and Therapeutic Goods Act 1966* the authority of the NSW Department of Health is required to prescribe for or supply to a drug dependent person[1] any drug of addiction (listed in Schedule 8 of the Poisons List[2)].

[1] A '**drug dependent person**' means a person who has acquired, as a result of repeated administration of a drug of addiction or a prohibited drug within the meaning of the *Drug Misuse and Trafficking Act 1985*, an overpowering desire for the continued administration of such a drug.

Therefore, a medical practitioner may not prescribe or supply any drug of addiction (listed in Schedule 8 of the Poisons List) for a person who, in the practitioner's opinion, is a drug dependent person[1] without the prior authority of the NSW Department of Health. The intent of this legislation is to prevent drug dependent persons from "shopping around" to obtain drugs and consequently receiving treatment from more than one medical practitioner concurrently.

In order to facilitate the management of persons admitted to hospitals in New South Wales, an exemption to the above requirement allows a medical practitioner to prescribe a drug of addiction, for up to 14 days, to a person who is an **inpatient** in a **public or private hospital**, without the need to obtain authority from the Department to do so, even when the patient is known or suspected to be a drug dependent person.

3 CLASSIFICATION OF THE OPIOID DEPENDENT PERSON

Opioid dependent persons fall into the following distinct categories:

1. On NSW Opioid Treatment Program (methadone or buprenorphine), *and*
   - 1.1. Not requiring additional opioids for analgesia, *or*
   - 1.2. Requiring opioid analgesia
2. Not on NSW Opioid Treatment Program and
   - 2.1. Requiring opioids to manage withdrawal, *and/or*
   - 2.2. Requiring opioids to manage pain

4 TREATMENT OF AN IN-PATIENT CURRENTLY ON AN OPIOID TREATMENT PROGRAM

These are persons for whom a medical practitioner holds an authority to prescribe methadone or buprenorphine for the treatment of opioid dependence under the NSW Opioid Treatment Program.

After verifying the patient's identity, contact **must** be made with both the authorised prescriber and the opioid treatment dosing point, i.e. the place where the patient attends for dosing, to confirm the current actual dose and the date & time of the last dose, including any take-away doses given. It is important to establish these facts as administration of a dose of an opioid drug may lead to overdose if the patient has received a dose recently or the wrong dose is given.

If there is any difficulty in obtaining details of the authorised prescriber from the patient, Pharmaceutical Services Branch may be contacted during office hours on (02) 9391 9944 for assistance.

(a) Not requiring additional opioids for analgesia

Provided that there is **no medical contraindication** to the administration of an opioid, methadone or buprenorphine should be continued in hospital. It must be prescribed by the patient's hospital medical practitioner in accordance with the dosage regimen prescribed by the patient's authorised methadone or buprenorphine prescriber.

Methadone, in oral liquid form, is administered as a once daily dose. Buprenorphine is a sublingual tablet and may be administered as a daily, second daily or third daily dose. The patient's authorised prescriber should be advised of the approximate length of stay in hospital in order to prevent the patient being exited from the program through 'non-attendance'.

[2] A list of commonly used substances and preparations classified as drugs of addiction (Schedule 8 of the New South Wales Poisons List) - TG 13 is available at http://www.health.nsw.gov.au/pubs/2000/pdf/poisons_gensellers.pdf or from Pharmaceutical Services Branch. Contact the Duty Pharmacist on (02) 9391 9944

When the patient is discharged, the authorised prescriber and the opioid treatment dosing point must be informed in advance of the discharge to ensure that appropriate arrangements are in place for the patient's continuation on the program.

Note: Patients on methadone or buprenorphine are unlikely to exhibit withdrawal symptoms until at least 24 hours after the last dose was administered. In the event that withdrawal symptoms occur and neither the authorised prescriber nor the opioid treatment dosing point can be contacted (e.g., after-hours), the objective signs of withdrawal should be managed, **until such time as contact can be made with the prescriber or opioid treatment dosing point**, as follows:

Methadone - the patient should be administered 30mg methadone orally. If required, further doses of 5mg may be given, titrated against observable signs of withdrawal, up to a maximum daily dose of 40mg.

Buprenorphine - the patient should be administered 4 mg of buprenorphine sublingually with further doses of 2mg, titrated against observable signs of withdrawal. (Note: the maximum dose of buprenorphine on any day should not exceed 32mg.)

(b) Requiring opioid analgesia

Administration of opioid analgesia to persons on a methadone or buprenorphine program must be carried out in consultation with a local Drug and Alcohol specialist. Where contact cannot be made with a Drug and Alcohol specialist, advice on clinical management can be obtained (24 hours a day) from the NSW Drug and Alcohol Specialist Advisory Service, on 9361 8006 (Sydney Metro) or 1800 023 687 (Outside Sydney)

(i) Patient is on a methadone program
Methadone should be administered as in (a) above and additional opioids may be prescribed to relieve pain. If analgesia is not achieved with normal dosage regimens, consultation **must** be undertaken with the patient's authorised methadone prescriber or a local Drug and Alcohol specialist.

(ii) Patient is on a buprenorphine program
Patients maintained on buprenorphine will have a diminished response to opioids prescribed for analgesia, i.e. patients on buprenorphine who suffer severe acute or chronic pain will require higher doses of opioid analgesia than individuals not on buprenorphine treatment. This is because of the 'blocking' effect of the buprenorphine on full opioid agonists.

Generally, if acute or sub-acute analgesia is required, a temporary increase in the buprenorphine dose may provide the additional analgesic cover. Where additional opioid analgesia is required, non-opioid analgesic options should be considered and either used alone or in concert with additional opioid analgesia (e.g. morphine), the dose of which should be titrated according to clinical response.

Patients who develop chronic pain, which does not respond to buprenorphine, may require transfer to methadone. Drug and Alcohol specialist advice on a safe transfer between treatments should be sought if this course is contemplated. The dose of analgesic should be closely monitored if buprenorphine is reduced or stopped. This is because there is the potential for over-sedation, or even overdose, from a high opioid dose as the buprenorphine levels reduce (with a corresponding reduction in the 'blocking' effects of buprenorphine). Where the buprenorphine treatment is stopped completely, the dose of opioid will need to be closely monitored every day for at least 4 - 5 days after the last buprenorphine dose and will probably have to be reduced over time, to avoid an overdose. If in doubt, Drug and Alcohol specialist advice should be sought to ensure safe and effective treatment of pain.

When the patient is discharged, the authorised prescriber and the opioid treatment dosing point must be informed, in advance of the discharge, of the dose and the date of last dose in hospital to ensure that appropriate arrangements are in place for the patient's continuation on the buprenorphine or methadone program.

If there is a need to continue opioid analgesia, the patient's authorised buprenorphine or methadone prescriber should be advised in addition to their general or treating practitioner.

5 TREATMENT OF AN IN-PATIENT DRUG DEPENDENT PERSON NOT CURRENTLY ON AN OPIOID TREATMENT PROGRAM

(a) Where Opioid Analgesia IS NOT Required But Symptoms Of Withdrawal Are Evident. Wherever possible, withdrawal symptoms should be symptomatically treated with non-opioids only.

However, opioids (i.e. methadone in oral liquid form, or buprenorphine sublingual tablets) may be used to treat withdrawal symptoms where:

(i) withdrawal symptoms could reasonably be expected to interfere with the optimum medical management of the patient, or

(ii) the patient is suffering from a serious or life-threatening illness and the patient's premature self-discharge before completion of therapy would prejudice optimum management.

Where methadone is prescribed for the treatment of withdrawal to a person not on an opioid treatment program, 10mg to 20mg per day, in oral liquid form, should be administered in divided doses. The dose may be gradually increased, by 5mg increments titrated against objective signs of withdrawal, to a maximum daily dose of 40mg. The dose may be combined into a single daily dose when stabilized. Doses should not be increased above 40mg daily unless consultation has taken place with a specialist in the management of drug dependence. Patients should be advised that this treatment does not constitute entry to the methadone program. Entry to this program **must** be through approved prescribers.

An alternative strategy is to use buprenorphine sublingually in a dose of 2mg every two to four hours if required to control withdrawal symptoms on day 1. On day 2, the total dose for day 1 should be given as a single dose, and then reduced by 2mg per day thereafter. This is a simpler form of withdrawal management and withdrawal is achieved more rapidly than with methadone. A Drug and Alcohol specialist should be consulted to facilitate this schedule. Patients should be advised that this treatment does not constitute entry to the buprenorphine program. Entry to this program **must** be through approved prescribers.

All patients given methadone or buprenorphine to allay symptoms of withdrawal from opioids should be slowly withdrawn from methadone or buprenorphine prior to discharge from hospital wherever possible. Where it is not possible to complete the withdrawal in hospital or where it is considered appropriate to extend the use of methadone or buprenorphine after discharge, arrangements for continuation should be made following consultation with an approved prescriber. This should be done well in advance of the patient's discharge.

(b) Where Opioid Analgesia IS Required

Tolerance to drugs may necessitate higher doses and/or greater frequency of administration in some cases to achieve satisfactory analgesia compared to an opioid naive patient with a similar condition.

Therefore, for acute problems with a clear diagnosis (e.g. trauma), opioid analgesia, within normal dosage regimens, should be provided in the first instance; above normal dosage or unduly prolonged prescribing should take place only after consultation with a specialist in the management of drug dependence. If contact cannot be made, advice on clinical management can be obtained (24 hours a day) from the NSW Drug and Alcohol Specialist Advisory Service, on 9361 8006 (Sydney Metro) or 1800 023 687 (Outside Sydney).

- **FURTHER INFORMATION**

Advice regarding the nearest approved methadone or buprenorphine prescriber can be obtained from the Pharmaceutical Services Branch of the NSW Department of Health (phone (02) 9391 9944).

General information may be obtained from the Duty Pharmaceutical Adviser, Phone (02) 9391 9944 or at the Branch website - http://www.health.nsw.gov.au/publichealth/pharmaceutical/

ACCESS TO DOSING SERVICES IN PUBLIC HOSPITALS FOR PATIENTS ON OPIOID TREATMENTS (PD2021_011)

PD2021_011 rescinds PD2006_052

POLICY STATEMENT

All NSW Health public hospitals and multipurpose services must ensure availability of supervised administration of opioid agonist treatment for patients on the NSW Opioid Treatment Program, where there are no other dosing services available and accessible.

SUMMARY OF POLICY REQUIREMENTS

All staff in NSW Health care settings are to ensure people on opioid agonist treatment experience person-centred, safe and high-quality intervention and care.

Public hospitals and multipurpose services must:

- Support supervised administration of opioid agonist treatment and develop procedures to communicate with local Alcohol and Other Drug (AOD) services to facilitate case management and support.
- Comply with safe practice and environment standards as per routine hospital accreditation.
- Ensure the appropriate procurement, storage, supplying, dispensing, administration and disposal of opioid agonist medications in line with the *Poisons and Therapeutic Goods Act* (1966); any current relevant regulations; and the NSW Health Policy *Medication Handling in NSW Public Health Facilities* (PD2013_043).
- Factor the requirements of this policy requirement into disaster planning and business continuity management.
- Ensure physical, electronic and procedural safety for patients and staff.
- Provide support and education for staff as appropriate, informed by the Local Health District AOD services.

Public hospitals and multipurpose services are also encouraged to consult with the Local Health District AOD services for clinical and strategic advice in developing and maintaining opioid treatment services. The Drug & Alcohol Specialist Advisory Service (DASAS) is also available for clinical advice.

Local Health District AOD services must:

- Develop procedures to communicate with public hospitals and multipurpose services to facilitate case management and support for patients receiving opioid treatment.

- Provide support and guidance as needed to public hospitals and multipurpose services dosing patients on opioid treatment.

For further information regarding the NSW Opioid Treatment Program, please see the following guidelines:

- *NSW Clinical Guidelines: Treatment of Opioid Dependence* (GL2018_019)
- Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence

INFORMATION SHARING - NSW HEALTH & DoCS - OPIOID TREATMENT - RESPONSIBILITY - CHILDREN UNDER 16 (PD2006_085)

1. PREAMBLE

1.1 In February 2006, Cabinet endorsed the development of a protocol between the NSW Departments of Health and the NSW Department of Community Services (DoCS) to facilitate exchange of information between these agencies where methadone is being made available to DoCS clients.

1.2 This protocol facilitates inter-agency exchange of information to assist DoCS casework staff to assess whether a child or children under 16 years of age is/are at a risk of harm due to a person's misuse of opioids while participating in an opioid treatment program. It complements and has been developed in the context of a number of key policies including the *NSW Drug and Alcohol Services Plan, the NSW Interagency Guidelines for Child Protection Interventions 2006* and the *Interagency Guidelines for the early intervention, response and management of drug and alcohol misuse*.

1.3 Participation in an opioid treatment program is considered a positive treatment option for individuals struggling with ongoing illicit opioid use. The focus of this protocol is information sharing to facilitate determination of whether, in specific cases, misuse of drugs supplied on the treatment program, and/or other circumstances in the household, combine to create inadvertent or deliberate risk of harm to children.

1.4 Accidental ingestion of takeaway doses of methadone by children or deliberate dosing of children by adults can be fatal. Takeaway doses of buprenorphine also present potential risk of harm to children. These risks are not confined to young children. The nature of the risk varies according to the age of the child. While accidental ingestion or deliberate dosing of methadone is a high risk for young children (under the age of six), risk of self-administration and experimentation increase with age and are most likely in adolescence.

1.5 Opioid treatment therapies involving methadone and buprenorphine are a medically accepted way of treating heroin addiction. Over thirty years of clinical experience and research has established that methadone is highly effective at retaining people in treatment, suppressing heroin use and associated crime, and reducing the risk of overdose and HIV. Research also confirms that buprenorphine treatment is effective in achieving these objectives. The most appropriate opioid treatment medication for a client is a clinical decision made by the prescribing practitioner and will reflect a wide range of factors related to the history of the client's drug use and treatment and other medical conditions. The effective treatment of opioid dependence is a long-term issue. Any reduction in dose or withdrawal from treatment must be monitored by the prescriber and conducted gradually.

1.6 Buprenorphine is increasingly used as an alternative to methadone in opioid treatment programs. The pharmacological characteristics of buprenorphine differ from methadone. The different characteristics of buprenorphine allow it to be consumed sublingually (under the tongue) in tablet form. As it can take between 2 and 7 minutes for the drug to be absorbed, it is thought to be unlikely that a child would be able to save the tablet in their mouth for long enough to absorb it. In contrast to methadone there have been no reported deaths of children from an overdose of buprenorphine in Australia and it is considered by the medical community to be a safer drug than methadone. However, there is insufficient evidence to provide assurance that buprenorphine is safe if ingested by children. When a client on buprenorphine is to be given takeaways, a combination formula is used, buprenorphine-naloxone. The combined product is designed to reduce the likelihood of clients injecting or diverting takeaway medication.

1.7 The NSW Department of Health authorises health practitioners to prescribe opioid treatment to persons registered on an opioid treatment program. Prescribers can be either public (career medical officers, registrars, drug and alcohol staff specialists, drug and alcohol nurse practitioners, visiting medical officers) or private (general practitioners, drug and alcohol nurse practitioners, psychiatrists).

1.8 In New South Wales approximately 60% of clients on opioid treatment receive their prescriptions from a private prescriber. The dispensing of the medication is most commonly provided through public or private outpatient clinics, community pharmacies and local hospitals (particularly in rural areas).

1.9 Prescribers are issued with NSW Health clinical guidelines relating to their role in methadone and buprenorphine treatment. The NSW Clinical Guidelines for the Treatment of Opioid Dependence recently revised by the NSW Department of Health include an updated chapter on takeaways that was revised in consultation with DoCS. These Guidelines specify the contraindications to providing methadone and buprenorphine takeaway doses, including current child welfare issues or DoCS involvement of children under 16 in a household.

2. RELEVANT LEGISLATION AND DOCUMENTS

2.1 The client information disclosed to DoCS under this protocol relates to the safety, welfare and wellbeing of a child or children and is provided in accordance with the *Children and Young Persons (Care and Protection) Act 1998*. The *NSW Health Privacy Manual, Version 2* identifies health information disclosed in this manner as exempt from privacy provisions of the *Health Records and Information Privacy Act 2002*.

2.2 The sections of the *Children and Young Persons (Care and Protection) Act 1998* that are relevant to this protocol are outlined below.

- Section 24 of the *Children and Young Persons (Care and Protection) Act1998* provides for a person to report to DoCS where he or she has reasonable grounds to suspect a child is at risk of harm. Reports made under this section in good faith are protected, and cannot generally be used against the reporter in litigation or formal disciplinary action.
- Section 27 of the *Children and Young Persons (Care and Protection) Act 1998* imposes a mandatory obligation on health service providers (including medical practitioners) to notify DoCS if in the course of their work, they form reasonable grounds to suspect a child is at risk of harm.
- Section 248 of the *Children and Young Persons (Care and Protection) Act 1998*. This section allows DoCS to require a "prescribed body" to provide DoCS with information relating to the safety, welfare and wellbeing of a particular child or young person or a class of children or young persons. Public health organisations under the *Health Services Act* (such as area health services) and organisations that provide health services to children are prescribed bodies.

2.3 Health Privacy Principle 11 of the *Health Records and Information Privacy Act 2002* provides personal health information can only be disclosed for the purposes for which it was collected, or other purposes recognised by the Act. These include release with consent, release where there is a serious risk of harm to a person and release authorised by a law (such as the *Children and Young Persons (Care and Protection) Act 1998).*

2.4 Under Section 28A of the *Poisons and Therapeutic Goods Act 1966* practitioners must apply to the Director-General to be approved as a prescriber of methadone and buprenorphine for the purpose of treating opioid dependent individuals in the state of New South Wales. Approvals are subject to several conditions one of the conditions being to follow conditions specified in the *NSW Clinical Guidelines for Methadone and Buprenorphine Treatment of Opioid Treatment (2006)*.

2.5 Reporting requirements for prescribers employed in Area Health Services are also covered in NSW Health documents, Policy Directive PD2013_007 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

3. OBJECTIVE

3.1 This protocol facilitates the sharing of information between the NSW Department of Health's Pharmaceutical Services Branch (PSB), opioid treatment prescribers and DoCS child protection casework staff concerning persons who are registered to receive opioid treatment (methadone or buprenorphine).

3.2 Information shared under this protocol is intended to assist DoCS to assess the risk of harm to children that arises due to their potential exposure to methadone or buprenorphine that is dispensed to registered opioid treatment clients so that the appropriate child protection responses may be initiated, where necessary.

3.3 The NSW Department of Health and DoCS have key roles in ensuring that DoCS child protection casework staff are adequately informed about the benefits and risks of standard treatments for opioid dependence and are able to obtain accurate information from prescribers to assist with assessment of risk of harm to children where concerns are reported in relation to opioid dependent persons.

4. TARGET CLIENT GROUP

4.1 Children under 16 years of age [as defined in the *Children and Young Person (Care and Protection) Act 1998*] who are at a risk of harm due to their relationship with a person undergoing opioid treatment.

4.2 The two categories of children are covered under this agreement are:

a. Children subject to current DoCS involvement where there is an open case plan; and
b. Children, whether known to DoCS or not, who become known to a prescriber through the prescriber's contact with a client in opioid treatment.

5. GENERAL ROLES AND RESPONSIBILITIES

5.1 The requirements to be discharged by public prescribers in sharing child protection information with DoCS in accordance with this protocol are based on the general obligations on NSW Health staff:

a. To make a report to the DoCS Helpline where he or she has reasonable grounds to suspect a child or young person is at risk of harm in accordance with sections 24 and 27 of the *Children and Young Persons (Care and Protection) Act 1998,* and

b. To provide DoCS with information relating to the safety, welfare or wellbeing of a child or young person when directed to do so by DoCS under section 248 of the *Children and Young Persons (Care and Protection) Act 1998.*

5.2 For private prescribers the obligations on reporting to DoCS are based on:

a. Conditions imposed on their authority to prescribe under the *Poisons and Therapeutic Goods Act 1966* and associated regulations that require prescribers to comply with the *NSW Clinical Guidelines for Methadone and Buprenorphine Treatment of Opioid Treatment (2006),* including to provide to DoCS casework staff information relevant to possible risk of harm to children as required under this protocol; and/or

b. The general requirement on private prescribers who work in an incorporated practice that provides services wholly or partly to children to comply with sections 27 and 248 of the *Children and Young Persons (Care and Protection) Act 1998*

5.3 NSW Health will review any unreasonable non-compliance by private sector prescribers to the reporting requirements in this protocol. This may result in a prescriber's authorisation to prescribe methadone and buprenorphine being revoked.

5.4 DoCS is responsible for assessing risk of harm to children covered by this protocol.

6. ROLES AND RESPONSIBILITIES RELATED TO CHILDREN SUBJECT TO CURRENT DOCS INVOLVEMENT

6.1 Where DoCS has an open case plan suggesting a parent or carer's misuse of an opioid or opioid treatment, including takeaway methadone or buprenorphine, DoCS will request information from PSB under section 248 of the *Children and Young Persons (Care and Protection) Act 1998* to establish current or recent participation in the opioid treatment program on the basis that in these circumstances the information is relevant to the safety, welfare and wellbeing of the child or young person.

6.2 In accordance with section 248, PSB will provide information to DoCS on whether the subject of the query is registered on the opioid treatment program or was registered for opioid treatment 30 days prior to the date of the request.

6.3 PSB will also provide DoCS with contact details of the current prescriber or most recent prescriber for those who are not on the program but were on the program in the 30 days prior to the request.

6.4 Following receipt of information that the subject of the request *is not* on the program and has not been on the program in the 30 days prior to the request, DoCS casework staff will pursue enquiries about opioid and/or other drugs through relevant section 248 enquiries of Area Health Services.

6.5 Many adult clients will have had treatment provided by the Area Health Services, not only in relation to opioids, but also for treatments relating to other drug or alcohol problems. The PSB database only holds information relating to schedule 8 drugs.

6.6 Following receipt of information that the subject of the request *is* on the program *or has been* on the program in the 30 days prior to the request, DoCS will contact the prescriber to request further information. This information request will focus on establishing whether there may be risk of harm concerns for a child or children as a result of the person's opioid treatment, particularly where takeaway doses are involved. Specifically, DoCS will request the following information:

- The prescriber's knowledge about the client's compliance with treatment;
- Whether the prescriber has sighted or examined a client's child/children in the preceding three months, the reasons for the examination and any associated concerns for the child/children's health and safety;
- Any recent observations that may indicate that the client's parenting is compromised;
- Any current concerns the prescriber has for the health and safety of a child/children based on knowledge of the client, the client's compliance with their treatment regime and/or any other issues that may impact on the safety of the child/children.

6.7 Questions for DoCS casework staff to ask of the prescriber during their initial query are at Attachment A. This is to alert prescribers to the information that will be pertinent to caseworker inquiries about their clients.

6.8 Following contact by DoCS, the prescriber will conduct an assessment of the most recent treatment review and determine whether another review is necessary (as per the *NSW Clinical Guidelines for the Treatment of Opioid Dependence 2006*).

6.9 In reviewing the appropriateness of takeaway doses the prescriber should always include dialogue with the dispenser (in most cases, a pharmacist). The dispenser may occasionally observe children, who attend dosing with the client and may be able to provide additional information as to the stability of the client. The outcome of any review, including dialogue with the dispenser should be documented.

7. ROLES AND RESPONSIBILITIES RELATING TO CHILDREN NOT SUBJECT TO DoCS INVOLVEMENT

7.1 The prescriber will conduct a normal review of the person's treatment regime (as per the *NSW Clinical Guidelines for the Treatment of Opioid Dependence 2006*), including dialogue with the dispenser (in most cases, pharmacist).

7.2 A prescriber who has a reasonable concern (based on their regular review of the person's current social circumstances) that a child/children under 16 years of age is/are at a risk of harm due to an adult's misuse of opioids.

a. Make a report to the DoCS Helpline
b. Identify him or herself as a prescriber, and
c. Provide to DoCS all relevant information that will assist DoCS to make an assessment of the risk of harm for the subject child or children. Provide to the DoCS caseworker all information about the person that may impact on a child's safety, welfare and well-being, based on their knowledge of the client and their compliance or non-compliance with their treatment regime.

7.3 DoCS will review any report received from a prescriber in accordance with existing practices.

7.4 A prescriber contacted by DoCS in response to a report will provide the caseworker with any additional information they have that is relevant in assisting the caseworker to complete an assessment of any child at risk concerns.

8. MONITORING, REPORTING AND EVALUATION

8.1 DoCS and the NSW Department of Health will monitor the operation of the protocol.

8.2 The protocol is to be formally reviewed and evaluated by DoCS in conjunction with the Department of Health no later than two years after the date of commencement. The results of this review will be reported to the respective Directors-General within 3 months of the completion of the review. A particular focus of this review will be the effectiveness of the protocol in responding to the issues identified by the Cabinet decision that authorised its development.

GLOSSARY

Mandatory Reporter

A person who as part of their professional or paid work or as the supervisor/manager of a person who as part of their professional or paid work, delivers health care, welfare, education, children's services, residential services or law enforcement to children or young persons.

Mandatory reporters are required under Chapter 3, Part 2, section 27 of the Act to make a report to DoCS if they suspect that a child is at risk of harm as detailed in Chapter 3, Part 2, section 23 of the Act.

Any prescriber who is not a mandatory reporter within the scope of the Act is required by directive of the Health Minister to report risk of harm under the terms of this protocol.

Mandatory Report

A report made to DoCS, usually via the Helpline to convey a concern about a child or young person who may be at risk of harm. The circumstances of risk of harm are outlined in Chapter 3, Part 2, sections 23, 24, 25 and 27, Chapter 7, Part 2, sections 120, 121 and 122 of the Act.

Risk of harm

Risk of harm is present if there are current concerns that a child or young person may suffer physical, sexual, psychological and/or emotional harm as a result of what is being done or not done by another person, often an adult responsible for their care. Risk of harm is defined in Chapter 3, Part 2, and section 23 of the Act.

Open case plan

A report on a child or young person has been allocated to a DoCS' caseworker for further assessment

PSB Database

An electronic database primarily used to issue authorities to medical practitioners to prescribe drugs of addiction (schedule 8) as required under section 29 of the *Poisons and Therapeutic Goods Act 1966*. This includes authorities to prescribe methadone or buprenorphine under the NSW Opioid Treatment Program, narcotic analgesic for the treatment of chronic pain, stimulants for the treatment of ADHD, etc.

Diversion/diverted dose

The misuse of a prescribed drug, most commonly for selling or injecting

Takeaway dose

A dose of methadone or buprenorphine to be taken in an unsupervised setting, usually at home. Takeaway doses are only provided after careful assessment of the client's stability.

Attachment A
Typical questions for DoCS Caseworkers to Ask Prescribers

Factors that may impact on parenting and/or risk of harm	Prescriber Comment Any risk of harm concerns identified
Is the client prescribed takeaway doses? Which treatment is prescribed - methadone or buprenorphine? How long has the client been on takeaway doses? When was the last review? Did the review consider impacts on any children the person may be caring for? Did the review identify any issues of concern?	
Are there any current issues with the client's compliance with treatment? If yes, please describe these issues. Is the client prescribed any other medication? If so, what?	
In the last 3 months, have you sighted or examined the child or siblings of the child about whom DoCS has a report?	
Are there any observations you have made in the last three months, which may indicate that parenting is compromised, eg. occasions when the child/ren looked ill, neglected, stressed or was/were otherwise behaviourally demanding? How did the client interact with the child/ren? Was the client aware of the child's needs?	
What is the client's behaviour like at prescriber practice/dosing site (i.e. no aggressive/ threatening behaviour towards staff/others reported)	
Has the client indicated whether there are any significant life events impacting upon them at this time (eg. relationship breakdown, pregnancy, grief or loss, legal issues, lack of housing)	
Does the client present with any other mental/ physical health needs?	
Do you have any information about the client's current: Employment/education or training Accommodation status	

RAPID OPIOID DETOXIFICATION - GUIDELINES (GL2011_009)

GL2011_009 rescinds GL2005_027.

PURPOSE

The purpose of *NSW Health Guidelines on Rapid Opioid Detoxification* is to provide information on a procedure which may be conducted in private health facilities, licensed for Rapid Opioid Detoxification (ROD) as per the *Private Health Facilities Regulation 2010* under the *Private Health Facilities Act 2007*. In accord with the regulation, Rapid Opioid Detoxification Class private health facilities must comply with the *Drug and Alcohol Withdrawal Clinical Practice Guidelines - NSW*.

KEY PRINCIPLES

ROD is not currently conducted NSW's public sector nor is it likely to be in the foreseeable future unless in the context of a clinical trial, thus the key principles of these guidelines are to ensure patients undertaking ROD procedures in a private health facility licensed for the purpose of ROD:

1. have been well informed of the treatment they are undertaking including potential risks and alternative treatment options;
2. have been advised verbally and in writing that rapid opioid treatment and naltrexone implants are still experimental treatments;
3. are advised verbally and in writing that naltrexone implants used in Australia have not been approved by the relevant regulatory authorities;
4. can competently provide signed, informed, consent to treatment;
5. have been satisfactorily assessed as appropriate for the treatment; and
6. are adequately monitored and supported during and post treatment.

The guidelines align with the *Private Health Facilities Regulation 2010* under the *Private Health Facilities Act 2007* which provides the recommended standards for the settings in which ROD is undertaken ensuring they are appropriately and adequately equipped. Refer section 4.1.7.

Further, the guidelines provide Public Hospital Emergency Departments and the like with appropriate recommendations on how to best manage patients who present post ROD treatment with complications and/or those who present in medical settings who are in continued treatment with naltrexone (including those with naltrexone implants).

USE OF THE GUIDELINE

As per the *Private Health Facilities Regulation 2010* (amended) under the *Private Health Facilities Act 2007,* compliance with the *NSW Health Guidelines on Rapid Opioid Detoxification* is a condition of a private health facility license for the purpose of ROD.

In addition these guidelines provide recommendations for clinical staff in medical settings such as Public Hospital Emergency Departments and the like for the management of patients who may present post ROD procedures with complications and/or patients presenting who are in continued naltrexone treatment (including naltrexone implants).

The Guidelines can be downloaded at
http://www.health.nsw.gov.au/policies/gl/2011/GL2011_009.html

FUNDING ARRANGEMENTS FOR OUTPATIENT USE OF HIGH COST DRUGS NOT FUNDED BY THE COMMONWEALTH (PD2005_395)

A number of high cost drugs prescribed in NSW for outpatient usage are not funded through the Pharmaceutical Benefits Scheme, Repatriation Pharmaceutical Benefits Scheme, or Section 100 of the *National Health Act* and may be subject to the provisions of this Circular. The responsibility for defining the high cost drugs that are subject to these funding arrangements is delegated by NSW Health to the NSW Therapeutic Advisory Group (NSW TAG), in consultation with Directors of Pharmacy and Drug Committees of tertiary units.

The NSW TAG defines High Cost Drugs for the purposes of these arrangements as medicines which:

1. are not listed for subsidy on the Schedule of Pharmaceutical Benefits under either Section 85 or Section 100 of the *National Health Act*, and
2. incur acquisition costs equivalent to or more than $500 per week per drug per patient (subject to annual review by NSW TAG), and
3. require particular expertise for management of patient care.

And which:

4. are being used in accordance with the Approved Product Information, **or**
5. are being used in a manner that is supported by high quality clinical evidence

Therapy with high cost drugs not funded by the Commonwealth should only be initiated in tertiary units (principal or major referral hospitals) with the approval of the hospital Drug Committee. Where the patient being treated at the tertiary unit resides in another Area, the initiating Area Health Service should inform the Area Health Service (or the appropriate hospital Drug Committee with delegated authority) in which the patient resides. This enables queries or clarifications regarding the clinical indications for the drug to be discussed and resolved between the Areas prior to the transfer of costs.

The Area Health Service of the unit initiating therapy is responsible for financing the cost of the drugs for twelve months from the date of discharge from the episode during which the therapy was commenced, or for twelve months from the date of commencement if therapy was initiated on a non-inpatient basis. After twelve months the responsibility for financing passes to the Area of residence of the patient. Notification and billing should occur at an Area level between CEOs.

To avoid duplication of supplies, the Area initiating treatment should give the Area of residence details of the therapy including the patient's initials, address, date of birth, date of commencement, quantity and cost of the drug at least three months prior to the transfer of funding responsibility. Notification of intention to bill should be made by way of a standard notification form developed by NSW TAG (available on the NSW TAG web site: http://www.nswtag.org.au).

These arrangements should not be used to cover:

1. Drugs that are being used in the context of a formal research protocol;
2. Drugs that are being used in "exceptional" circumstances (as described in *NSW Health Department IB2004/15: Off-Label Use of Medicines and Use of Medicines Obtained under the Commonwealth Personal Importation Scheme in NSW Public Hospitals)*;
3. Drugs that are being used under the Special Access Scheme.

In such circumstances, the patient should continue to attend the hospital where the research or exceptional use was approved, unless new approvals are obtained via the local hospital and/or service provider. Financing of such therapy remains the responsibility of the hospital that has facilitated approval for such use.

For the purpose of this circular, outreach clinics are considered part of their original tertiary unit. However, the responsibility for supply and funding of drug therapy prescribed as a result of outreach clinic consultations is the responsibility of the Area Health Service in which the outreach clinic is located, unless such drug therapy has been specifically identified under the outreach service agreement.

These arrangements do not apply to financing outpatient chemotherapy cycles.
NSW TAG may be contacted at **nswtag@stvincents.com.au**.

83(11/03/10)

NSW CLINICAL GUIDELINES: TREATMENT OF OPIOID DEPENDENCE

(GL2018_019 and abbreviated version GL2018_018)
GL2018_019 rescinds GL2006_019

The Guidelines provide clinical guidance and policy direction for opioid agonist treatment in NSW. They align with national directions and recommendations, and incorporate the latest international clinical evidence.

This Guideline can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_019

An abbreviated version of the Guideline is availabed at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_018

308(30/07/18)

ACCREDITATION OF COMMUNITY PRESCRIBERS – S100 HIGHLY SPECIALISED DRUGS FOR HIV AND HEPATITIS B (PD2019_005)

PD2019_005 rescinds PD2013_055

PURPOSE
The purpose of this Policy Directive is to detail the NSW Health requirements for the accreditation and authorisation of non-affiliated medical practitioners or nurse practitioners to prescribe Highly Specialised Drugs (HSD) under section 100 (s100) of the Commonwealth *National Health Act 1953* for the treatment of Hepatitis B (HBV) and Human Immunodeficiency Virus (HIV). S100 HSD are medicines for the treatment of conditions, which, because of their clinical use or other features, may generally only be prescribed by specialist medical practitioners affiliated with public or private hospitals with appropriate specialist facilities. As it is important that people living with HBV and HIV have access to high quality health care in primary care settings, the s100 HSD Program also provides for non-affiliated medical practitioners and nurse practitioners to be accredited to prescribe s100 HSD used in the treatment of HBV and HIV. With the introduction of new direct acting antiviral (DAA) treatments for Hepatitis C, it is now out of scope for inclusion as an s100 Highly Specialised Drug requiring accreditation and authorisation of community prescribers. In March 2016 the new DAAs for Hepatitis C were listed on the Pharmaceutical Benefits Scheme. The DAAs are now available on both the General Schedule (S85) and under the HSD Program (S100). Medical practitioners or nurse practitioners experienced in treating Hepatitis C, or in consultation with a specialist experienced in treating Hepatitis C, can now prescribe DAAs under General Schedule (S85) and prescriptions can be dispensed through community pharmacies.

308(31/01/19)

MANDATORY REQUIREMENTS

A non-affiliated medical practitioner or nurse practitioner may only prescribe HSDs for HBV and HIV if they are authorised as a community prescriber as outlined in this policy.

IMPLEMENTATION

1. The Ministry of Health will appoint approved clinical authorities who will:

   1.1 Convene a Clinical Advisory Committee/s with sufficient specialist experience and knowledge to adjudicate applications for community prescribing accreditation in the areas of HBV and/or HIV.

   1.2 Recommend to the Ministry of Health applicants the Clinical Advisory Committee/s have assessed as having suitable grounding and experience for community prescribing with reference to any relevant clinical standards, treatment guidelines, models of care and government directives.

   1.3 Periodically adjudicate community prescribers' ongoing suitability for community prescribing accreditation, with reference to recent clinical practice, continuing professional development (CPD), and links with appropriate specialists and specialist treatment facilities.

   1.4 Annually, or on request, provide the Ministry of Health with a copy of the register of community prescribers who continue to be suitable for community prescribing accreditation in accordance with item 1.3. The register shall include at least the following fields: Title, First Name, Last Name, Practice Address, Post Code, Phone, Email, Provider Type, Affiliated Specialist and Specialist Treatment Facility.

   1.5 Maintain a register of accredited community prescribers.

2 The Ministry of Health is required to:

   2.1 Provide a mechanism for community prescriber and training programs that reflect relevant clinical standards, treatment guidelines, models of care and government directives.

   2.2 On the basis of recommendations made by an approved clinical authority (per items 1.2 and 1.4 above), authorise community prescribers to prescribe HSD.

   2.3 Notify community prescriber applicants of the outcome of their applications.

   2.4 Oversight execution of a declaration that outlines the terms of the community prescriber program.

   2.5 Annually issue a list of authorised HBV and HIV community prescribers to NSW public hospital pharmacy departments.

3 Local Health Districts are required to:

   3.1 Ensure that all HSD prescribing, dispensing and claiming is done in line with Commonwealth and State requirements for the HSD Program, including establishing appropriate audit processes.

1. BACKGROUND

1.1 About this document

Highly Specialised Drugs (HSD) are medicines Highly Specialised Drugs (HSD) are medicines for the treatment of conditions, which, because of their clinical use or other features, may generally only be prescribed by specialist medical practitioners affiliated with public or private hospitals with appropriate specialist facilities. As it is important that people living with HBV and HIV have access to high quality health care in primary care settings, the HSD Program also provides for non-specialist medical practitioners and nurse practitioners to be accredited to prescribe s100 HSDs used in the treatment of HBV and or HIV for dispensing at a public hospital pharmacy department.

1.2 Key definitions

Affiliated medical practitioner: refers to a staff hospital specialist or visiting or consulting specialist of a hospital with HBV or HIV facilities.

Approved clinical authority: refers to a committee or organisation recognised by the Ministry of Health under this policy as having sufficient medical expertise to assess community prescribing accreditation applications.

Community prescriber: refers to a medical practitioner or nurse practitioner accredited and authorised to prescribe HSDs in accordance with this policy.

1.3 Legal and legislative framework

The HSD Program is a joint initiative of the Australian Government and the states and territory governments. The Program operates under section 100 of the *National Health Act 1953* (Cth). Section 100 allows for special arrangements to be made for the supply of drugs that, because of their clinical use or other special features, are restricted to supply through public and private hospitals that have appropriate specialist facilities.

A medical practitioner or nurse practitioner, who is not affiliated with an appropriate specialist unit at a public or private hospital, may only prescribe HSDs with the approval of the state or territory.

Patients must be under appropriate medical care. They must also be an eligible person under the *Health Insurance Act 1973* (Cth). An eligible person must be:

- an Australian resident;
- a person covered by a Reciprocal Health Care Agreement, or
- an eligible overseas representative.

2. PRESCRIBING

2.1 HSD Prescribing for HBV or HIV Medications

To write HSD prescriptions, a prescriber must be a medical practitioner issued with a PBS prescriber number and meet at least one of the following:

2.1.1. A visiting or consulting hospital medical specialist practitioner affiliated with a recognised specialist treatment facility.

2.1.2. An accredited community prescriber authorised by the Ministry of Health to prescribe HBV medication as outlined in Section 2.2 of this policy.

2.1.3. An accredited community prescriber authorised by the Ministry of Health to prescribe oral HIV medication as outlined in Section 2.3 of this policy.

2.1.4. A hospital medical practitioner or community general practitioner in exceptional situations where it is impractical to obtain a prescription for HBV or HIV medication from the treating specialist and where that specialist medical practitioner has provided written agreement for the prescription to be issued.

2.2 HBV Community Prescribing (Shared Care)

Authorisation to prescribe maintenance drug treatment for HBV may be granted on an individual basis by the Ministry of Health to non-affiliated medical practitioners or nurse practitioners where the approved clinical authority is satisfied:

2.2.1 The applicant has:
- a) completed appropriate training and assessment requirements;
- b) demonstrated equivalent prior experience;
- c) current authorisation as a HBV community prescriber by another Australian State or Territory participating in the HSD Program.

2.2.2 The applicant demonstrates preparedness to participate in relevant continuing professional development (CPD).

2.2.3 There is evidence of an agreement to participate in shared care with a treating specialist associated with a recognised hospital viral hepatitis treatment facility The applicant and his/her patients have full and timely access to the services of a nominated public hospital viral hepatitis treatment facility.

2.3 HIV Community Prescribing

Authorisation to prescribe oral agents for the treatment of HIV other than by specialists may be granted on an individual basis by the Ministry of Health to non-affiliated medical practitioners or nurse practitioners where the approved clinical authority is satisfied:

2.3.1 The applicant has:
- a) completed appropriate training and assessment requirements OR
- b) demonstrated equivalent prior experience OR
- c) current authorisation as a HIV community prescriber by another Australian State or Territory participating in the HSD Program.

2.3.2 The applicant demonstrates preparedness to participate in relevant CPD.

2.3.3 The applicant can demonstrate an established link with a specialist in HIV, located within a recognised specialist HIV treatment facility approved by the Ministry of Health.

FURTHER INFORMATION

Further information on training courses, eligibility criteria and application procedures are available from approved clinical authorities. At the time of publication, the approved clinical authority for HBV and HIV community prescribing is:

Australasian Society for HIV, Viral Hepatitis amd Sexual Health
Locked Mail Bag 5057
DARLINGHURST NSW 1300
Telephone: (02) 8204 0700
Facsimile: (02) 9212 2382
ashm.org.au

Further information about the HSD Program is available from Medicare Australia at:
medicareaustralia.gov.au/provider/pbs/highly-specialised-drugs/

HIGHLY SPECIALISED DRUGS PROGRAM - GUIDELINES FOR UNDERTAKING CLINICAL TRIALS (PD2005_078)

The purpose of this circular is to advise hospitals of guidelines recommended by the Highly Specialised Drugs Working Party in determining economical appropriateness of clinical trials on their premises.

The Highly Specialised Drugs Working Party (HSDWP) is a committee of Commonwealth, State and Territory officials established under the Australian Health Ministers' Advisory Council (AHMAC) to advise on funding aspects of certain highly specialised drugs.

The HSDWP has recently been discussing ways to assist in ensuring the cost effectiveness of major new drugs supplied through public hospitals. The HSDWP appreciates that clinical trials often carried out in public teaching hospitals have short term cost implications for the hospitals and, in the longer term, can influence the use and cost of the drugs after marketing approval.

The PBS system provides a mechanism for negotiating reasonable costs for PBS listed drugs. There is, however, no such mechanism for public hospitals involved in clinical trials to influence the eventual purchase price of innovative drugs that are prescribed by clinicians but are not listed on the PBS.

In view of this, AHMAC has requested that the HSDWP advise State/Territory Health Departments of Working Party recommendations aimed at allowing the purchaser control over the conditions of supply. The HSDWP has developed guidelines covering economic matters for use by public hospitals in considering whether it is appropriate for a clinical trial to be conducted on its premises. Such considerations should commence **at the earliest possible stage** when sponsors approach specialists to make applications to the hospitals institutional ethics committees to conduct drug trials.

The guidelines recommended by the HSDWP are:

1. Sponsors of products intended for clinical trials should be required to provide a firm indication of the product price following eventual marketing approval. Presently, many sponsors refuse to specify, *at the trial stage*, the subsequent purchase price or price range for the drug. Sponsors should provide hospitals with information on the potential financial implications of maintaining patients on their products if the clinical trial demonstrates acceptable safety and efficacy and marketing approval is obtained.

2. Sponsors should be expected, when appropriate, to design clinical trials to include gathering of data on the value for money of the drug for the use under investigation.

3. Sponsors should undertake to meet all the reasonable direct and indirect costs to hospitals in conducting clinical trials. Over recent years there has been a tendency for sponsors not to meet all the legitimate costs of conducting drug trials. At times, companies provide only the drug without any other financial assistance for the trial.

4. Sponsors should undertake not to introduce any "administration fees" in the period following a drug trial and leading up to registration for marketing, or be prepared to justify any fee.

   Some manufacturers do not, or are slow, in seeking marketing approval and have introduced "administration fees" for the supply of drugs under the Special Access Scheme (SAS) following the conclusion of clinical trials. These are solely determined by the manufacturer and in many cases are equivalent to the intended product price after marketing approval.

It should be noted that the Therapeutic Goods Administration is considering placing a limit on the volume of a product's use under the Special Access Scheme to prevent the Scheme being used as an alternative to marketing.

5. Sponsors should undertake to pay hospitals for preparing individual case reports for products provided through the Special Access Scheme. Some suppliers require ongoing patient profiles during treatment.

6. Unregistered products used in clinical trials cannot be promoted by the sponsor. Hospital staff should be made aware of the code of conduct of the Australian Pharmaceutical Sponsors Association. By this code, the Industry self-regulates promotion of pharmaceutical products. Any infringement of the code should be reported to:

Secretary
Code of Conduct Subcommittee
Australian Pharmaceutical Manufacturers Association
Level 2, 77 Berry Street
NORTH SYDNEY NSW 2060

PRIORITY ACCESS TO PUBLIC OPIOID TREATMENT PROGRAM SERVICES FOR PATIENTS RELEASED FROM CUSTODY (PD2021_027)

PD2021_027 rescinded PD2005_313

POLICY STATEMENT

Patient released from custody in NSW who are on opioid agonist treatment are to be given priority access to public Opioid Treatment Program (OTP) services in local health district in which they reside post-release.

SUMMARY OF POLICY REQUIREMENTS

NSW Health OTP services are to retain patients in treatment, where possible, as they transition between custody and the community. Priority access is to occur regardless of whether the patient has commenced opioid agonist treatment (OAT) in a correctional setting or in the community, or whether the patient has been released from a public or private correctional centre.

Transfer of care arrangements

The custodial health service is to refer the released patient to the local health district for ongoing management. Services must continue the patient's OAT unless clinically contraindicated. The patient can transfer to a private OTP service post-release pending clinical risk assessment and review by the District-based Alcohol and other Drug Service. For Aboriginal patients, this can include linkages to the patient's nearest Aboriginal Community Controlled Health Service.

The custodial health service is to arrange the transfer of care by providing advance notice of the patient's expected release from custody (where possible) and facilitate the booking of initial appointments for the patient to the District OTP service within 24 hours of expected release if the patient is on oral or sublingual OAT. This includes providing relevant documentation to the District.

Where a patient is unexpectedly released from custody and the transfer of care has not been prearranged, the custodial health service is to advise the patient to attend their previous, or nearest, public OTP service and is to provide the patient with relevant contact details.

District services receiving a patient unexpectedly released from custody without a prearranged transfer of care are to contact Justice Health and Forensic Mental Health Network Drug and Alcohol Central Office or the Remote On-Call After Hours Medical Service (ROAMS) and ensure that the appropriate arrangements are made for the patient.

Business Hours (Monday to Friday)
Phone: (02) 9700 2101
Fax: (02) 9700 3605
Email: JHFMHN-DischargePlanning@health.nsw.gov.au

Weekends and Public Holidays
ROAMS
1300 076 267 (Option 3)

District-based services are to have procedures in place to ensure their OTP clinic's authorised practitioner takes over care of the patient (including obtaining a s.29 authority for that patient) as soon as possible.

When patients on OAT transfer from custody to any community-based treatment, the following documentation is to be provided as part of clinical handover of care to the receiving service:

- Details of the custodial health service provider that was managing the patient prior to transfer of care.
- Details of OTP service provider the patient is being referred to for ongoing care.
- The patient's intended address and contact details, if known, when transferring to the community
- An OAT prescription /medication order from the custodial prescriber for the transition period
- Recent administration information including dosing history. If the patient is being treated with depot buprenorphine, then drug administration and dosing history for the last 3 months is to be included.
- A copy of the Patient Identification form including photo
- Recent Clinical Review report detailing the patient's current health concerns and current medications.

Transfer of care considerations for patients on depot buprenorphine

Patients on depot buprenorphine are to be provided with the option of continuing depot buprenorphine, where possible. Where depot buprenorphine cannot be continued in the community upon the patient's release, they may be transferred to sublingual buprenorphine. All transfers to and from depot buprenorphine are to be guided by the NSW Health Clinical Guidelines for use of Depot Buprenorphine.

For patients on **monthly** depot buprenorphine injections, a prescription or medication order for at least one single monthly depot buprenorphine dose post-release must be provided to the new service provider. For these patients, the custodial health service provider will aim for the last dose to be within one to two weeks of anticipated release. This may require flexible administration of the last injection of depot buprenorphine within the three to five-week period from previous dose/s.

For patients on **weekly** depot buprenorphine, prior to release, a prescription/medication order for one single weekly depot buprenorphine injection must be provided to the new service provider, with two repeats.

Transfer of s.29 authorities to prescribe methadone or buprenorphinei

The custodial health provider will ensure patients initiated or continue OAT while in custody will have s29 authority completed in custody. It is the responsibility of the District to ensure the transfer of the authority to prescribe Opioid Agonist Treatment for patient's post-release. The District prescriber is to apply for a s.29 authority to prescribe within 21 days after the patient's release from custody.

Relevant forms are accessed at https://www.health.nsw.gov.au/aod/Pages/depotbuprenorphine.aspx

HIGH-RISK MEDICINES MANAGEMENT (PD2020_045)

PD2020_045 rescinds PD2019_058

POLICY STATEMENT

All NSW Health organisations must have systems in place for the safe management and use of high-risk medicines.

This Policy Directive includes individual policy standards for the following high-risk medicines: hydromorphone, methotrexate (oral), neuromuscular blocking agents, opioids, paracetamol, potassium (intravenous), vincristine and anticoagulants.

SUMMARY OF POLICY REQUIREMENTS

All public health facilities must maintain a high-risk medicines program in accordance with NSW Health Policy on Medication Handling in NSW Public Health Facilities.

All public health facilities must maintain as part of the high-risk medicines program, a specific high-risk medicines register. The specific high-risk medicine register must include medicines used locally within the facility identified to be at 'high-risk' of misadventure.

Local protocols must be developed for all identified high-risk medicines specified on the register. The protocols are to be developed in consultation with relevant specialists and overseen and approved by the District or Health Service Drug and Therapeutics Committee(s) (however named). Protocols must include a timeframe for review.

Each high-risk medicine protocol must include patient monitoring which is relevant and appropriate for the patient's clinical circumstances. This is to ensure a timely response to adverse events or side effects associated with drug treatment.

All public health facilities are to employ strategies to mitigate the risk of medicines on the mandatory local high-risk medicines registers.

Adverse incidents involving high-risk medicines must be reported in the facility incident management system and reviewed through local quality management systems.

The High-Risk Medicines Management: Procedures can be download from:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_045

CHANGES TO PRESCRIBING AND DISPENSING OF BOTULINUM TOXIN AND GROWTH HORMONE (IB2015_049)

PURPOSE

From 1 September 2015, new arrangements will be in place to govern the supply of Pharmaceutical Benefit Scheme subsidised growth hormone and botulinum toxin.

This information bulletin provides further detail on the practical implications of the new arrangements for NSW public hospitals.

KEY INFORMATION

GROWTH HORMONE

PBS Changes to prescribing and dispensing

- From 1 September 2015, the way PBS subsidised growth hormone (somatropin) is prescribed, dispensed and accessed is being amended by the Commonwealth to better align with other PBS arrangements.
- Currently, prescribers make a written application to the Commonwealth Department of Health to prescribe growth hormone.
- From 1 September 2015, prescribers will make a written application to the Commonwealth Department of Human Services – Medicare under the PBS Written Authority system.
- Prescriber eligibility criteria will remain unchanged (i.e. the eligible medical practitioner must hold a specialist qualification for the condition).
- Medicare will notify the prescriber of the outcome and the prescriber will be responsible for notifying the patient's parent/carer of the outcome of the application.
- Approved PBS authority prescriptions will be used by the patient's parents/carers to obtain growth hormone supplies at the pharmacy of their choice – the Commonwealth Department of Health will no longer manage the ordering and monitoring of growth hormone supplies.
- Patients will be able to present authorised prescriptions to any PBS-approved pharmacy.

Important practical arrangements and implications for NSW Public Hospitals

- NSW Health is not a signatory to the Pharmaceutical Reforms and therefore under the new arrangements NSW public hospital pharmacy departments are not able to claim the Commonwealth reimbursement for an authorised PBS prescription for growth hormone.
- In NSW this means, when providing a service to a privately referred non-admitted patient, an authorised PBS prescription is provided to the patient/carer who then presents the script to a community or private hospital pharmacy where the supplies will be ordered, delivered and dispensed to the parent/carer.

Co-payments

- Normal PBS patient co-payments will now apply.

For further information, please view the following FAQ link developed by the Commonwealth:
http://www.pbs.gov.au/info/general/changes-to-certain-s100-programs

KEY INFORMATION

BOTULINUM TOXIN

PBS Changes for prescribers and hospital pharmacies

- Section 100 Botulinum Toxin Program is being modified by the Commonwealth to align with other PBS arrangements, using PBS prescriptions and s94 Hospital Pharmacy coordination points.
- All changes to the Botulinum Toxin Program will take effect from 1 September 2015.
- Prescribers will no longer need to register with the Commonwealth, but specialists will be restricted, by specialty, to prescribing for specific indications. Details are in the *Criteria for Availability* in the PBS Schedule.
- Only s94 (PBS-eligible) hospital pharmacies will be able to claim reimbursement.
- Community pharmacies are not included in this program.
- Botulinum toxin, and related products, will continue to be listed in the PBS Schedule under *s100 Botulinum Toxin*.

Important practical arrangements and implications for NSW Public Hospitals

- NSW Health is not a signatory to the Pharmaceutical Reforms and as such NSW public pharmacies will not be able to claim PBS reimbursement for botulinum toxin from 1 September 2015.
- In NSW, when providing a service to a privately referred non-admitted patient, prescribers will have two options. The prescribers may either come to an arrangement directly with a s94 pharmacy or with a third party with appropriate arrangements in place, to dispense, deliver and claim reimbursement of the PBS botulinum toxin.
- The private hospital will claim reimbursement online via PBS Online.
- Importantly, the prescriber must arrange with the s94 pharmacy or alternative supplier the appropriate transportation and provision of the toxin so that the patient has no involvement in the transportation.
- Under no circumstances are patients to be in possession or involved in the transport of the botulinum toxin.

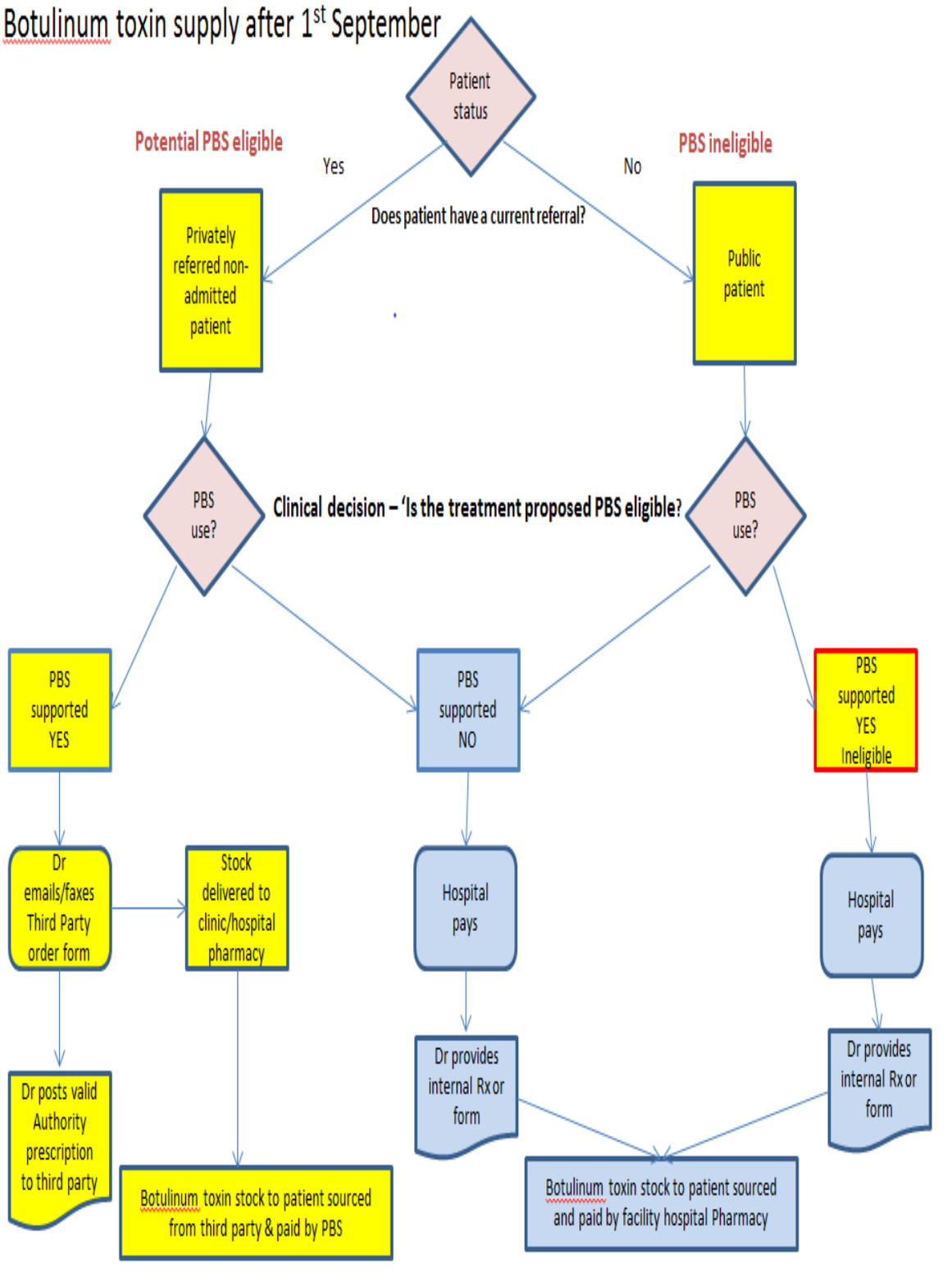
Co-payments

- Normal PBS patient co-payments will now apply to botulinum toxin dispensed at a s94 pharmacy.

An indicative botulinum toxin supply diagram follows.

For further information, please view the following FAQ link developed by the Commonwealth:

http://www.pbs.gov.au/general/changes-to-certain-s100-programs/faqs-botulinum-toxin-25-june-2015.pdf


Botulinum toxin supply after 1st September
Patient status
Potential PBS eligible
Yes
No
PBS ineligible
Does patient have a current referral?
Privately referred non-admitted patient
Public patient
PBS use?
Clinical decision – 'Is the treatment proposed PBS eligible?
PBS use?
PBS supported YES
PBS supported NO
PBS supported YES Ineligible
Dr emails/faxes Third Party order form
Stock delivered to clinic/hospital pharmacy
Hospital pays
Hospital pays
Dr provides internal Rx or form
Dr provides internal Rx or form
Dr posts valid Authority prescription to third party
Botulinum toxin stock to patient sourced from third party & paid by PBS
Botulinum toxin stock to patient sourced and paid by facility hospital Pharmacy

VACCINE STORAGE AND COLD CHAIN MANAGEMENT POLICY STATEMENT (PD2020_028)

PD2020_028 rescinds PD2017_014

POLICY STATEMENT

All NSW facilities must adhere to mandatory vaccine storage and cold chain management requirements to ensure vaccine are stored in accordance with best practice guidelines, vaccine cold chain breaches are identified and managed consistently and efficiently, and all patients receive potent and effective vaccines.

SUMMARY OF POLICY REQUIREMENTS

All facilities must ensure that policies, procedures and protocols are in place for effective vaccine storage and cold chain management according to the current editions of the *National Vaccine Storage Guidelines 'Strive for 5'* and the digital *Australian Immunisation Handbook.*

All vaccines must be stored in a purpose-built vaccine refrigerator that is continually data logged. The data logging report is downloaded and reviewed at least weekly.

All refrigerators must have an audible alarm preferably with a back-to-base alarm or automated temperature monitoring system.

A base-line vaccine storage self-audit is conducted initially and annually in March thereafter (available on the Quality Audit Reporting System – QARS).

Local procedures must be in place to respond to cold chain breaches and power failures, including reporting temperatures outside +2°C to+8°C range to the local public health unit (PHU) on 1300 066 055 within the same working day. Vaccines must be quarantined until advice is received from the PHU.

Cold chain breaches resulting in vaccine wastage or recall and revaccination of patients must be reported in the Incident Management System to facilitate investigation, resolution and minimise the risk of future incidents.

All vaccine refrigerator current/minimum/maximum temperatures are visualised and manually recorded twice daily on the NSW Health vaccine refrigerator monitoring chart.

Staff education should be facilitated through the MyHealth 'Vaccine Storage and Cold Chain Management' module and cold chain management resources available on the NSW Health cold chain webpage.

The Vaccine Storage and Cold Chain Management Policy and Procedures can be downloaded from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2020_028

TAKE HOME NALOXONE (PD2020_027)

PD2020_027 rescinds PD2019_036

POLICY STATEMENT

NSW Health enables health workers to supply take home naloxone as part of a structured overdose response intervention for the purpose of preventing opioid overdose-related mortality and morbidity, where the conditions and processes described in this Policy are adhered to. It also outlines workforce training and credentialing, governance and medication handling (including ordering, storing and supplying) requirements for participating organisations.

This Policy is relevant to the supply of naloxone to clients for later use and **does not** apply to health workers directly administering naloxone and other emergency procedures in response to a suspected patient overdose in a health service setting.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive is for the management of clients by health workers of the MSIC, NSW Local Health Districts, Justice Health & Forensic Mental Health Network and the St Vincent's Health Network services who work with clients at risk of opioid overdose.

Eligible health workers at participating services must have successfully completed the Take Home Naloxone training and credentialing requirements set out in the Take Home Naloxone Procedures in order to supply naloxone using this model.

Trained and credentialed health workers who are not otherwise authorised to supply naloxone medications must comply with the Procedures when supplying naloxone.

Medical practitioners and nurse practitioners may follow these Procedures or may continue to follow existing models for prescribing and supply of scheduled medicines.

If pharmacists employed by Local Health Districts are to supply naloxone without prescription, they must do so in compliance with this Policy and within scope of the legislative authority.

The Policy provides the basis for Local Health District Drug and Therapeutics Committees to adopt the THN intervention. The MSIC must adopt and comply with the Policy.

All facilities offering this intervention must implement appropriate governance structures and identify and minimise the risks of adverse events. In facilities that adopt the intervention a designated Responsible Person (a senior nurse, pharmacist, medical practitioner or manager at the facility) is required to perform the duties of the Responsible Person as described in the Procedures.

In implementing this Policy, district/service managers and directors, and the designated Responsible Person, must ensure that a health worker operating under this Policy is aware of their responsibility to deliver the intervention in accordance with sections 2.3 and 2.4 of the Take Home Naloxone Procedures.

District/service managers and directors, and the designated Responsible Person, must ensure that naloxone is supplied appropriately. In Local Health Districts and the Justice Health & Forensic Mental Health Network, naloxone is obtained from the Pharmacy Department to the service in accordance with *NSW Health Medication Handling in NSW Public Health Facilities* (PD2013_043). Local Health District Pharmacies will provide naloxone to these services using imprest stock procedures. The Registered Nurse or Manager in charge of the unit is responsible for ordering and storage of imprest stock medications. Responsibility can be delegated to an appropriately authorised person where no Registered Nurse is employed in the service – such as may occur with a Local Health District-employed NSP manager under an HSM award (S 6.1, PD PD2013_043).

In the St Vincent's Health Network, naloxone is obtained from a Health Network pharmacy.

In the MSIC, naloxone is obtained from a licensed pharmaceutical wholesaler.

District/service managers and directors, and the designated Responsible Person, must ensure that naloxone is stored in locked cupboards with restricted access by credentialed health workers and the Responsible Person only. The manufacturer's original packaging must be used.

Dispensing labels must be supplied by the pharmacy department. Dispensing labels may be affixed by the credentialed health worker, if the local Drug & Therapeutics Committee has approved this procedure. Labelling requirements are described further in Section 2.3.6 of the Procedures.

District/service managers and directors, and the designated Responsible Person, must ensure that relevant information is supplied with the naloxone, including the Consumer Information Sheet appropriate to the supplied naloxone product.

In public health facilities, all records relating to the supply of medication must be retained in accordance with the *State Records Authority General Retention and Disposal Authority for Public Health Services: Patient/Client Records* (GDA 17).

In the MSIC, records relating to the supply of take home naloxone under this Policy must be retained in accordance with the *Health Records and Information Privacy Act 2002*.

The Take Home Naloxone Policy and Procedures can be downloaded from:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2020_027

ELECTRONIC MEDICATION MANAGEMENT SYSTEM GOVERNANCE AND STANDARDS (PD2019_050)

PURPOSE

This Policy Directive describes the governance and standards which must be met where an electronic medication management system (eMeds system) is used in a NSW public health facility to prescribe medications for administration to a patient and, where applicable, for pharmacist dispensing.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations must implement this Policy by 31 January 2020 in settings where eMeds systems are used.

IMPLEMENTATION

NSW Ministry of Health:

- Provide the mandatory requirements and standards for the policy.
- Provide the necessary legal instruments under the Poisons and Therapeutic Goods Regulation 2008 to enable eMeds system use under the policy.

Clinical Excellence Commission:

- Support implementation of the policy where applicable to medication safety.

Chief Executives, Health Service Executives, Managers:

- Assign responsibility, personnel and resources to implement the policy.
- Provide line managers with support to implement the policy in their areas.
- Ensure that local policies, protocols and procedures are in place at each facility to support implementation of the policy.

Directors of Clinical Governance:

- With other Executive members, ensure successful implementation of the policy within each Public Health Organisation.

Drug and Therapeutics Committees:

- Develop, approve and oversee the implementation of local policies, protocols and procedures where required.
- Provide local oversight of the safe implementation of this policy.

Electronic Medication Management System Governance and Standards: Procedures

BACKGROUND

About this document

These procedures describe the governance and standards which must be met where an electronic medication management system (eMeds system) is used in a NSW public health facility to prescribe medications for administration to a patient and, where applicable, for pharmacist dispensing.

Key definitions

must	Indicates a mandatory action requiring compliance by staff at public health facilities, in accordance with a legislative requirement and/or a NSW Health policy or directive.
should	Indicates a recommended action that should be followed unless there is a sound reason for taking a different course of action.
administration	The decision to give a medication, giving the medication (such as by mouth, topically or by injection) then documenting that the medication has been given.
authorised prescriber, authorised practitioner	An 'authorised prescriber' in NSW Health Policy Directive *Medication Handing in NSW Public Health Facilities*.
business processes	The procedures for eMeds system use under a local protocol approved by the hospital or health organisation's Drug and Therapeutics Committee.
dispensing	The labelling and supply of a medication, and recording of the supply, by a pharmacist for use by a particular patient on the order of an authorised prescriber. The order may be for patient take-home use of the medication or for administration to an inpatient or outpatient.
electronic medication management system, eMeds system	The software and associated hardware (such as computer terminals and screens) used to create and document the entire medication process from the authorised practitioner's (authorised prescriber's) medication order, to the pharmacist's review of the medication order and supply of medication, to the nurse's record of administration of the medication, and all the processes in between. eMeds systems are sometimes within the electronic medication record (eMR), such as Cerner Millennium eMeds.
prescribing	The decision to treat a patient with a medication and the creation of a medication order in an eMeds system to direct administration or dispensing of the medication. Prescribing in an eMeds system includes continuation, renewal of, or amendment to, a previously valid medication order. Prescribing may be by: a) an authorised practitioner under the Poisons and Therapeutic Goods Regulation 2008, or b) another person authorised under a protocol approved by the health facility's Drug and Therapeutics Committee that accords with requirements under the Poisons and Therapeutic Goods Regulation 2008.

KEY INFORMATION

The Chief Executive must establish a governance process and is accountable for approving and ongoing assurance over the use of the eMeds system to prescribe, administer and dispense (if applicable) medications to ensure the safe use of the system in accordance with the NSW Health eMeds System Standards (in section 3) and must:

- Implement local procedures for assigning roles and access to the system
- Appoint a person responsible for assigning individual access credentials to system users
- Assign accountability for policy compliance to the health facility's Drug and Therapeutics Committee (DTC) or clinical governance committee.

The DTC must approve and regularly review the local business processes on use of the eMeds system, including the identification and management of system risks and issues from data extraction to support quality improvement and medication safety.

The DTC should ensure integrated clinical decision support and medicines information is appropriate and current.

Particular care should be applied where multiple eMeds systems or hybrid systems are used. Risks of duplicate orders, duplicate records of administration or non-contemporaneous orders must be managed through the local business processes.

The eMeds system use should conform to the recommendations in:

- The following Australian Commission on Safety and Quality in Healthcare guidelines, as amended from time to time;
    - *'Electronic Medication Management Systems: A Guide to Safe Implementation'* and addendum, *'Electronic Medication Management Systems Business Requirements'*
    - *'National Guidelines for On-Screen Display of Medicines Information'*
    - *'Recommendations for Terminology, Abbreviations and Symbols used in Medicines Documentation'*
- *'Building sustainable governance of electronic medication management: Guiding Principles for Drug and Therapeutic Committees in NSW'* - NSW Therapeutic Advisory Group Inc. and eHealth NSW (2017).
- The eHealth NSW eMeds/eMR Design Standards (at http://ehnsw.sharepoint.nswhealth.net/apps/ClinP-eMedsHub/Pages/Design-standards.aspx).

  Chief Executives may conduct a gap analysis of current system conformance with these recommendations.

Legal and legislative framework

An authorised practitioner under the Poisons and Therapeutic Goods Regulation 2008 (the Regulation) may electronically prescribe medication in an eMeds system that:

- complies with the NSW Health eMeds System Standards (in section 3), and
- is approved for use by the health facility's Chief Executive.

Compliance with this Electronic Medication Management System Governance and Standards Procedure:

- Means use of the eMeds system is an approved form of prescribing under the Regulation.
- Replaces current individual eMeds system approval by the Ministry for Health for use at specified hospitals.

However, eMeds systems that do not comply with these procedures may alternatively be approved by the Ministry of Health on a case by case basis where assurance of patient safety and data security is in place. The Chief Executive may apply for approval to the Chief Pharmacist, NSW Ministry of Health at MOH-PharmaceuticalServices@health.nsw.gov.au.

eMeds systems are generally an end to end digital process. Hybrid systems with paper outputs other than in section 4 (for medication charts) and section 5 (for prescriptions) may require separate approval and mitigation of specific risks.

Approvals have been issued for specific hospitals or Local Health Districts and include the eMeds functionality in Cerner Millennium, DXC MedChart, eRIC (Intensive Care) and ARIA, CHARM and MOSAIQ oncology systems. These approvals will remain in place until 31 January 2020 to enable transition arrangements if required.

Exemptions to the Regulation are in place to exempt pharmacists from marking dispensed prescriptions "Cancelled".

System approval under the NSW Health eMeds System Standards does not include the keeping of a Schedule 8 drug register in electronic form (including those in Opioid Treatment Program electronic recording systems).

NSW HEALTH EMEDS SYSTEM STANDARDS

Standard	Notes on Compliance
1) Use of the electronic medication management system and associated business processes must be under the governance of the health facility's Drug and Therapeutics Committee or other delegated clinical governance committee which should include expertise in medication safety, quality use of medications and clinical informatics.	
2) Each system user must be assigned individual access credentials, secured by at least one method of authentication, which identifies them as an authorised user of the system. Authorised users must keep their access credentials confidential and secure.	
3) Together the system and associated business processes must restrict access by each authorised user to roles of prescribing, administration and dispensing (if applicable) permitted: a) under the Poisons and Therapeutic Goods Regulation 2008 (where relevant), and/or b) in accordance with any practice conditions imposed by the user's place of employment.	The system must allow prescribing by users other than an authorised prescriber, for example under a Standing Order, as nurse-initiated medication and for radiopharmaceuticals, contrast and Total Parenteral Nutrition. The business processes should ensure compliance with health practitioner registration endorsements and practice restrictions.
4) The system must allow for the administration and dispensing (if applicable) of medication prescribed verbally (face to face or by telephone) or by facsimile or electronic mail.	
5) The system and associated business processes must assure the identity of the authorised user for transactions involving prescribing, administration and dispensing (if applicable) of a medication.	
6) The system and associated business processes must ensure that an electronic medication order is created and presented in such a manner that the receiving user can be confident of the validity and currency of the order.	Quality assurance processes must be in place to ensure that medication prescribing data elements, such as in medication order sentences and order sets, are accurate.

7) The system must support co-signing of records of prescribing, administration and dispensing (as applicable) where required under Regulation, policy or associated business processes.	Includes witnessing of medication administration.
8) The system must display sufficient patient identifiers, including the patient's name and date of birth, to ensure that the user can verify the identity of the patient for each prescribing, administration and dispensing (as applicable) transaction.	
9) The system and associated business processes must ensure the quantity of medication prescribed and intended to be dispensed by a pharmacist is documented in a manner that prevents accidental or intentional dispensing in excess of the quantity prescribed.	Where the medication order is visible to multiple dispensing sites this may be achieved via an appropriately configured prescription exchange service that prevents dispensing medication in excess of the amount prescribed.
10) Records of prescribing, administration and dispensing (as applicable) created by an authorised user must be securely stored under that person's identity and readily visible in the system user interface to other authorised users, including any amended records.	
11) The system and associated business processes must ensure that administration or dispensing (as applicable) are not undertaken in excess of twelve months from the date of prescribing.	Medication order renewal or review constitutes prescribing when documented in the system with the date and time the action occurred. Prescriptions for dispensing Schedule 4 Appendix D and Schedule 8 medications for patient take home are only valid for six months.
12) All current records and relevant ceased records (as appropriate in the circumstances), of prescribing and administration of medication, and any associated records, must be retrievable during system downtime.	
13) Appropriate, documented downtime procedures must be in place to ensure accurate and safe prescribing and administration of medication during and after system downtime to ensure continuity of care. The procedures must be reviewed regularly, rehearsed and available to authorised system users.	
14) All records of prescribing, administration and dispensing (if applicable) of medication, and any associated records, must be retained for the periods required under legislation and NSW Health policy, as amended from time to time.	
15) All records of prescribing, administration and dispensing (if applicable), and any associated records, must be available in a timely manner to a person eligible under legislation or NSW Health policy to inspect such records, including an inspector appointed under section 42 of the Poisons and Therapeutic Goods Act 1966.	

16) The prescribing data elements required for a valid medication order are: a) the patient's name, date of birth and unique identifier(s) b) the authorised prescriber's name c) the medication's active ingredient/s and/or brand name (where approved for use at the health facility) and (if applicable) the strength and dose form d) adequate directions to administer the medication, being; i) the dose, including when the dose may be varied ii) the frequency and, as applicable, the date and times for administration iii) the route for administration, including where this may be varied e) the amount of medication prescribed, being; i) for medication administration to patients at the health facility (inpatients or outpatients); a. the number of doses, or b. the intended duration of treatment (which may be until discharge for an inpatient), or c. the date and time when prescribing review is required (either nominated by the prescriber or as a function of the system as described in the business processes) ii) for pharmacist dispensing for administration to patients at the health facility (inpatients or outpatients); a. the number of doses, or b. the amount determined by the pharmacist under the business processes iii) for pharmacist dispensing for patient take-home use; a. the number or doses, or b. the intended duration of treatment, or c. the amount determined by the pharmacist under the business processes f) the date and time of prescribing g) where applicable, the date and time the previous order for the medication is ceased.	For a 'when required' ('prn') medication, adequate direction for use should include: • the maximum individual dose • the frequency for administration • the maximum daily dose. The business processes may limit the amount the pharmacist should dispense. The pharmacist may dispense any reasonable amount up to that permitted by the valid medication order. The quantity of medication dispensed for inpatients on discharge may be limited under the local business processes.

USE OF PRINTED (PAPER) MEDICATION CHARTS

Printed (paper) medication charts created using an eMeds system to direct medication administration and dispensing must be approved by the health facility's Drug and Therapeutics Committee. This includes use of locally approved standard medication order sets (medication regimens) printed on a paper medication chart.

Printed medication charts created using an eMeds system may also be used in the following circumstances:

- For patient transfer, where printed by a system user assigned responsibility under the business processes
- For eMeds system downtime – see Standard 13 in section 3, where printed by a system user assigned responsibility under the business processes. Note: a detailed assessment and heuristic review of the medication charts recommended for unplanned downtime (724 Downtime Viewer Version 5.3 and Version 5.7) from the Cerner eMR in NSW has been completed. This assessment is available from the eMR Connect Program (email: HSNSW-emmenquiries@health.nsw.gov.au).

Together the system and business processes must ensure the printed medication chart orders are accurate, current and complete, and with only one version in use. Business processes must also ensure the printed medications chart is retained in the patient's medical record.

USE OF PRINTED (PAPER) PRESCRIPTIONS

As an alternative to traditional handwritten prescription an authorised prescriber may generate, print and sign in handwriting a paper-based prescription created using an eMeds system in the following circumstances:

- To prescribe a medication for dispensing in a hospital pharmacy in accord with the business processes
- When the eMeds system does not comply with Standard 9 in Section 3 and therefore there is a risk of accidental or intentional dispensing in excess of the quantity prescribed
- To prescribe a medication in the category Section 100 Highly Specialised Drugs to meet Pharmaceutical Benefits Scheme (PBS) requirements to be eligible for Commonwealth reimbursement
- To prescribe a medication for dispensing in a community pharmacy, including for public health facility aged care residents (residential care and flexible care residents under the Commonwealth Aged Care Act 1997).

Standards for printed paper prescriptions

Where the eMeds system is used to create a paper prescription for dispensing of a medication by a hospital or community pharmacist for patient take-home use, the prescription must comply with the NSW Ministry of Health TG184 '*Criteria for Issuing Non-handwritten (Computer Generated) Prescriptions*' (available at http://www.health.nsw.gov.au/pharmaceutical/Documents/prescriptions-nonhandwritten.pdf).

General criteria

Under the criteria in TG184 the following mandatory prescribing data elements must be created with and printed by the eMeds system:

- The date on which the prescription is issued.
- The name of the patient (including given name, or initial letter).
- The full residential address of the patient.

- The name of the substance or the preparation containing it, including the strength where more than one strength is available.
- The quantity to be dispensed in figures (numerals) and, for a Schedule 8 medication, in words (Note: there is an exemption for a Schedule 8 medication where the prescription is dispensed at the hospital pharmacy).
- Adequate directions for use.
- The number of repeats authorised if repeats are ordered.
- The interval for repeats if required by legislation (Schedule 4 Appendix B and Schedule 8 medications) or otherwise deemed appropriate by the prescriber.

The eMeds system must require:

- The prescription to be created by the prescriber only.
- The prescriber to sign, in their own handwriting, the paper prescription form as near as practicable below the last item prescribed on the form.
- The prescription to be printed on a form which is pre-printed with the name and address and contact telephone number of the prescriber **OR** which the system prints on the prescription **OR** which is pre-printed with at least the address and contact telephone number of the practice/hospital **and** the system individually prints the name of the prescriber on the prescription during generation.
- Either a statement to be printed on each prescription form indicating the total number of items prescribed on that prescription form, **or** any unused area on the prescription form to be scored, hatched or marked to prevent any other item being printed in that area.
- A number which uniquely identifies the prescription **OR** which uniquely identifies the medication printed on the prescription and which can be related to the clinical or prescription record of the patient.
- When the patient is an infant or a child under the age of twelve, the age of the patient to be included on the prescription.
- When the prescriber requires a dose that is less than 1mL and that dose is recorded as a decimal value, the dose to be printed with a leading zero (that is, 0.3mL rather than .3mL).
- The particulars of any prescription issued to be included in the clinical or prescription record of the patient, retained for at least seven years from the date on which the prescription was created and accessible when required.

Additional requirements for Schedule 8 medications

A prescription for a Schedule 8 medication must not include any other medication.

The eMeds system must prompt the prescriber to hand write the mandatory data elements other than the date and the patient's name and address, namely:

- The name of the substance or the preparation containing it, including the strength where more than one strength is available.
- The quantity to be dispensed in figures (numerals) and words (Note: there is an exemption for a Schedule 8 medication where the prescription is dispensed at the hospital pharmacy).
- The directions for use.
- The number of repeats authorised if the prescription is to be dispensed more than once and, if repeats are ordered, the time interval for repeats.

General notes

- The mandatory prescribing data elements produced in accordance with the criteria must be issued without alteration to ensure both that the system record is consistent with the prescription and that the dispensing pharmacist will not be concerned about either accuracy or possible imposition.
- Any additional requirements of the Commonwealth Government PBS must be observed.
- Schedule 4 medication prescriptions issued by dentists, optometrists or podiatrists must be endorsed "For dental treatment only", "For optometrical treatment only" or ‘For podiatry treatment only” respectively. Schedule 8 medication prescriptions issued by dentists must be endorsed "For dental treatment only".
- A prescription duplicate must not be issued other than for a PBS medication (Note: The prescriber must destroy a duplicate prescription containing only PBS medication which is printed by a system default).
- For a PBS medication issued with a prescription duplicate the mandatory prescribing data elements must only be handwritten on the prescription marked to be retained by the dispensing pharmacist.
- Where a system for producing non-handwritten prescriptions does not satisfy the criteria in TG184 the individual approval of the Secretary, NSW Health must be sought.

NEW REPORTING REQUIREMENTS FOR THE *OPIOID OVERDOSE RESPONSE & TAKE HOME NALOXONE* INTERVENTION (IB2020_004)

PURPOSE

This Information Bulletin is relevant to all services that supply naloxone to clients in compliance with the *NSW Opioid Overdose Response & Take Home Naloxone Policy Directive* (PD2019_036). This includes Alcohol and Other Drugs services, Needle Syringe Programs and a range of other services.

The Australian Government is conducting a take home naloxone access pilot through the Pharmaceutical Benefits Scheme ('PBS pilot'). The PBS pilot subsidises the full cost of take home naloxone supplied to people at risk of experiencing or witnessing opioid overdose.

The PBS pilot runs from **1 December 2019 to 28 February 2021** and NSW is participating. From **1 March 2020**, NSW Health services supplying take home naloxone for ORTHN interventions can access naloxone through the PBS pilot for free. A PBS prescription is not required.

This Information Bulletin outlines how ORTHN sites must collect and provide legally mandated data for take home naloxone supplied during the PBS pilot.

The information bulliten in full is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2020_004

328(03/03/20)

PHARMACY DEPARTMENT REIMBURSEMENT AND DATA COLLECTION DURING PBS-SUBSIDISED NALOXONE PILOT (IB2020_005)

PURPOSE

The Australian Government is conducting a pilot under Section 100 of the Pharmaceutical Benefits Scheme (PBS) for subsidised supply of take home naloxone to people at risk of experiencing or witnessing opioid overdose. NSW is participating in the pilot.

During the pilot period of **1 December 2019 to 28 February 2021**, PBS-listed naloxone medicines (all formulations) indicated for the reversal of opioid overdose have S100 listing under the *National Health (Take Home Naloxone Pilot) Special Arrangement 2019* (*Special Arrangement*) and can be supplied or dispensed without a PBS prescription and with no patient co-payment. These conditions are extended to NSW public hospitals despite NSW not currently being a signatory to the Pharmaceutical Reform Agreement.

This Information Bulletin is relevant to pharmacy departments that purchase and supply Nyxoid® and Prenoxad® as imprest, ward or clinic stock for NSW Health ORTHN sites.

An ORTHN site is a NSW Health service delivering take home naloxone interventions in compliance with the *NSW Opioid Overdose Response & Take Home Naloxone Policy Directive* (PD2019_036).

This Information Bulletin outlines how hospital pharmacy departments may seek reimbursement for naloxone supply and how legally mandated data must be collected and provided for naloxone supplied or dispensed as part of the pilot.

The information bulliten in full is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2020_005

328(03/03/20)

TAKE HOME NALOXONE SUPPLY BY HOSPITAL UNITS (IB2020_036)

PURPOSE

NSW is participating in the Australian Government Section 100 Pharmaceutical Benefits Scheme (PBS) pilot for subsidised supply of take home naloxone to people at risk of experiencing or witnessing opioid overdose.

This Information Bulletin provides guidance to pharmacy departments, emergency departments (EDs), pain clinics and other hospital units wishing to supply PBS-subsidised naloxone for patients on discharge.

For supply of naloxone by 'credentialed health workers' in alcohol and other drugs and needle syringe program settings, please refer to NSW Health Policy Directive *Take Home Naloxone* (PD2020_027), Information Bulletin's *New Reporting Requirements for Opioid Overdose Response and Take Home Naloxone Intervention* (IB2020_004) and *Pharmacy Department Reimbursement and Data Collection During PBS-Subsidised Naloxone Pilot* (IB2020_005).

The information bulliten in full is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2020_005

No content remains in this chapter

Final amendment 307 - 20 August 2019

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters

CHAPTER 22 – STATISTICAL INFORMATION AND DATA

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NON-ADMITTED PATIENT ACTIVITY REPORTING REQUIREMENTS (PD2013_010)

PD2013_010 rescinds PD2012_037 & PD2005_291.

PURPOSE

The purpose of this policy is to mandate the requirement for NSW health services to report non-admitted patient activity to the Ministry of Health. This reporting requirement underpins the activity based funding model that is being implemented at the state and national level. The document outlines the requirements for reporting both summary level and patient unit record level non-admitted patient data. The activity covered by this policy includes hospital emergency department services, hospital outpatient care services and non-residential community health services.

MANDATORY REQUIREMENTS

All non-admitted patient service units providing services from 1 July 2013 must be registered and aligned with recognised clinical teams in both HERO and WebNAP. Service units must be appropriately classified to the revised HERO establishment type classification applicable to the 2013/14 financial year.

All pathology testing services, radiology imaging services, and pharmacy dispensing services pertaining to non-admitted patients must be reported at the summary level to WebNAP. Any requirement to report patient level data for these services will be issued in a separate policy.

All Emergency Department (ED) services provided to patients on a non-admitted patient basis that are not reported to the Emergency Department Data Collection at the patient level must be reported at the summary level via WebNAP. ED patient level data is not in scope of the reporting requirements to WebNAP.

All other non-admitted patient services containing clinical and/or therapeutic content that warrant a note being made in the patient's medical record that are delivered on or after 1 July 2013 must be reported:

- as a monthly occasion of service summary count until 30 June 2014, or the date patient level data is reported and reconciles with summary counts for all non-admitted patient service units using the same source system build and extract for a period of 6 months; and
- as an occasion of service patient level record via WebNAP until 30 June 2014; and
- as a patient level service record via EDWARD from 1 July 2014; and
- at the patient level to any other data repository as required by other policies until such time that they are rescinded. See Section 6.4 to 6.8 of the Non-admitted Patient Policy and Procedures (Attachment 1) for further details.

All data elements in the minimum data set prescribed in Section 2 of the Non-admitted Patient Policy and Procedures (Attachment 1) must be reported in compliance with the classification standards issued in the relevant data dictionary (EDWARD or WebNAP) and the "Non-admitted Patient Activity Reporting Business Rules" guidelines.

Data reported via WebNAP or EDWARD must be submitted, and be of acceptable quality, by the 15th working day of the month following the delivery of the service.

When reporting to EDWARD Local Health Districts (LHDs) and Specialist Health Networks (SHNs) must report client/patient characteristics via the client/patient registration data extract (from iPM or Cerner PAS), and patient level service details via one of the two community heath and outpatient care service event data extract formats. A period of parallel reporting of patient level data to both WebNAP and EDWARD is expected prior to 30 June 2014.

LHDs/SHNs must reconcile both the summary and patient level data reported to WebNAP and EDWARD against the source system, ensure the mandatory reporting requirements have been met, ensure all in-scope activity has been reported, and ensure that the data quality is fit for purpose (which includes activity based funding).

Where the patient level data from a source system build is reported to EDWARD, HIE or other Ministry of Health data repository, and the data has been determined by the LHDs/SHNs to be of equal or superior quality to WebNAP, the LHDs/SHNs using that source system build may, as a group, apply to the Health System Information and Performance Reporting Branch for an early exemption from reporting to patient level and/or summary level data to WebNAP.

IMPLEMENTATION

It is the responsibility of LHDs/SHNs to fund, specify, develop, test and implement:

1. WebNAP summary level and patient unit record level extracts from all non-admitted patient source systems by 1 July 2013.
2. EDWARD patient level extracts (either minimum or maximum format) from all non-admitted patient source systems by 1 July 2014.
3. Modifications to source systems, such that they fully comply with the minimum data set requirements for reporting to WebNAP and EDWARD.

LHDs/SHNs must ensure that all non-admitted services provided from 1 July 2013:

- are either recorded on a source system with a fully functional non-admitted patient level extract OR manually entered into WebNAP; and
- the patient unit record level data occasions of service reconciles with summary level occasions of service counts; and
- are reported under service units registered in HERO and WebNAP that align with recognised clinical teams, and are correct classified to the most appropriate 2013/14 'establishment type' in HERO.

See Section 11 of the Non-admitted Patient Policy and Procedures (Attachment 1) for the roles and responsibilities of the LHD/SHN Chief Executive and Non-Admitted Patient Data Steward/ Coordinator, and the Health System Information and Performance Reporting Branch.

All associated documentation is available via the NSW Health Intranet from the following URL:

- **http://internal.health.nsw.gov.au/data/collections/nap/index.html**

1. Background

1.1 About this document

The purpose of this policy and procedure document is to:

- Prescribe the minimum data set to be reported for all non-admitted patient services at both the summary and patient level.
- Prescribe the data repositories to which data must be reported, and the formats it must comply with.
- Prescribe the due dates for reporting.
- Prescribe the roles and responsibilities for implementation and on-going management of the policy and reporting procedures.

The activity covered by this policy includes hospital emergency department services, hospital outpatient care services, outreach services and non-residential community health services provided by NSW Health Services.

This document is relevant to NSW Health and affiliated health organisation:

- LHD/SHN/SVHN chief executives.
- LHD/SHN/SVHN non-admitted patient data collection stewards/coordinators.
- Hospital general managers and community health service managers.
- Managers of NSW Health non-admitted patient service units.
- Non-Admitted patient source system administrators.
- Chief Information Officers.

1.2 Key definitions

1.2.1 Definition: Non-admitted patient service

A *non-admitted patient service* is an interaction between a healthcare provider and a person who is not formally admitted to a hospital or multi-purpose service, that contains clinical and/or therapeutic content that results in a dated entry being made the person's physical or electronic medical record. The interaction may be for an assessment, examination, consultation, treatment and/or education.

1.2.2 Definition: Non-admitted patient support activity

A *non-admitted patient support activity* is an activity or interaction that supplements and/or supports the health or health care of a non-admitted person, personal carers or the community generally, but does not contain clinical and/or therapeutic content that results in a dated entry being made in the person's physical or electronic medical record.

1.2.3 Definition: Non-admitted patient appointment

A *non-admitted patient appointment* is a planned or walk-in visit time slot allocated for one person to receive a *non-admitted patient service* through an interaction with one or more healthcare provider at the same time or in succession on the same calendar day. One non-admitted patient appointment may consist of one or many non-admitted patient occasions of service. A non-admitted patient appointment may or may not result in a non-admitted patient service being provided.

1.2.4 Definition: Non-admitted patient occasion of service

A *non-admitted patient occasion of service* is a *non-admitted patient service* or a *non-admitted patient support activity* reported for each provider type and service type combination on each occasion a service is provided to the patient within one non-admitted patient appointment on one calendar day.

1.2.5 Definition: Non-admitted patient (national) service event

A *non-admitted patient (national) service event* is an interaction between one non-admitted patient and one or more healthcare provider(s) who are working within the context of one service unit on one calendar day. The interaction must contain clinical and/or therapeutic content (i.e. an assessment, examination, consultation, treatment and/or education), that results in a dated entry being made in the patient's medical record. Non-admitted patient (national) service events exclude services provided by stand-alone diagnostic service units, travel by the healthcare provider or patient, services where the patient is not present, or services provided to persons who are admitted patients at the time of service provision.

Note: One *non-admitted patient (national) service event* may consist of one or more *non-admitted patient occasion of service* records, and one or more *non-admitted patient appointments. Non-admitted patient support activity* does not meet the definition of a *non-admitted patient (national) service event*, and is therefore excluded.

Source: Compiled from the Tier 2 Non-Admitted Services Compendium 2013-2014, Independent Hospital Pricing Authority.

1.2.6 Definition: Emergency Department non-admitted patient service

An *Emergency Department non-admitted patient service* is a *non-admitted patient service* provided by a hospital's Emergency Department team.

1.2.7 Definition: Ancillary occasion of service

An ancillary occasion of service is a service provided to one patient who is the subject of:

- one pathology diagnostic test, or a simultaneous set of related pathology tests, provided by a hospital's pathology service unit;
- one radiology/imaging diagnostic test, or a simultaneous set of related radiology/imaging services, provided by a hospital's radiology and organ imaging service unit;
- the filling of one order/script of pharmaceuticals, regardless of the number of items dispensed per script, provided by a hospital's pharmaceutical dispensing service unit.

1.2.8 Definition: Non-admitted patient service unit

A *non-admitted patient service unit* is a recognised clinical team of one or more healthcare providers within a hospital, multi-purpose service or community health service that provides *non-admitted patient services* and/or *non-admitted patient support activities* in defined locations, at regular or irregular times. A non-admitted patient service unit generally consists of multiple healthcare providers, who may be practicing the same or different disciplines or specialties. In some health services a service unit may consist of only one individual healthcare provider.

1.2.9 Definition: Service unit level 'establishment type'

The service unit level 'establishment type' is NSW Health's classification of service units that aligns to the National Tier 2 Clinic Type classification.

1.2.10 Definition: National Weighted Activity Unit (NWAU)

The National Weighted Activity Unit (NWAU) is a measure of Health Service activity expressed as a common unit, against which the National Efficient Price (NEP) is paid. It provides a way of comparing and valuing each public hospital service (whether they be admissions, emergency department presentations or outpatient episodes), by weighting for its clinical complexity. The average hospital service is worth one NWAU – the most intensive and expensive activities are worth multiple NWAUs, the simplest and least expensive are worth fractions of an NWAU.

Source: http://www.publichospitalfunding.gov.au/glossary

1.2.11 Definition: Local Health Districts (LHDs)

Local Health Districts (LHDs) means the following local health districts constituted under Section 17 and specified from time to time in Schedule 1 of the *Health Services Act 1997*:

- Central Coast Local Health District
- Illawarra Shoalhaven Local Health District
- Nepean Blue Mountains Local Health District
- Northern Sydney Local Health District
- South Eastern Sydney Local Health District
- South Western Sydney Local Health District
- Sydney Local Health District
- Western Sydney Local Health District
- Far West Local Health District
- Hunter New England Local Health District
- Mid North Coast Local Health District
- Murrumbidgee Local Health District
- Northern NSW Local Health District
- Southern NSW Local Health District
- Western NSW Local Health District

Note: For the purpose of this policy and procedures, with the exception of organisations prescribed for reporting under the "St Vincent's Health Network", affiliated health organisations prescribed under Schedule 3 of the *Health Services Act 1997* that are located within the boundaries of a Local Health District are in scope of the Local Health District's reporting requirements.

1.2.12 Definition: Specialty Health Networks (SHNs)

Specialty Health Networks mean the following statutory health corporations prescribed under Schedule 2 of the *Health Services Act 1997*:

- The Sydney Children's Hospital Network (Randwick and Westmead)
- Justice Health and Forensic Mental Health Network

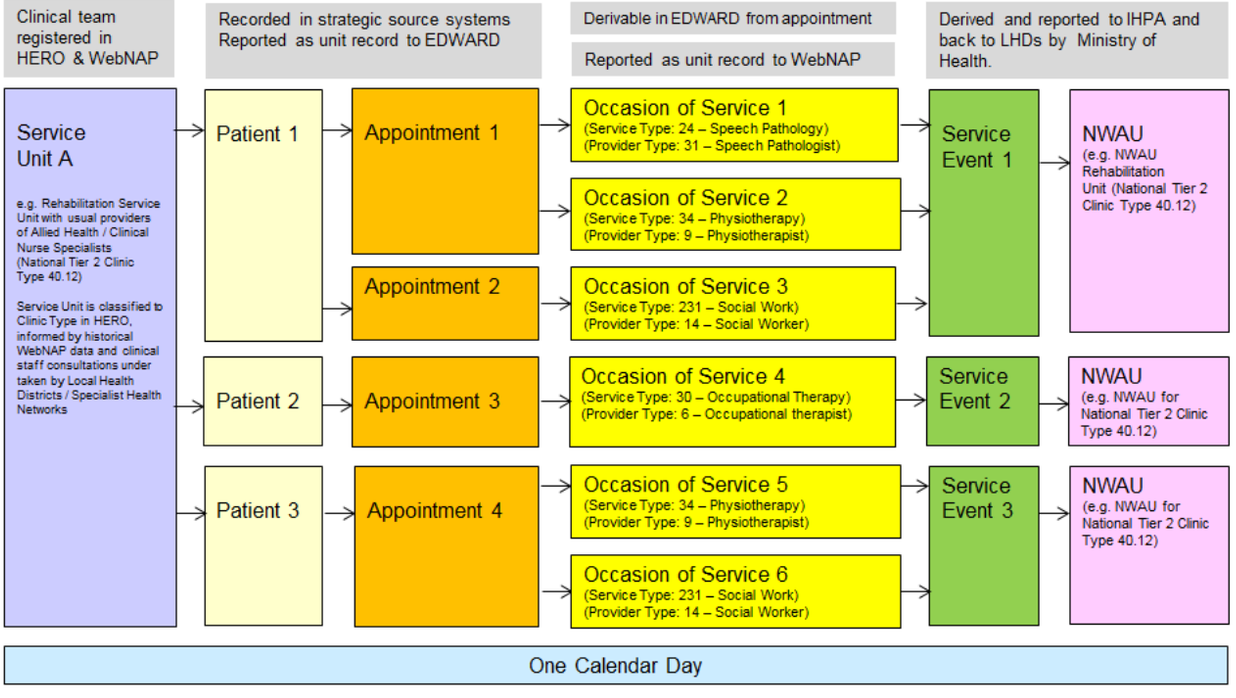
1.2.13 Definition: St Vincent's Health Network (SVHN)

The St Vincent's Health Network means the following affiliated health organisations prescribed under Schedule 3 of the *Health Services Act 1997*:

- St Vincent's Hospital, Darlinghurst
- Sacred Heart Hospice, Darlinghurst
- St Joseph's Hospital, Auburn

1.3 Diagram of conceptual relationships

The diagram below shows the conceptual relationships between service units, patients, appointments, occasion of service, service type, provider type, national service event and the National Weighted Activity Unit (NWAU) for funding.



1.4 Statutory reporting obligations

This policy supports onward reporting to a number of non-admitted patient activity related national data sets:

- Establishments National Minimum Data Set, Australian Institute of Health and Welfare, Australia Department of Health and Ageing.
- Outpatients National Minimum Data Set, Australian Institute of Health and Welfare, Australian Department of Health and Ageing.

- Non-admitted Patient Activity Based Funding Data Set, Independent Hospital Pricing Authority.
- Non-admitted Patient Activity Costs Data Collection, Independent Hospital Pricing Authority.

The policy makes reference to the additional requirements for onward reporting to the following non-admitted patient activity national data sets:

- Alcohol and other drugs National Minimum Data Set, Australian Institute of Health and Welfare, Australian Department of Health and Ageing.
- Community Mental Health National Minimum Data Set, Australian Institute of Health and Welfare, Australian Department of Health and Ageing.
- Mental Health Establishments National Minimum Data Set, Australian Institute of Health and Welfare, Australian Department of Health and Ageing.
- Home and Community Care National Minimum Data Set, Australian Institute of Health and Welfare.
- Aged Care Assessment Program National Minimum Data Set, Australian Department of Health and Ageing.

1. Non-admitted Patient Data Collection Coverage

2.1 Coverage statement

The policy and procedures covered by this document apply to all activity that meets the definition of a *non-admitted patient service* provided by, or contracted out by, any of the following:

- Local Health District
- Specialty Health Network
- An affiliated health organisation, prescribed under the *Health Services Act, 1997.*

All *non-admitted patient services* provided by the above organisations are in scope of the reporting requirements regardless of the patient service billing arrangement (i.e. non-charge, privately referred, compensable, Medicare ineligible, patient fee co-contribution etc.) and funding program or funding source.

All *non-admitted patient support activities* are non-mandatory reporting requirements, which may be reported at the discretion of the LHD/SNH.

2.2 Coverage Clarification: Services provided by external parties under a contract with a NSW Health organisation

Non-admitted patient services that are contracted out to any private sector organisation, not for profit organisation, or Visiting Medical Officer that are paid for by a NSW Health organisation under a fee for service or sessional service contract are in scope of the reporting requirements of the non-admitted patient activity reporting requirements prescribed by this policy and procedures document.

Privately referred activity provided under these contractual arrangements where a NSW Health organisation bills the patient, or a 3rd party organisation, are in scope of the reporting requirements.

Note: Contracts need to include a clause that requires the contracted service provider to make available to the purchasing organisation the data/information required to fully comply with the minimum data set and reporting requirements outlined in this document. The activity is to be reported against a 'virtual' service unit that is to have the purchasing hospital or community health services as the parent organisation.

2.3 Coverage Clarification: Services provided by a private practice, hospital or day procedure centre

Non-admitted patient services that are provided by a private practice, private hospital or private day procedure centre that rents space to operate on NSW Health property under a commercial contract and directly bills the patient or a 3rd party organisation (other than a NSW Health organisation) under their own Australian Business Number are not in scope of the non-admitted patient activity reporting requirements prescribed by this policy and procedures document.

2.4 Coverage Clarification: Services provided to a patient of a private practice, hospital or day procedure centre

Non-admitted patient services that are provided by a NSW Health organisation to a patient of a private practice, private hospital or private day procedure centre under a fee for service or sessional service contract basis, or where the NSW Health organisation directly bills a 3rd party insurer, Medicare or the patient to recover full cost of providing the service (such as pathology services), are not in scope of the non-admitted patient activity reporting requirements prescribed in this document.

2. Minimum data set for all non-admitted patient services

3.1 Overview

This section prescribes the minimum data set that must be reported for all non-admitted patient services, regardless of their clinical specialty.

The following standards have been used in the tables to indicate the requirements:

- "#" Indicates a field that is in scope of national reporting requirements to the Independent Hospital Pricing Authority, or used to derive or map to a data element in scope of those requirements.
- Where the WebNAP and EDWARD data repositories have a different concept name, both descriptions have been provided.
- In terms of mandatory status:
  - "Yes" means the data element is available and must be reported.
  - "Conditional" means that the data element is mandatory for reporting under particular conditions. These conditions are clarified below each table.
  - "No" means the data element is available in the system, but optional for reporting. Such data element may support local reporting.
  - "n.a." means 'not applicable', that is, the data element is not in scope of the data repository.

There are additional requirements to report non-admitted patients services to other data collections where they are of the following type:

- alcohol and other drug services (**PD2015_014**),
- mental health services (**PD2006_041** & **PD2006_042**),
- emergency department services (**PD2005_198**),
- home and community care services (**PD2008_050**), and
- aged care assessment program services (**PD2007_080**).

The additional requirements for reporting to these data collections are prescribed in separate policies shown above. The requirement for NSW Health Services to report to those separate data collections will continue until such time that those policies are rescinded and/or all non-admitted patient data collections have been migrated to EDWARD.

3.2 Non-admitted patient service unit characteristics

3.2.1 Mandatory data elements - service unit

The table below shows the business mandatory status of characteristics about non-admitted patient service units that must be reported to the Ministry of Health.

Data Element	Mandatory for WebNAP	Mandatory for HERO/EDWARD
Service Unit HERO Identifier #	Yes	Yes
Service Unit WebNAP Code	Yes	No
Service Unit Name	Yes	Yes
Service Unit Establishment Type Code #	n.a.	Yes
Service Unit First Open Date	Yes	Yes
Service Unit Permanent Closure Date	Yes	Yes
Service Unit Address - Physical	n.a.	Yes
Administrative Parent Facility HIE Facility ID	Yes	No
Administrative Parent Facility HERO ID #	No	Yes
Local Health District/Specialty Health Network HIE Facility ID	Yes	No
Local Health District/Specialty Health Network HERO ID #	n.a.	Yes
Local Health District Physical Location Boundary	n.a.	Yes
Service Unit Source System	n.a.	No

3.2.2 Optional data elements - service unit

The table below shows the optional characteristics about non-admitted patient service units that may be recorded (for example, to support local reporting requirements).

Data Element	Available in WebNAP	Available in EDWARD
Service Unit Division Name	Yes	No
Service Unit Division Code	Yes	No
Service Unit Cost Centre	Yes	Yes
Service Unit Community Health Service Flag	No	Yes

3.2.3 Mandatory data elements - service option

The registration of “service options” is only relevant to services reported using WebNAP and is a requirement that enables loading and data entry of summary level data.

Note: The Service Option is reported on the same file as the Service Unit. Therefore the mandatory fields for both Service Unit (above) and Service Option (below) must be reported in the extract file submitted to WebNAP.

Data Element	Mandatory for WebNAP
Service Unit WebNAP Code	Yes
Service Option – Effective From Date	Yes
Service Option – Effective To Date	No
Service Option – Provider Type Code	Yes
Service Option – Service Type Code	Yes
Service Option – Setting Code	Yes
Service Option – Modality Code	Yes
Service Option – Funding Source Code	Yes

3.3 Non-admitted patient level data

3.3.1 Overview

Non-admitted patient level data consists of patient characteristics, and service characteristics. When reporting activity to WebNAP the unit record level data is an occasion of services. When reporting non-admitted patient activity to EDWARD or HIE, the unit record level data reported varies according to the source system and data collection data is reported to, and includes appointments, encounters, service episodes or service contacts.

Note: The concept that must be reported to the Independent Hospital Pricing Authority for activity based funding - a nationally defined 'service event' - will be derived by the Ministry of Health when preparing the data for national reporting, based on the national business rules.

3.3.2 Mandatory data elements - patient characteristics

The table below shows the patient characteristics that are in scope of reporting and their mandatory status for reporting via WebNAP and EDWARD for services provided on or after 1 July 2013.

For variable patient characteristics, such as address of usual residence, the characteristics at the time the service was provided must be reported.

Note: Patient characteristics must be recorded in either the iPM or Cerner HNA Millennium patient registration module, and should be transferred to other non-admitted patient source systems as HL7 messages. Updates and corrections must always be made in iPM and Cerner HNA Millennium. See the Client Registration Policy and Client Registration Guidelines for further details on these requirements.

Data Element	Mandatory for WebNAP	Mandatory forEDWARD
Patient – Identifier Type Flag #	Yes	Yes
Patient – Identifier Issuing Authority	N.a.	Yes
Patient – Identifier #	Yes	Yes
Patient – Area Unique Person Identifier	No	n.a.
Patient – Facility Medical Record Number	No	n.a.
Patient – First Name (WebNAP) *1 Patient – Given Name (EDWARD) *1	Yes	Yes
Patient – Last Name (WebNAP) *1 Patient – Family Name (EDWARD) *1	Yes	Yes
Patient – Gender (WebNAP) Patient – Sex Code (EDWARD) #	Yes	Yes
Patient – Date of Birth #	Yes	Yes
Patient – Country of Birth Code #	Yes	Yes
Patient – Aboriginality Code (WebNAP) Patient – Indigenous Status Code (EDWARD)	Yes	Yes
Patient – Street Address of Usual Residence #	Yes	Yes
Patient – Suburb / Locality of Usual Residence #	Yes	Yes
Patient – Postcode of Usual Residence #	Yes	Yes
Patient – State of Usual Residence #	N.a.	Yes
Patient – Country of Usual Residence #	N.a.	Yes
Patient – DVA Card Type *2	Conditional	Conditional
Patient – DVA File Number *2	Conditional	Conditional

*1 – See Client Registration Policy and Client Registration Guidelines for standards for registering clients as anonymous patients.
*2 – DVA Card Type and File Number is required when the Financial Group/Financial Class/Billing Category indicates the service costs are the responsibility of the Department of Veterans' Affairs.

3.3.3 Mandatory data elements - service characteristics

The table below shows the service characteristics that are in scope of reporting and their mandatory status for reporting via WebNAP and EDWARD for services provided on or after 1 July 2013.

Data Element	Mandatory for WebNAP	Mandatory for EDWARD
Service Event Source System Identifier	Yes	Yes
Service Encounter Record Identifier	N.a.	Yes
Service Event Record Identifier	Yes	Yes
Source of Referral Code (WebNAP) # Request Source Type Code (EDWARD) #	Yes	Yes
WebNAP Source of Referral Name	Yes	No
Referral Issue Date/Time (WebNAP) Request Correspondence Date/Time (EDWARD)	No	No
Referral Receipt Date (WebNAP) Request Received Date (EDWARD)	Yes	Yes
Booking Create Date/Time (WebNAP) Offer Issue Datetime (EDWARD)	Yes (*1)	Yes (*1)
Service Event Start Date/Time #	Yes	Yes
Provider Type Code (WebNAP) Individual Provider Speciality / Discipline Code (EDWARD)	Yes	Yes
Setting Type Code (WebNAP) # Primary Setting Type Code (EDWARD) #	Yes	Yes
Modality of Care Code (WebNAP) # Service Contact Mode Code (EDWARD) #	Yes	Yes
Initial or Subsequent Service Code	Yes	Yes
Group Session Flag #	N.a.	Yes
Group Session Identifier #	N.a.	Yes
Client Participated Flag	N.a.	Yes
Financial Group Code (WebNAP) # Billing Category Code (EDWARD) #	Yes	Yes
Funding Source Code (WebNAP) Primary Program Funding Source Code (EDWARD)	Yes	Yes
Service Type Code (WebNAP) NAP Service Type Code (EDWARD)	Yes	Yes
Care Type NHDD Code #	N.a.	Yes
Medicare Benefit Scheme Item Number(s) (WebNAP) Service Activity Reference Source Identifier (EDWARD) Service Activity Reference Domain Identifier (EDWARD) Service Activity Code (EDWARD)	Conditional (*1)	Conditional (*1)
Service Event End Date/Time	Yes (*1)	Yes (*1)
Direct Contact Time Band	N.a.	No

Note: (*1) These data elements become mandatory for reporting from 1 July 2014.

3.4 Non-admitted patient summary level data

3.4.1 Mandatory data elements

The table below shows the data elements that are mandatory for reporting summary level occasion of service counts to WebNAP.

Data Element
Service Unit WebNAP Code
Service Unit HERO Identifier
Service Unit Name
Administrative Parent Facility HIE Facility ID
Service Type Code
Setting Type Code
Provider Type Code
Modality of Care Code
Funding Source Code
Reporting Month
Reporting Year
Occasion of Service Count – Department of Veterans' Affairs Financial Group
Occasion of Service Count – Department of Veterans' Affairs (Contracted) Financial Group
Occasion of Service Count – Department of Veterans' Affairs (Privately Referred) Financial Group
Occasion of Service Count – Ineligible Financial Group
Occasion of Service Count – Lifetime Care and Support Financial Group
Occasion of Service Count – Motor Accident Authority Financial Group
Occasion of Service Count – Motor Accident Authority (Driver at Fault) Financial Group
Occasion of Service Count – Motor Accident Authority (Not Driver at Fault) Financial Group
Occasion of Service Count – Workcover Compensable Financial Group
Occasion of Service Count – Transcover Compensable Financial Group
Occasion of Service Count – Other Compensable Financial Group
Occasion of Service Count – Non-Chargeable Financial Group
Occasion of Service Count – Private Contract Financial Group
Occasion of Service Count – Private Referred Financial Group
Occasion of Service Count – Special Purposes Trust Financial Group
Occasion of Service Count – Total Group Sessions
Occasion of Service Count – Total Group Patients

3. Requirement to register and classify service units

4.1 Requirement to register non-admitted patient service units

All non-admitted patient service units must be registered in HERO. Where activity is reported via WebNAP, an equivalent service unit must also be setup in WebNAP.

4.2 Requirement to ensure registered non-admitted patient service units align with clinical service teams and structures

Historically some health services created non-admitted patient service units in WebNAP that do not align with recognised clinical service teams and structures. These historical service units may have been established to simplify summary level statistical reporting.

To support the activity based funding model from 1 July 2013, and support reporting at the patient level, registered non-admitted patient service units must be a reflection of the recognised clinical teams within a single hospital or community health service.

Any service unit that has does not reflect a recognised clinical team within a single hospital or community health service must be closed by 30 June 2013 and replaced by service units that are recognised clinical service teams within a single hospital or community health service.

4.3 Requirement to classify non-admitted patient service units

Each service unit must be appropriately classified to an 'establishment type'.

The 'establishment type' classification (categories and definitions) has changed to align with the 2013/14 IHPA Tier 2 Clinic Type classifications. This classification is expected to change each year as non-admitted patient activity based funding matures. A review of the assigned 'establishment type' must therefore be undertaken in June every year.

Where the service unit registered in HERO and WebNAP meets the definition of multiple 'establishment type' categories it should be flagged for a more detailed review. If the service unit aligns with only one recognised clinical team within a single hospital, multi-purpose service or community health service, the service unit must be allocated to the category that represents the majority of services provided (i.e. 50% or more of the services provided).

If a service unit registered in HERO and WebNAP aligns with two or more recognised clinical teams within a single hospital, multi-purpose service or community health service the service unit registration should be end dated as a reporting entity, and new service units should be registered for reporting that align with the recognised clinical teams. Each new service unit should be assigned the appropriate establishment type. Activity should thereafter be reported under those replacement service units.

Historical data may be used to assist in the allocation of the service unit's 'establishment type' in HERO. However, as historical data may be unreliable, an independent review of the provider type/ discipline/speciality of the individual healthcare providers and clinical services provided should be conducted to identify the correction service unit level 'establishment type'.

Note: The classification of a service unit to the most appropriate service unit level 'establishment type' category is essential because it is a key factor in determining the levels of Activity Based Funding.

4.4 Requirement to report summary level and patient level data under the same service unit

From 1 July 2013, it is a mandatory requirement to report the summary level total occasion of service counts to WebNAP under the same service unit as used for reporting the patient level data that make up that total.

4.5 Requirement to automate calculation of summary level occasions of services based on patient level data

The summary counts reported to WebNAP must be based on automated aggregation of the patient level data to ensure front line staff do not have to separately record data at both the patient level and summary level.

4.6 Requirement to align service units in source systems, HERO and WebNAP

From 1 July 2013, it is a requirement for service units to align in source systems, HERO and WebNAP.

There must be a one to one relationship between the service units registered in HERO and WebNAP.

Service units registered in HERO must align with the service units (clinics) as created in source systems. There should generally be a one to one relationship between the service unit created in a source system and the service unit registered in HERO and WebNAP.

When activity is reported to EDWARD the source system service unit must be aliased with the HERO Identifier assigned to the service unit by HERO during the registration process. This ensures data quality issues can be communicated to the clinical team that provided the services.

One service unit in a source system may not be created as two or more service units in HERO or WebNAP.

Note: If reporting activity via EDWARD any activity reported for a service unit that is not aliased with the HERO Identifier will be excluded from reporting – these records are hidden from end users by the EDWARD security framework as the source of the data cannot be determined.

4.7 Requirement to record the HERO Identifier against the service unit in WebNAP

The HERO Identifier must be reported against every WebNAP service unit. This is required to support the linkage of WebNAP service units to the HERO service unit where the service unit level 'establishment type' will be maintained.

4.8 Data quality audits

The Ministry of Health will undertake data quality audits. These may focus on the following:

- the structure of service units, to ensure against the splitting of service unit structures merely to increase the number of national service event records per patient per calendar day;
- the 'establishment type' that service units have been assigned in HERO, to assure against the assignment of an establishment type that attract a higher NWAU and does not accurately reflect the majority of services provided by the service unit;
- the quality and completeness of data reported for specific data elements (e.g. the Service Type is appropriate for the Provider Type reported); and
- source system functionality and build compliance with the mandatory reporting requirements, including the availability of all mandatory fields, availability of all categories within a standard classification and mappings to the State level standard classification code set.

To support the data quality audits, where a service unit can be classified to more than one establishment type or the service unit name does not clearly match one establishment type, LHDs/ SHNs/SVHN must document the justification for the final classification decision in HERO in the entity registration "Comments" or "Services Provided" field.

4. Requirement to report summary occasion of service counts

From 1 July 2013, all non-admitted patient services provided within each calendar month must continue to be reported via WebNAP at the summary level as a monthly total occasion of service count for each unique combination of the following attributes:

- Service unit
- Service option, that is a combination of:
  - Provider Type Code

  - Service Type Code
  - Service Setting Code
  - Modality of Care Code
  - Funding Source Code
- Financial Group Code

Summary counts may either be reported via the WebNAP Version 2.0 data extract summary file format or directly entered into WebNAP.

Monthly occasion of service summary counts must be reported to WebNAP until 30 June 2014, or the date approved by the Director, Health System Information & Performance Reporting Branch. Prior to 30 June 2014, summary counts must reconcile with the patient level data reported via WebNAP for at least 6 months.

LHDs/SHNs may apply to the Director, Health System Information & Performance Reporting Branch for an early exemption from summary level reporting for all non-admitted patient service units using the same source system build and extract where they can demonstrate that the equivalent patient level data has reconciled with summary counts for a period of 6 months.

Note: There is no requirement or facility to report summary level non-admitted patient data to EDWARD.

5. Requirement to report patient level data

6.1 Requirement to report non-admitted patient occasion of service unit record level data to WebNAP

WebNAP has been established as an interim patient level reporting system.

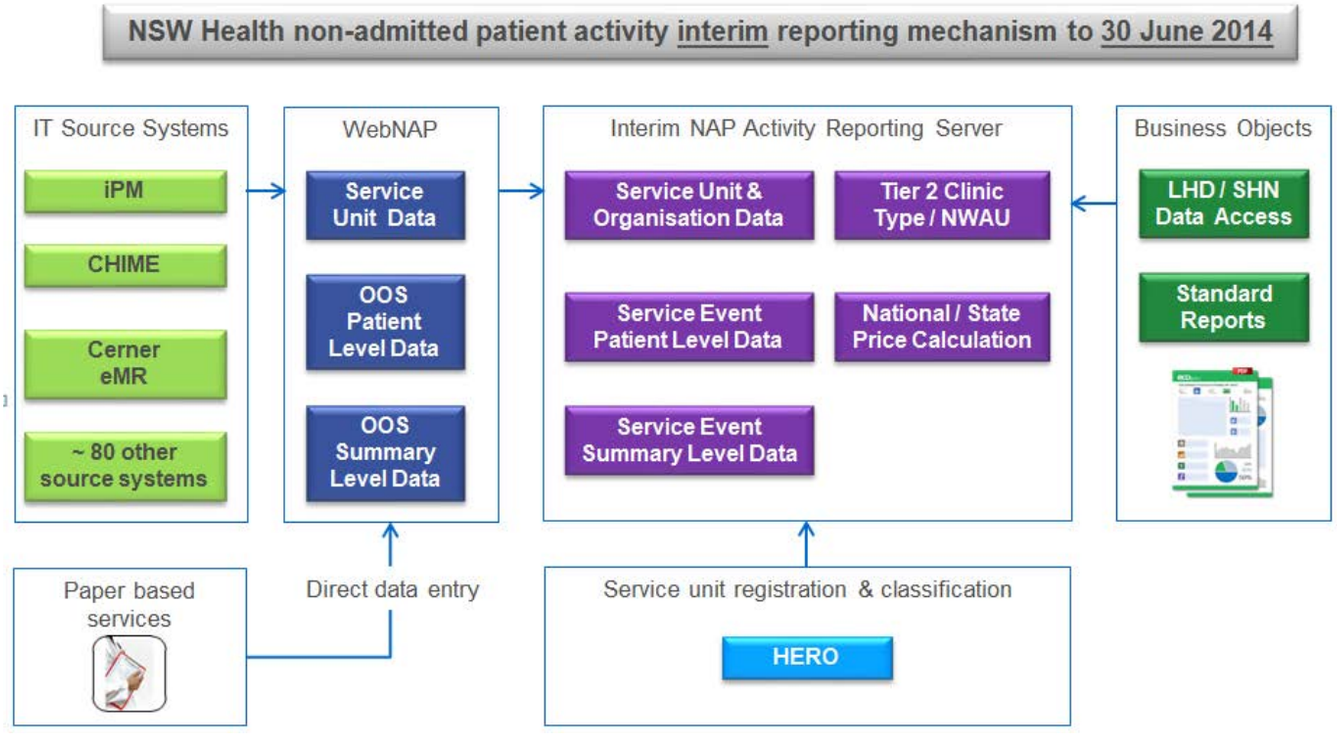
The following non-admitted patient services are not required to be reported to WebNAP at the patient level under this policy:
- Emergency Department services,
- Pathology testing services,
- Radiology imaging services, and
- Pharmacy dispensing services.

Any requirement to report pathology testing, radiology imaging and pharmacy dispensing services at the patient level will be prescribed in a separate policy.

All other services that meet the definition of a non-admitted patient service that are provided up to and including 30 June 2014 must be reported via WebNAP at the patient level.

Where a source system is used to record non-admitted patient services via WebNAP the activity must be reported via the WebNAP Version 2.0 patient level extract format. See the "WebNAP Version 2.0 extract requirement specification" guideline document for detailed requirements.

Where a source system is not used, each patient level occasion of service record must be entered into WebNAP via direct data entry screens, or otherwise prepared in the WebNAP Version 2.0 patient level extract format and uploaded.

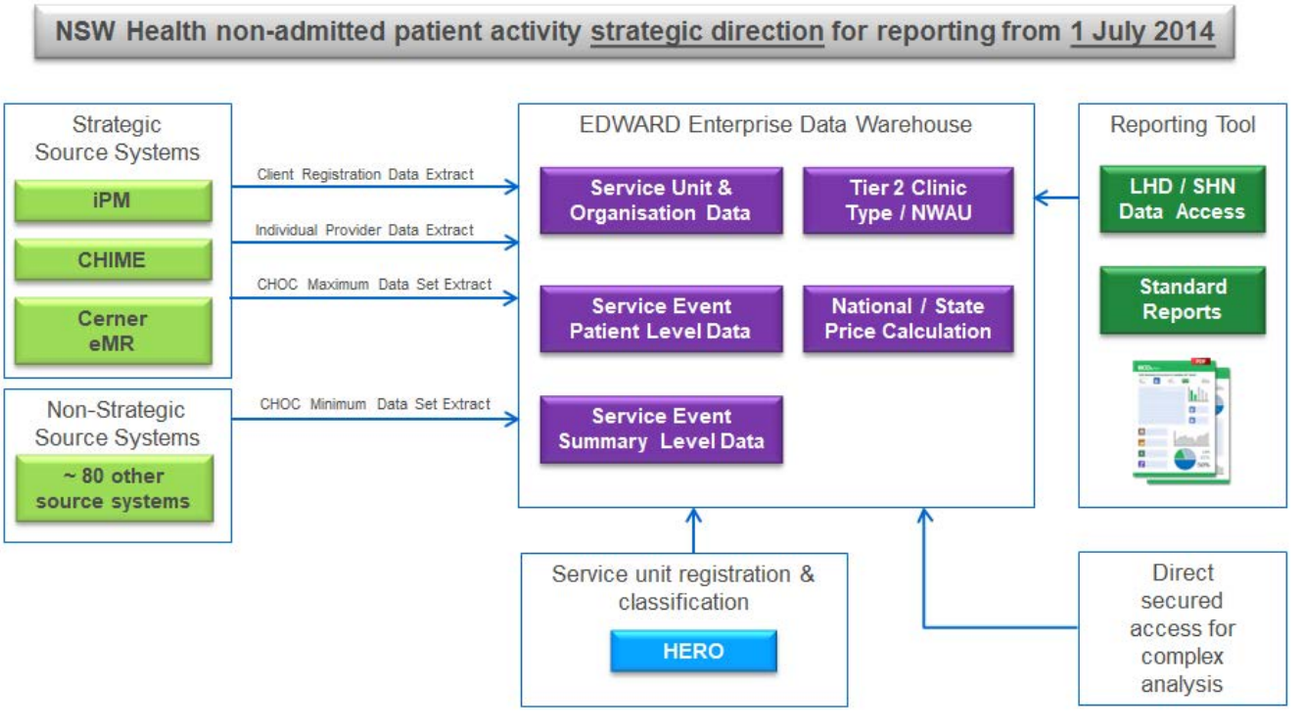


6.2 Reporting patient level data via EDWARD

It is NSW Health's strategic direction to move to non-admitted patient level reporting via EDWARD from 1 July 2014. LHDs/SHNs/SVHN must take the necessary steps to move to reporting via EDWARD by this date.

To report data to EDWARD the following must be in place by 1 July 2014:

- All patient/clients must be registered in either the iPM or Cerner HNA Millennium patient registration module, in line with the Client Registration Policy Directive; and
- All patient/client identifiers must be recorded the iPM or Cerner HNA Millennium patient registration module, in line with the Client Registration Policy Directive; and
- The EDWARD Client Characteristics Interface from the iPM or Cerner HNA Millennium patient registration module must be in production and report data daily to EDWARD; and
- Either:
  - the EDWARD Community Health and Outpatient Care Maximum Data Set Interface must be in production and report data daily (or at least monthly) to EDWARD from the relevant non-admitted patient source system build OR
  - the EDWARD Community Health and Outpatient Care Minimum Data Set Interface must be in production and report data daily (or at least monthly) to EDWARD from the relevant non-admitted patient source system build.



The Ministry of Health will consider requests from Local Health Districts and Specialty Health Networks to report patient level data via EDWARD instead of WebNAP prior to 1 July 2014 if the all of the above is in place and the LHD/SHN/SVHN has:

- Resolved any source system build non-compliance with the EDWARD data dictionary and interface requirement specifications for data elements within scope of the non-admitted patient minimum data set prescribed in this policy; and
- Reconciled the data in EDWARD against source systems; and
- Provided written confirmation to the Health System Information and Performance Reporting Branch that the data reported via EDWARD is reconciled with the source and meets the minimum data set requirements; and
- Formally requested an exemption from reporting patient level data to WebNAP via written correspondence from the Chief Executive to the Director, Health System Information and Performance Reporting Branch.

Parallel reporting to WebNAP is expected until such time that the Local Health District or Speciality Health Network has fully complied with the above.

Note: There are a number of advantages of EDWARD over WebNAP, including more streamlined data submission, safeguards against duplicate records, a dedicated reporting area, and server capacity.

6.3 Reporting of Emergency Department services

Summary level counts of non-admitted patient occasion of service delivered on or after 1 July 2013 must be reported to WebNAP for all emergency department services where:

- the patient is not formally admitted to the hospital, and
- the service is not reported at the patient level to the Emergency Department Data Collection.

Non-admitted patient services that are delivered in Emergency Departments must be reported at the patient level to HIE (Health Information Exchange)/EDWARD in compliance with the reporting requirements of the Emergency Department Data Collection policy.

Emergency Department presentations delivered on or after 1 July 2013 that are in scope of patient level reporting to the Emergency Department Data Collection must not be reported to WebNAP at either the summary level or patient level.

Note: The total number of services provided by Emergency Departments provided on or after 1 July 2013 will be the sum of the summary level occasions of service reported to WebNAP and the total presentations (admitted and non-admitted) reported at the patient level to the Emergency Department Data Collection.

6.4 Reporting of mental health services

Non-admitted patient mental health services must be reported as follows:

- At the summary level occasion of service counts to WebNAP; AND
- At the occasion of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the service event patient level to HIE in accordance with the Community Mental Health Ambulatory (CHAMB) Data Collection and Mental Health Assessment and Outcomes Team (MHOAT) Data Collection requirements.

Note: Mental health services recorded on CHIME are also in scope of reporting of service events to EDWARD.

6.5 Reporting of alcohol and other drug services

Non-admitted patient alcohol and other drug services must be reported as follows:

- At the summary level occasion of service counts to WebNAP; AND
- At the occasion of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the service episode level to HIE in accordance with the requirements of the Alcohol and Other Drugs Data Collection.

6.6 Reporting of home and community care services

All non-admitted patient home and community care (HACC) program services, including services delivered under the program that contain no clinical or therapeutic content, must be reported at the service event patient level to HACCIRS data repository.

Non-admitted patient service units that deliver services that contain clinical and/or therapeutic content to HACC program eligible clients/patients only, or to a mix of HACC eligible and HACC ineligible clients/patients, must also report the services:

- At the occasion of service summary level to WebNAP; AND
- At the occasions of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014.

Note: HACC eligible patients need to be reported to WebNAP with a Funding Source Code of '5; (Federal) and to EDWARD with a Primary Program Funding Source Code of '01' (Home and Community Care Program).

6.7 Reporting of oral health services

Non-admitted patient oral health services must be reported as follows:

- At the occasion of service summary level to WebNAP; AND
- At the occasions of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the visit level to the NSW Oral Health Data Collection via the ISOH extract files set.

6.8 Reporting of aged care assessment program services

Non-admitted patient aged care assessment program services must be reported as follows:

- At the occasion of service summary level to WebNAP; AND
- At the occasions of service patient level to WebNAP (or EDWARD if exemption to report to WebNAP has been requested and granted) to 30 June 2014; AND
- At the patient level to EDWARD from 1 July 2014; AND
- At the assessment process and care/plan outcome level to the Aged Care Assessment Program Minimum Data Set.

6.9 Reporting of ancillary services

Pathology testing services, radiology imaging services, and pharmacy dispensing services pertaining to non-admitted patients must be reported as summary level occasion of service counts to WebNAP.

Medical consultation services provided by ancillary services are in scope of the reporting requirements described in this policy and procedures document and must be reported at both the summary and patient level.

Note: Any requirement to report Pathology testing services, radiology imaging services, and pharmacy dispensing services at the patient level will be issued in a separate policy.

6.10 Reporting of transport services

Community transport services provided to clients/patients should be reported to the NSW Health Integrated Community Transport Data Set (ICTDS).

6.11 Reporting of services to clients/patients who are not registered

Non-admitted patient services that are provided to clients/patients in the community who are not registered because they are receiving a community group immunisation/screening service, health promotion service, needle exchange service, or services where registration may inhibit their participation in the service (such as supervised injecting room services) must be reported at the summary level but patient level reporting is optional.

Where such activity is reported at the summary level only they must be reported under a service unit setup for the reporting of this summary level activity only – no patient level activity should be reported under these service units.

6.12 Requirement to comply with business rule guidelines

All non-admitted patient activity data reported to EDWARD or WebNAP must be reported in compliance with the non-admitted patient activity reporting business rules guidelines.

The guidelines provide detailed level information about the data collection's scope (inclusion and exclusions). In addition, the reporting requirements for specific scenarios are provided.

Access to the business rules is provided via the following URL:

- **http://internal.health.nsw.gov.au/data/collections/index.html**

6.13 Requirement to comply with data dictionary classifications

Data reported via WebNAP must comply with the WebNAP Data Dictionary for 2013/14 published on the NSW Health Intranet.

Data reported via EDWARD must comply with the Client Characteristics, Individual Service Provider Characteristics, Community Health and Outpatient Care Service Event Maximum Data Set and Community Health and Outpatient Care Minimum Data Set EDWARD Data Dictionaries published in HIRD (Health Information Resources Directory).

Access to these data dictionaries are provided via the following URL:

- **http://internal.health.nsw.gov.au/data/collections/index.html**

Compliance means all the relevant classification categories (or local equivalents) must be available in source systems and be mapped to the appropriate state code.

Note: The classification standards between WebNAP and EDWARD differ. This can be handled in source systems by using the more detailed classification (usually EDWARD) and mapping the classification to the relevant WebNAP or EDWARD code as an outbound alias/alternative identifier code.

6. Requirement to register source system build used for recording non-admitted patient services

It is a mandatory requirement for Local Health Districts and Specialty Health Networks to identify and register each build/instance of each source system used for recording non-admitted patient services with the Ministry of Health.

Note: The register of the source system builds will be maintained by the Health System Information and Performance Reporting Branch. A unique source system build identifier will be assigned and this unique source system build identifier must be reported on each patient unit record submitted to WebNAP and EDWARD. This information will be used to monitor completeness of the data collection across the relevant data repositories, and identify data quality or non-compliance issues relating to a specific build of a source system.

7. Requirement to provide status report of source system extract implementation

A monthly status report of the progress of modifications to each source system build to comply with the minimum data set and the classifications prescribed in the data dictionaries, and the development of the source system's WebNAP and EDWARD extracts, must be provided to the Health System

Information and Performance Reporting Branch by the Local Health District/Specialty Health Network until such time that both the WebNAP Version 2.0 extracts and, following this, the EDWARD extracts, are delivered and installed in production environments.

8. Due dates for reporting

Non-admitted patient activity data at both the summary level and patient level must be submitted, and be of acceptable quality, by the 15th working day of the month after the month the service was delivered.

Data reported via EDWARD from strategic source systems, such as iPM, CHIME and the Cerner HNA Millennium Electronic Medical Record, is expected to be transferred automatically on a daily basis.

9. Quality and completeness of data

The quality of non-admitted patient activity data will be assessed through a set of data validation rules.

Data must be reported in a form compliant with the codes published in the WebNAP data dictionary (where activity is reported to WebNAP) or EDWARD data dictionaries (where activity is reported to EDWARD.

It is the source system administrator's responsibility, and the LHD/SHN non-admitted patient data steward/coordinator's responsibility, to ensure the local categories displayed to source systems users align with state standard categories and map to the appropriate state code. There must be at least one local classification category for each state classification category. Local categories that do not map to one state category in the WebNAP or EDWARD classification (that is they map to two or more categories), should be end dated so that they can no longer be selected by source system users from 1 July 2013.

For all data elements reported as a code, the local classification to state standard classification mappings must be submitted to the Data Quality Unit of the Health System Information and Performance Reporting Branch for a quality review prior to the production implementation of each extract and following any major change to local classifications.

10. Implementation

11.1 Source system and extract development

It is the responsibility of Local Health Districts and Specialty Health Networks to fund, specify, develop, test and implement:

- WebNAP Version 2.0 summary level and patient level extracts from all source systems.
- EDWARD extracts from source systems (other than iPM and CHIME which have been delivered).
- Changes to existing EDWARD iPM, CHIME and Cerner source system extracts to accommodate local variations of source system builds.
- The addition of all data elements in scope of the minimum data set into their source systems if they currently do not exist.
- The alignment of classifications and code mappings in source systems for all in scope data elements in compliance with the WebNAP, HIE and EDWARD data dictionaries.
- The creation of business rules, such as mandatory status on fields, within source systems to ensure completeness and accuracy of data.

Local Health Districts and Specialty Health Networks should liaise with the HealthShare Community Health and Outpatient Care Program regarding any shared services and IT capital program funding that may provide to assist health services comply with the statutory reporting requirements outlined in this policy.

11.2 Non-Admitted Patient Data Set Sponsor Responsibilities

By default, the Chief Executive of each LHD/SHN/SVHN is the Non-Admitted Patient Data Set Sponsor for the data pertaining to services provided by hospitals, multi-purpose services and community health services of the LHD/SHN/SVHN. The data sponsor role is responsible for:

- directing the resources required to comply with the reporting obligations prescribed by this policy;
- reporting on progress and issues relating to the reporting requirements at the executive level; and
- authorising access to data relating to services provided by their Local Health District/Specialty Health Network within the constraints of NSW Health Privacy Policy and legislation.

The Chief Executive may formally delegate the responsibilities of this role within the Local Health District or Specialty Health Network.

11.3 Non-Admitted Patient Data Steward/Coordinator Responsibilities

The Chief Executives of Local Health Districts and Specialty Health Networks must nominate a position for the role of Non-Admitted Patient Data Steward/Coordinator, and advise the Health System Information & Performance Reporting Branch of the incumbent's details.

The Non-Admitted Patient Data Steward/Coordinator role is responsible for:

- Ensuring all non-admitted patient service units are registered in HERO and WebNAP and that they align.
- Ensuring all non-admitted patient service units are correctly classified in HERO to the service unit level 'establishment type', which will be a key factor in cost weight assignment under the activity based funding model.
- Ensuring all service units have reported both summary level and patient level data to the Ministry of Health each month.
- Ensuring all source system builds used by service units within their Local Health District have classifications that comply with the relevant data dictionary and are correctly mapped to the relevant state categories and codes.
- Ensuring data reported to WebNAP and/or EDWARD is reconciled against source systems.
- Ensuring all service units are reporting all in scope services.
- Ensuring that non-admitted patient reporting business rules are being complied with by all services.
- Ensuring there are procedures in place for all new non-admitted patient services to be registered in HERO and WebNAP, and that they are informed of their reporting obligation.
- Ensuring there are procedures in place for all closed service units to be registered as closed in HERO and WebNAP.
- Ensuring that the summary level occasion of service count reported match the number of patient level data records reported each month.
- Ensuring data has been uploaded into WebNAP by the due date and that there a mitigation procedures in place to avoid the risk of creating duplicate records in data resubmissions.
- Reporting on progress made towards the establishment of production quality extracts of both summary level and patient level data to WebNAP and EDWARD.

11.4 Health System Information and Performance Reporting Branch Responsibilities

The Health System Information and Performance Reporting Branch is responsible for:

- Compiling the data from EDWARD, HIE and WebNAP into a single standardised data set and making it available in a secure way to Local Health Districts and Specialty Health Networks for their local analysis and reporting purposes.
- Transforming occasion of service records into service events that comply with the Independent Hospital Pricing Authority unit record counting rules.
- Providing end user orientation/training for WebNAP, HIE and EDWARD.
- Providing clarifications or reporting rules for particular scenarios in response to requests from Local Health Districts/Specialty Health Networks.
- Reviewing, and authorising, requests to migrate from reporting occasions of service via WebNAP to service events via EDWARD.

Attachment 1: Implementation checklist

LHD/SHN/SVHN/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Register all non-admitted patient service units in HERO and WebNAP	❑	❑	❑
	Notes:		
2. Align source system, HERO and WebNAP Service Units.	❑	❑	❑
	Notes:		
3. Record HERO Identifier of Service Unit against Service Unit registration in WebNAP	❑	❑	❑
	Notes:		
4. Review establishment type classification of Service Unit registrations in HERO against new definitions and classification changes implemented to align with Independent Hospital Pricing Authority requirements.	❑	❑	❑
	Notes:		
5. Conduct survey of source systems used to record non-admitted patient services, and obtain unique identifier for each source system build from Ministry of Health.	❑	❑	❑
	Notes:		

22. STATISTICAL INFORMATION AND DATA 22.24

IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
6. Modify source systems to comply with non-admitted patient minimum data set requirements.	❑	❑	❑
	Notes:		
7. Modify source systems to comply with non-admitted patient minimum data set requirements.	❑	❑	❑
	Notes:		
8. Modify existing WebNAP extracts to comply with the Version 2.0 interface format at both summary level and patient level.	❑	❑	❑
	Notes:		
9. Create new WebNAP extracts to comply with the Version 2.0 interface format at both summary level and patient level for source systems that don't yet have an extract by 30 June 2013	❑	❑	❑
	Notes:		
10. Establish policy and process to register all new service units prior to service commencement.	❑	❑	❑
	Notes:		
11. Establish processes to train all service units, including new service units prior to service commencement, on the mandatory minimum data set reporting requirements.	❑	❑	❑
	Notes:		
12. Identify all users that requried WebNAP accounts (e.g. for file upload or direct data entry for reporting of patient level data, complete application form and establish access.	❑	❑	❑
	Notes:		
13. Train service units without source systems on unit record level data entry directly into WebNAP.	❑	❑	❑
	Notes:		

22. STATISTICAL INFORMATION AND DATA 22.25

IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
14. Establish policy and process to register all new service units prior to service commencement.	❑	❑	❑
	Notes:		
15. Identify all users that requried EDWARD accounts (e.g. for reconciling iPM/CHIME data or statistical reporting), complete application form and establish access.	❑	❑	❑
	Notes:		
16. Review/reconcile non-admitted patient service event data in EDWARD for iPM and CHIME. Resolve data quality issues and compliance gaps.	❑	❑	❑
	Notes:		
17. Establish processes for approval of access to non-admitted patient (de-identified) data.	❑	❑	❑
	Notes:		
18. Review resourcing for the collection – consider establishment of hospital level data stewards to support Local Health District data steward.	❑	❑	❑
	Notes:		

NSW HEALTH DATA GOVERNANCE FRAMEWORK (GL2019_002)

(GL2019_002 rescinded PD2005_155)

PURPOSE

The NSW Health Data Governance Framework outlines the roles and responsibilities involved in data governance and the structures in place to ensure effective and consistent management of the data assets of NSW Health.

Effective data governance builds organisational capital, strengthens governance structures and ensures NSW Health data is managed, used and protected in line with legal and community expectations.

The Framework facilitates data quality and comprehensiveness, appropriate access to data, information security, and standardisation of concepts.

KEY PRINCIPLES

The Framework stipulates the accountabilities of all staff, contractors and other persons who, in the course of their work, contribute to or have access to a NSW Health statewide data asset. These accountabilities extend to establishment and justification for data assets, preparation and publication of all metadata, as well as exhaustive processes for the maintenance and disclosure of data from all NSW Health state-wide data assets.

These accountabilities apply to staff in the Ministry, as well as in all Districts and Networks, Pillars and any contracted agencies with access to NSW Health state-wide data assets.

A data asset is within the scope of this Framework if it meets all of the following criteria:

- Holds all relevant information from across NSW Health entities
- Is made up of patient, staff, workforce, organisation, student or financial information
- Is mandated either by law or a policy recognised by NSW Health.

The Framework also provides the ‘Principles of Data Governance for NSW Health’ that support the structured and consistent management of data assets and outlines the essential components of data governance, including description of the roles of Data Sponsor, Data Custodian and Data Steward.

The authority of the NSW Health Data Governance Framework is subject to compliance with relevant statutes, regulations and policies, including the NSW Health Code of Conduct.

The Framework should be made available to all staff and contractors to whom it applies.

USE OF THE GUIDELINE

The key responsibilities of NSW Ministry of Health, Pillars and eHealth NSW are to:

- Provide data sponsorship, custodianship and stewardship of state wide data assets
- Ensure alignment of data and IT governance
- Manage IT architecture, data architecture, infrastructure and security
- Work with Data Sponsors and Data Custodians to align data and IT governance
- Ensure information system developments consider downstream impacts on state wide data assets
- Provide data governance advice and education
- Establish data governance policies and procedures
- Ensure relevant delegations are in place to permit release of data in strict compliance with all relevant legislation, policies and standards

The key responsibilities of Local Health District / Specialty Health Network DataSources are to:

- Ensure compliance with all relevant legislation, policies and standards relating to data collection and supply
- Provide a timely response to any issues and matters raised by the Data Custodian or Data Steward
- Ensure that data is assessed and managed in line with data standards
- Inform Data Sponsors/Custodians of any local issues that will have an impact on data quality and integrity
- Provide data governance advice and education
- Designate a data asset co-ordinator or primary contact to liaise with the Data Custodian or Data Steward in relation to the data asset
- Establish local data governance processes, in compliance with relevant legislation, policies, standards and the NSW Health Data Governance Framework

It is the responsibility of all data users to:

- Ensure that data is recorded or collected according to data standards
- Report data errors and quality issues in a timely manner
- Ensure data security and privacy are maintained whenever data is accessed
- Ensure login details are kept confidential and are only used by the designated user
- Report any breach or suspected breach of data security or privacy
- Sign an acknowledgement of their obligations to protect data privacy
- Ensure compliance with all relevant legislation, policies and standards, including the NSW Health Code of Conduct
- Obtain approval from Data Sponsor or delegated authority for public release of data
- Abide by all terms and conditions associated with approval for access to data.

The Guidelines can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_002

NSW EMERGENCY DEPARTMENT DATA COLLECTION (EDDC) REPORTING AND SUBMISSION REQUIREMENTS (PD2018_047)

(PD2018_047 replaced PD2005_198)

PURPOSE

This Policy Directive covers reporting and submission requirements for the Emergency Department Data Collection (EDDC). This data is used to monitor patient presentations to, and the activity undertaken in, the Emergency Departments (EDs) of public hospitals and in scope contracted private hospitals in NSW. The collated data allows comparisons to ED benchmarks and targets. It is also used to review utilisation of the services, evaluate the effectiveness of strategies to improve performance and patient management, assist in funding and the allocation of resources, the planning of future services and for epidemiology and public health reporting at a state and national level.
The policy statement outlines the scope, submission and reporting, governance and responsibilities of the collection.

MANDATORY REQUIREMENTS

An EDDC record must be provided for each presentation to a NSW public hospital or contracted private hospital Emergency Department. This is to include all Emergency Services with an Emergency Service Role Delineation of Level 1 or above.

IMPLEMENTATION

Chief Executives of LHDs and SHNs are to ensure:

- This Policy Directive is distributed to all staff involved in collecting and supplying data for the EDDC. This includes staff of Emergency Department units, medical record and information services staff, staff supporting patient administration systems (PAS), HIE/EDWARD Coordinators and information / performance reporting staff .
- Sufficient and appropriate resources are assigned to enable the collection, capture, submission and monitoring of the EDDC data. This should include local data governance, data quality monitoring and associated processes.
- Staff have access to electronic systems able to report the data items in accordance with the *Emergency Department Data Collection Data Dictionary*.
- Data collected in accordance with this policy directive is submitted in compliance to the schedule provided and in the form required for submission.

NSW Emergency Department Data Collection (EDDC) Reporting and Submission Requirements: Procedures

BACKGROUND

About this document

This Policy Directive covers reporting and submission requirements for the Emergency Department Data Collection (EDDC). This data is used to monitor patient presentations to, and the activity undertaken in, the Emergency Departments (EDs) of public hospitals and in scope contracted private hospitals in NSW. The collated data allows comparisons to ED benchmarks and targets. It is also used

to review utilisation of the services, evaluate the effectiveness of strategies to improve performance and patient management, assist in funding and the allocation of resources, the planning of future services and for epidemiology and public health reporting at a state and national level.
This Policy Directive rescinds and replaces Policy Directive PD2005_198 concerning the NSW Emergency Data Collection.

Scope

An EDDC record must be provided for each presentation to a NSW public hospital or contracted private hospital Emergency Department. This is to include all Emergency Services with an Emergency Service Role Delineation of Level 1 or above.
An Emergency Presentation is where a person presents to the Emergency Department for emergency care and treatment. This includes patients that are transferred from another unit or ward within the facility or another facility's Emergency Department for treatment within the ED.
Presentations to an Emergency Department include, but are not limited to, patients who:

- Register to be seen for an ED service but did not wait for the service to be delivered
- Are triaged and advised to seek alternate services, and then depart the ED
- Are dead on arrival if an ED clinician certifies the death
- Are provided with clinical assessment and advice via telehealth. Such services must be identified as being provided via telehealth

A patient treated in the ED who is subsequently admitted to the hospital will require the reporting of an ED presentation to the EDDC and an admitted patient record reported to the Admitted Patient Data Collection.
All patients remain in-scope for this collection until they are recorded as having physically departed the emergency department, regardless of whether they have been admitted.
Not in scope of the EDDC is:

- Care provided to a patient in a general practitioner co-located unit
- Care provided to a patient at an urgent care centre (UCC) located separate to an emergency department
- Advice provided by an ED clinician to a patient located in a ward or elsewhere in the hospital. The clinical notes of the patient should reflect the consultation of the ED clinician and the clinical advice provided.
- A person who may be seeking assistance at the ED that does not register as a presenting patient and does not wait to be assessed

NSW Health provides data consistent with these rules when reporting to the Commonwealth and other National agencies. To prevent double-counting, ED services are excluded from other national reporting data sets, as appropriate, when provided by NSW Health.

USES OF THE EDDC

The EDDC is used for the following purposes:

- Performance reporting including the monthly Health System Performance Report;
- Annual Report – summary of activity
- Bureau of Health Information reporting
- Commonwealth reporting e.g. *Non-Admitted Patient Emergency Data Care National Minimum Data Set* (NAPED NMDS)

- Activity based funding / management
- Review of health service delivery including models of care (redesign)
- BioSurveillance (public health)
- Quality and safety projects
- Clinical outcomes evaluation
- Workforce planning
- Research purposes with the approval of a human research ethics committee (requires written request to access de-identified data)
- Other ad-hoc reporting, as required.

SUBMISSION AND REPORTING FRAMEWORK

Emergency Departments in scope of the EDDC are required to submit data to the:

- NSW Ministry of Health's Health Information Exchange (HIE) each week. Those ED presentations where the arrival occurs in the period12:00am Monday to 11:59pm Sunday are to be submitted to the Ministry by 5pm Wednesday following the end of that submission period.

  Data may be supplied and accepted on a more frequent basis (e.g. each night) to allow EDs to obtain more timely feedback on the quality of ED data that may better suit the operational processes of EDs, such as to identify records that are in breach of performance targets and to review the accuracy of the recorded data.
- Enterprise Data Warehouse (EDWARD) on a daily rather than weekly basis. Data submitted to EDWARD must comply with the EDWARD Emergency Department Service Event Data Stream and associated requirements specifications.

Data Quality

Each record submitted to the EDDC must be complete with each reported item in the record compliant with the relevant EDDC Data Dictionary and relevant interface specification. It is the responsibility of facilities and LHD/SHNs to ensure the completeness and accuracy of data.
The Ministry undertakes data quality checks to ensure that data submitted is compliant with reporting specifications. Incomplete records or records with errors are identified.
Some examples of data quality checks include:

- Review of Triage Category 1 breaches
- Identifying records where time of discharge from ED is earlier than the time of presentation.
- Provision of a recognised diagnosis code for all relevant presentations

The Commonwealth also applies data quality checks to data submitted under the *Non-Admitted Patient Emergency Department NMDS*. The Ministry of Health will review the data using the Commonwealth edits and seek correction and resubmission by facilities/LHD/SHNs.

GOVERNANCE

Reporting of all ED presentations in scope of the NSW EDDC is a mandatory requirement that enables NSW Health to manage the NSW Health system and meet its state and national reporting commitments, including obligations under the National Health Reform Agreement.
The Collection is managed by the System Information and Analytics Branch (SIA) on behalf of NSW Health.
Data Sponsor: Deputy Secretary, System Purchasing and Performance
Data Custodian: Executive Director, SIA
Data Steward: Data Integrity Officer, SIA
The Data Steward primarily liaises with members of the Emergency Department Data Collection Working Group (EDDCWG). The EDDCWG has representation from each LHD/SHN and meets on a regular basis to discuss EDDC specification, collection, submission and reporting issues. Each LHD/ SHN data steward/EDDC Working Group representative has responsibility for ensuring compliance and providing data to the EDDC and provides a contact point between the Ministry and LHD/SHN for issues related to the EDDC. This forum provides an opportunity to discuss EDDC issues and changes. All LHDs and SHNs are expected to have representation in that forum to facilitate the exchange of information and views.
The EDDC Working Group reports to the Health Information Performance and Governance Committee (HIPGC). The HIPGC is NSW Health's peak data governance forum operating across data collections / streams.

IMPLEMENTATION

Chief Executives of LHDs and SHNs are to ensure:

- This Policy Directive is distributed to all staff involved in collecting and supplying data for the EDDC. This includes staff of Emergency Department units, medical record and information services staff, staff supporting patient administration systems (PAS), HIE/EDWARD Coordinators and information / performance reporting staff .
- Sufficient and appropriate resources are assigned to enable the collection, capture, submission and monitoring of the EDDC data. This should include local data governance, data quality monitoring and associated processes.
- Staff have access to electronic systems able to report the data items in accordance with the *Emergency Department Data Collection Data Dictionary*.
- Data collected in accordance with this Policy Directive is submitted in compliance to the schedule provided and in the form required for submission.

RESPONSIBILITIES

The following responsibilities are listed relating to the EDDC:

Data Sponsor

The Data Sponsor is responsible for the overall strategic management, governance and operation of The Collection including providing direction, guidance and authorising appropriate resources for management of the Collection. The Data Sponsor is also responsible for the Collection's data governance framework including the overall privacy, security and confidentiality provisions.

Data Custodian

The Data Custodian manages and implements the data delivery process in concert with the Data Steward. The Data Custodian has responsibility at a corporate level for setting development and data management processes including the timely publication of policy directives and metadata resources to outline data standards and support conformity with the Collections requirements and data quality standards.

Data Steward

The Data Steward is responsible for the day to day operation of the Collection including its administration in compliance with corporate and system wide processes and policies and developing and arranging the publication of policies and metadata resources etc. The Data Steward monitors data submission and completeness and leads stakeholder liaison and communication of collection advice across the system and maintains the Data Collection Work Plan.

LHD / SHN EDDC Data Steward

The LHD/SHN EDDC Data Steward is responsible for the local compliance with relevant data collection, capture and submission policies, processes and standards. LHD / SHN Data Stewards are also responsible for identifying, addressing and escalating issues that impact The Collection both locally and at a system wide level.

Relevant Health Service Staff (Clinical or Corporate)

Relevant Health Service Staff (clinical or corporate) are responsible for the accurate and timely collection, recording and submission of data within information systems or records as appropriate to their role.

IT Support Personnel

IT Support Personnel provision systems that support the capture, management and submission of EDDC data in accordance with The Collection's requirements.

LHD/SHN Working Group Representatives

LHD/SHN EDDC Working Group Representatives are to actively participate in the activities of the Working Group as outlined in the Terms of Reference including communicating Collection relevant information between the Ministry and their LHD / SHN.

REFERENCES AND RESOURCES

Further information concerning The Collection and submission of EDDC data is available on the NSW Health Intranet from the following URL:
http://internal.health.nsw.gov.au/data/collections/edc/index.html
This includes links to the following resources:

- **EDDC Data Dictionary**

Detailed information on the EDDC data items, codes and guidance on completion of each data item is contained in the *New South Wales Emergency Department Data Collection Data Dictionaries.* Separate data dictionaries are relevant for HIE and EDWARD data submission.

- **Submission Guidelines**

Technical advice concerning the means of submitting data to The Collection including specifications of the rules for extraction from source systems and the form of the data that is to be to be submitted in order that it can be processed by the state wide repositories for incorporation into the central EDDC.

- **Collection Updates**

Advice on changes to the EDDC which are subject to consultation and coordination with LHD / SHNs, leading to publication of notification of changes prior to implementation.

- **Related Policies/ Guidelines/ Manuals**

Other materials that describe how to obtain access, data quality rules, implementation guides, advice on system mapping, external references as well as resources for data analysts may also be provided.

For further information about this Policy Directive or The Collection contact:

Position Data Integrity Officer
Information Management and Quality Unit
System Informatics and Analytics Branch
NSW Ministry of Health

Contact Komala Goutham
Email **Komala.Goutham@health.nsw.gov.au**
Phone 02 9391 9613

NSW SUB-ACUTE AND NON-ACUTE PATIENT (SNAP) DATA COLLECTION – REPORTING AND SUBMISSION REQUIREMENTS (PD2018_007)

PD2018_007 rescinds PD2008_025

PURPOSE

This Policy Directive covers reporting and submission requirements for the sub-acute and non-acute patient (SNAP) data collection.

SNAP data is primarily used by the NSW Ministry of Health and its administrative units to monitor delivery of sub-acute and non-acute admitted patient services by public hospitals and publically contracted care in other facilities in NSW. This enables a review of service utilisation, identification of health service trends, appropriate allocation of resources and monitoring of the performance of service delivery units against benchmarks. The data is also used for epidemiological studies and public health reporting at a state and national level and is a Commonwealth reporting requirement as part of the National Health Information Agreement.

MANDATORY REQUIREMENTS

Reporting of all admitted sub-acute and non-acute episodes of care in-scope of the NSW SNAP data collection (public hospitals) is a mandatory requirement, enabling NSW to comply with the Public Health Act 1991 and to meet its state and national reporting commitments and its obligations under the National Health Reform Agreement.

IMPLEMENTATION

Chief Executives of Local Health Districts and Specialty Health Networks are to ensure:

- This Policy Directive is distributed to all staff involved in collecting and supplying data for the SNAP data collection. This includes staff of sub-acute and non-acute services, medical record and information services, and clerical staff tasked with maintaining currency of patient data in the patient administration system (PAS) and/or data entry into Synaptix.

- Staff have access to electronic systems to enable collection of data items in accordance with this Policy Directive and associated resources.

- Data collected in accordance with this Policy Directive complies with the reported schedule outlined.

NSW Sub-Acute and Non-Acute Patient (SNAP) Data Collection – Reporting and Submission Requirements: Procedure

PURPOSE AND INTENT

This Policy Directive covers reporting and submission requirements for the sub-acute and non-acute patient (SNAP) data collection.

SNAP data is primarily used by the NSW Ministry of Health and its administrative units to monitor delivery of sub-acute and non-acute admitted patient services by public hospitals and publically contracted care in other facilities in NSW. This includes a review of service utilisation, identification

of health service trends, appropriate allocation of resources and monitoring the performance of service delivery units against benchmarks. SNAP data is also used for epidemiological studies and public health reporting at a state and national level and is reportable to the Commonwealth under the National Health Information Agreement.

SCOPE

This Policy Directive applies to all NSW public hospitals as well as publically contracted care in other facilities within NSW.

A SNAP record must be provided for each sub-acute or non-acute episode of care delivered to a patient formally admitted to a public hospital within NSW. A sub-acute or non-acute episode of care is defined as a same day or overnight episode of care with one of the following care types:

- palliative care
- rehabilitation
- psychogeriatric
- geriatric evaluation and management
- maintenance care

Sub-acute and non-acute treatment and/or care can occur in a hospital or in a patient's home environment under the Hospital in the Home (HITH) program, where the patient is categorised as a 'daily HITH' patient (refer NSW HITH Guideline GL2013_006).

All sub-acute and non-acute patients remain in-scope for this collection until they are formally separated or undergo a statistical separation in the form of a care type change to a care type out of scope for this collection.

USES OF THE SNAP DATA COLLECTION

The SNAP data collection is used for the following purposes:

- Developing performance and service agreements between the Secretary, NSW Health and Districts/Networks
- Monthly performance reporting
- Performance reporting annual report – summary of activity
- Bureau of Health Information reporting
- Commonwealth reporting including the Australian Institute of Health and Welfare (AIHW), the National Health Funding Administrator and the Independent Hospital Pricing Authority (IHPA)
- The Activity Based Management (ABM) SNAP Application (App), which links SNAP data to the admitted patient data collection for the purpose of assessing data completeness, data quality and clinical benchmarking
- Claiming payments, e.g. National Health Funding Administrator, health insurers
- Activity based funding and activity based costing
- Models of care (redesign)
- Biosurveillance (public health)
- Quality and safety projects
- Clinical outcomes evaluation
- Workforce planning

- Research purposes with the approval of a human research ethics committee (requires written request to access de-identified data)
- Submissions to external benchmarking organisations such as the Palliative Care Outcomes Collaborative (PCOC); Australasian Rehabilitation Outcome Centre (AROC); Health Round Table (HRT)
- Other ad-hoc reporting, as required.

SUBMISSION AND REPORTING FRAMEWORK

Local Health Districts and Specialty Health Networks (Districts/Networks) must ensure that SNAP data for all completed sub-acute and non-acute episodes of care has been entered into the SNAP data collection application (SYNAPTIX – a centralised data collection tool which replaced SNAPshot in 2009) by the fifth working day of the month following completion of the episode, i.e. data for all episodes completed in January must be entered into SYNAPTIX by the fifth working day of February.

A financial year-to-date data extraction from SYNAPTIX is carried out by ABM by the tenth day of each month. Data is then matched with admitted patient data extracted from the state Health Information Exchange (HIE). A second data extract may occur mid-month.

The HIE is the considered source of truth for SNAP data with the exception of the following data elements in SYNAPTIX:

- SNAP assessment tool
- SNAP episode/phase start and end dates

Data Quality

Data quality checks are undertaken by ABM to ensure submitted data is compliant with reporting specifications. This enables incomplete records or records with errors to be identified. SNAP data quality is monitored using the ABM SNAP App which is available to authorised users via the NSW Health Intranet. Error records must be checked and corrected by the reporting hospital. Depending on the type of error, corrections of either

SYNAPTIX or in the patient administration system (PAS) may be required. Error correction rates are monitored and benchmarked via the ABM SNAP App.

It is the responsibility of clinicians, administrative and clerical staff, information management and technology staff and health service managers to ensure the completeness and accuracy of SNAP data.

Some examples of data quality checks include:

- cross check of care type with the admitted patient data collection
- reporting of leave days
- availability of sufficient information to group to an AN-SNAP class, e.g. assessment data such as Functional Independence Measures (FIMs); Health of the Nation Outcomes Scales (HoNOS); Resource Utilisation Group – Assisted Daily Living (RUG/ADL); rehabilitation impairment code; and palliative care phase.

GOVERANCE

Reporting of all admitted sub-acute and non-acute episodes of care in-scope of the NSW SNAP data collection (public hospitals) is a mandatory requirement. This enables NSW to comply with the Public Health Act 1991, to meet state and national reporting commitments and obligations under the National Health Reform Agreement.

The collection is managed by ABM on behalf of NSW Health.

Sponsor:	Executive Director, ABM
Data Custodian:	Executive Director, ABM
Data Steward:	SNAP Manager, ABM

The Data Steward manages two state groups that oversee the SNAP data collection:

- The NSW Sub-Acute ABM Working Group (represented by SNAP clinicians from Districts/Networks) meets on a regular basis to assist the NSW Ministry of Health to develop a better understanding of sub and non-acute services in NSW; and to assist in developing options for costing and funding those services as part of implementing the current national health reform agenda.

- The SNAP Coordinators Group (represented by SNAP District/Network data stewards) is advised of endorsed changes and collection directions. Each District/Network data steward/SNAP coordinator group representative has responsibility for ensuring compliance and providing data to the SNAP data collection, and provides a contact point between ABM and Districts/Networks for issues concerning the SNAP data collection.

Both forums provide an opportunity to discuss SNAP data collection issues and changes.

IMPLEMENTATION

Chief Executives of Districts/Networks are to ensure:

- This Policy Directive is distributed to all staff involved in collecting and supplying data for the SNAP data collection. This includes staff of sub-acute and non-acute services, medical record and information services staff, and clerical staff tasked with maintaining currency of patient data in the patient administration system (PAS) and/or data entry into SYNAPTIX.

- Staff have access to electronic systems to enable collection of data items in accordance with this Policy Directive and associated resources.

- Data collected in accordance with this Policy Directive complies with the reporting schedules outlined.

RESPONSIBILITIES

The following responsibilities relate to the SNAP data collection:

- Sub-acute and non-acute personnel within Districts/Networks (clinical and clerical):
  - ensuring that data is collected according to relevant protocols, e.g. FIM
  - collection of clinical data items such as assessment data FIMs; HoNOS; RUG/ADL; rehabilitation impairment code; and palliative care phase
  - accurate recording of clerical data items such as patient demographics, episode start and end dates, leave taken, care type changes, financial class

- District/Network SNAP Coordinators Group representative/data steward:
  - ensures SNAP data is recorded in the SYNAPTIX application in a timely and accurate manner
  - establish procedures and processes for following up data completeness and quality issues within Districts/Networks
  - communicate change within Districts/Networks as well as advice to and from the Ministry and ABM
  - undertake training in the SYNAPTIX application and SNAP data collection for local stakeholders
  - act as local SYNAPTIX super user

- NSW Sub-Acute ABM Working Group:
  - provide clinical oversight of the data collection.
  - provide expert opinion on matters affecting the SNAP collection in relevant clinical areas and consult with and represent clinical stakeholders during SNAP classification reviews

- Collection sponsor ABM:
  - responsible for ensuring the SNAP data collection is resourced and continues to meet business needs. Such resources include appropriate system architecture, disaster recovery and business continuity planning, comprehensive system and end-user documentation and maintenance of metadata/data dictionary

- Data custodian (ABM and Districts/Networks):
  - exercises within their mandate
    - ownership and control of the collection
    - authorising access
    - release of data and changes to the collection

- Data steward (ABM):
  - monitors data quality and completeness, providing advice to the data custodian on issues and proposals for change
  - act as state SYNPTIX administrator

DEFINITIONS

ABM	Activity Based Management
AIHW	Australian Institute of Health and Welfare
AN-SNAP	Australian National Sub-Acute and Non-Acute Patient Classification
APDC	Admitted Patient Data Collection
AROC	Australian Rehabilitation Outcomes Centre
AR-DRG	Australian Refined Diagnosis Related Group
FIM	Functional Independence Measure
GEM	Geriatric Evaluation and Management
HIE	Health Information Exchange
HITH	Hospital in the Home
HoNOS	Health of the Nation Outcome Scales
IHPA	Independent Hospital Pricing Authority
NSW	New South Wales
PAS	Patient Administration System
PCOC	Palliative Care Outcome Collaboration
PD	Policy Directive
RUG-ADL	Resource Utilisation Group – Assisted Daily Living
SNAP	Sub-Acute and Non-Acute Patient
SNAP App	Online multipurpose program
SYNAPTIX	Standalone data collection tool

REFERENCES AND RESOURCES

Further information about the collection and submission of SNAP data is available on the NSW Health intranet at **http://internal.health.nsw.gov.au/abf_taskforce/snap**. This includes links to the following resources:

- NSW SNAP Data Collection Handbook - detailed information on SNAP data items, codes and guidance on completion of each data item
- SNAP Fact Sheet - summary information regarding the SNAP classification
- SYNAPTIX Users Guide - a comprehensive guide on the use of the SYNAPTIX application
- SYNAPTIX Reporting Manual - supports data collectors and educates users on the SYNPATIX application
- NSW SYNAPTIX Data Error Corrections Guide - instructions on how to correct SNAP data errors
- ABM SNAP Application User Guide - information and instructions on how to use the SNAP App to monitor data completeness and quality

INPATIENT STATISTICS COLLECTION (ISC) - PUBLIC FACILITIES - SEPARATIONS DATED FROM 1 JULY 2001 (PD2005_210)

1. Introduction

This circular details the following issues in relation to the Inpatient Statistics Collection (ISC) from 1 July 2001:

1. Introduction
2. Scope and Coverage
3. Data Items to be Reported
4. Methods of Reporting
5. Data Resubmission
6. Data Quality
7. Reporting Requirements
8. Fines
9. Access to Penalty Payment Revenue
10. Compliance Monitoring
11. Roles and Responsibilities
12. Security of Data
13. Collection Resources
14. Tools and Access Required
15. Contact Information

1.2 It is essential that this circular be distributed to all staff involved in collecting and supplying data for the ISC. This includes ISC coordinators, medical record staff, admissions staff and Emergency Department staff who admit patients.

1. Scope and Coverage

2.1 The Inpatient Statistics Collection covers all patients admitted to public hospitals, public psychiatric hospitals, public multi purpose services, private hospitals, private day procedure centres, and sleep disorder centres. The collection excludes private residential aged care facilities, Commonwealth funded residential aged care facilities and beds, and hospital boarders.

2.2 An “admitted patient” is defined as a person who undergoes a hospital’s formal admission process to receive treatment and/or care. This treatment and/or care can occur in hospital and/or in the person’s home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient’s condition requires clinical management and/or facilities not available in their usual residential environment;
- the patient requires observation in order to be assessed or diagnosed;
- the patient requires at least daily assessment of their medication needs;
- the patient requires a procedure, or number of procedures, that cannot be performed in a stand-alone facility, such as a doctor’s room without specialised support facilities and/or expertise available (eg cardiac catheterisation);
- there is a legal requirement for admission (eg under child protection legislation);
- the patient is aged nine days or less.

2.3 Persons seeking aged care respite at facilities with Commonwealth funded residential aged care beds should be registered as aged care residents at the facility, rather than admitted as patients, and are excluded from the collection B this activity is reported instead to the Residential Aged Care Collection. When respite is provided to a person for reasons other than he/she is requiring aged care (e.g. because the person requires respite care because he/she is intellectually impaired) the person should be admitted as a patient and reported to the Inpatient Statistics Collection.

2.4 The following facilities are in scope of the collection and must report inpatient activity to the Area Health Service and Department to the specifications in this circular.

Central Sydney Area Health Service (X100)

Facility Name	Code	Type
Balmain Hospital	A201	Public
Canterbury Hospital	A202	Public
Concord Hospital	A237	Public
Royal Prince Alfred Hospital	A208	Public
Rozelle Hospital	A101	Dental
RPAH Institute of Rheumatology & Orthopaedics	A239	Public
Thomas Walker Hospital	A236	Public
Tresillian Hospital Petersham	A230	Public
Tresillian Hospital Willoughby	B230	Public
United Dental Hospital	C153	Dental

Northern Sydney Area Health Service (X105)

Facility Name	Code	Type
Gladesville Macquarie Hospital	B101	Psyc
Greenwich Home of Peace Hospital	B208	Public
Hornsby and Ku-ring-gai Hospital	B210	Public
Manly District Hospital	B212	Public
Mona Vale District Hospital	B214	Public
Neringah Hospital	B209	Public
Royal North Shore Hospital	B218	Public
Royal Rehabilitation Centre	B221	Public
Ryde Hospital	B224	Public
Sydney Dialysis Centre	B219	Public

Western Sydney Area Health Service (X120)

Facility Name	Code	Type
Auburn Hospital	D201	Public
Blacktown Hospital	D203	Public
Cumberland Hospital	D102	Psyc
Lottie Stewart Hospital	D217	Public
Mount Druitt Hospital	D218	Public
St Joseph’s Hospital	D213	Public
Westmead Hospital	D224	Public

Wentworth Area Health Service (X125)

Facility Name	Code	Type
Blue Mountains District Anzac Memorial Hospital	D204	MPS
Nepean District Hospital, Penrith	D210	Public
Springwood Hospital	D214	MPS
Tresillian Hospital Wentworth	D230	Public

South Western Area Health Service (X130)

Facility Name	Code	Type
Bankstown-Lidcombe Hospital	D227	Public
Bowral and District Hospital	N219	Public
Braeside Hospital	D228	Public
Camden Hospital	D205	Public
Campbelltown Hospital	D215	Public
Fairfield Hospital	D206	Public
Karitane Child & Family Health Services	C203	Public
Liverpool Hospital	D209	Public

Central Coast Area Health Service (X135)

Facility Name	Code	Type
Gosford Hospital	B202	Public
Long Jetty Hospital	B204	Public
Woy Woy Hospital	B203	Public
Wyong Hospital	B206	Public

Hunter Area Health Service (X140)

Facility Name	Code	Type
Belmont District Hospital	Q214	Public
Cessnock District Hospital	Q202	Public
Denman Hospital	Q210	Public
Dungog and District Hospital	Q203	Public
James Fletcher Hospital - Hunter Hospital Site	Q102	Psyc
James Fletcher Hospital - Morisset Hospital Site	Q101	Psyc
John Hunter Hospital	Q230	Public
Kurri Kurri District Hospital	Q205	Public
Maitland Hospital	Q206	Public
Merriwa District Hospital	Q208	Public
Muswellbrook District Hospital	Q209	Public
Nelson Bay & District Polyclinic	Q225	Public
Newcastle Mater Misericordiae Hospital	Q211	Public
Royal Newcastle Hospital	Q213	Public
Scott Memorial Hospital	Q216	Public
Singleton District Hospital	Q217	Public
Wilson Memorial Hospital	Q219	Public

Illawarra Area Health Service (X145)

Facility Name	Code	Type
Bulli Hospital	P202	Public
Coledale Hospital	P203	Public
David Berry Hospital	P291	Public
Milton-Ulladulla Hospital	P205	Public
Port Kembla District Hospital	P206	Public
Shellharbour Hospital	P211	Public
Shoalhaven District Memorial Hospital	P207	Public
Wollongong Hospital	P208	Public

South Eastern Sydney Area Health Service (X155)

Facility Name	Code	Type
Calvary Hospital Kogarah	C202	Public
Gower Wilson Memorial Hospital	C205	Public
Prince Henry Hospital	C207	Public
Prince of Wales Hospital	C208	Public
Royal Hospital for Women	C201	Public
Sacred Heart Hospice	A209	Public
St George Hospital	C213	Public
St Vincent's Hospital	A212	Public
Sutherland Hospital	C214	Public
Sydney Children's Hospital	C238	Public
Sydney-Sydney Eye Hospital	A233	Public
War Memorial Hospital	C206	Public

The Children's Hospital at Westmead (X160)

Facility Name	Code	Type
Bear Cottage	B239	Public
The Children's Hospital at Westmead	A207	Public

Corrections Health Service (X170)

Facility Name	Code	Type
Corrections Health - Long Bay	C121	Prison
Corrections Health - Mulawa	D122	Prison

Northern Rivers Area Health Service (X400)

Facility Name	Code	Type
Aruma Home, Grafton	H151	Psyc
Ballina Hospital	H201	Public
Bonalbo Hospital	H207	Public
Byron District Hospital	H204	Public
Campbell Hospital	H205	Public
Casino & District Memorial Hospital	H206	Public
Grafton Base Hospital	H210	Public
Kyogle Memorial Hospital	H213	Public
Lismore Base Hospital	H214	Public
Maclean District Hospital	H217	Public
Mullumbimby District Hospital	H220	Public
Murwillumbah District Hospital	H221	Public
Nimbin Hospital	H215	Public
Tweed Heads District Hospital	H223	Public
Urbenville and District Multi-Purpose Centre	H224	MPS

Mid North Coast Area Health Service (X410)

Facility Name	Code	Type
Bellinger River District Hospital	H203	Public
Bulahdelah District Hospital	J223	Public
Coffs Harbour and District Hospital	H208	Public
Dorrigo Multi-Purpose Centre	H209	MPS
Gloucester Soldier's Memorial Hospital	J224	Public
Kempsey District Hospital	H212	Public
Macksville & District Hospital	H216	Public
Manning River Base Hospital	J225	Public
Wauchope District Memorial Hospital	H225	Public
Wingham & District War Memorial Hospital	J226	Public

New England Area Health Service (X420)

Facility Name	Code	Type
Armidale and New England Hospital	J201	Public
Ashford Hospital	J209	Public
Barraba and District Hospital	J202	Public
Bingara District Hospital	J203	Public
Boggabri District Hospital	J204	Public
Bundarra Hospital	J210	Public
Glen Innes District Hospital	J205	Public
Gunnedah District Hospital	J206	Public
Guyra District War Memorial Hospital	J207	Public
Inverell District Hospital	J208	Public
Manilla District Hospital	J211	Public
Moree Hospital	J212	Public
Narrabri District Hospital	J213	Public
Prince Albert Memorial Hospital	J214	Public
Quirindi District Hospital	J215	Public
Tamworth Base Hospital	J216	Public
Tingha Hospital	J217	Public
Vegetable Creek Hospital	J218	Public
Walcha District Hospital	J219	Public
Warialda District Hospital	J220	Public
Wee Waa District Hospital	J221	Public
Werris Creek District Hospital	J222	Public

Macquarie Area Health Service (X430)

Facility Name	Code	Type
Baradine Multi-Purpose Centre	K207	MPS
Binnaway Hospital	K208	Public
Cobar District Hospital	K203	Public
Coolah District Hospital	K205	Public
Coonabarabran District Hospital	K206	Public
Coonamble District Hospital	K209	Public
Dubbo Base Hospital	K211	Public
Dunedoo War Memorial Hospital	K212	Public
Gilgandra District Hospital	K213	Public
Gulargambone Hospital	K210	Public
Gulgong District Hospital	K215	Public
Mudgee District Hospital	K216	Public
Narromine District Hospital	K217	Public
Nyngan District Hospital	K218	Public
Trangie Multi-Purpose Centre	K219	MPS
Warren Multi-Purpose Centre	K221	MPS
Wellington District Hospital	K222	Public

Mid Western Area Health Service (X440)

Facility Name	Code	Type
Bathurst Base Hospital	L201	Public
Blayney District Hospital	L202	Public
Bloomfield Hospital	L101	Psyc
Canowindra Soldier's Memorial Hospital	L203	Public
Condobolin District Hospital	L205	Public
Cowra District Hospital	L206	Public
Cudal War Memorial Hospital	L207	Public
Eugowra Memorial Hospital	L208	Public
Forbes District Hospital	L209	Public

Grenfell Multi-Purpose Centre	L210	MPS
Lake Cargelligo Multi-Purpose Centre	L212	MPS
Lithgow District Hospital	L213	Public
Molong District Hospital	L214	Public
Oberon Multi-Purpose Centre	L215	MPS
Orange Base Hospital	L216	Public
Parkes District Hospital	L217	Public
Peak Hill District Hospital	L218	Public
Portland District Hospital	L220	Public
Rylstone District Hospital	L221	Public
St Vincent's Community Hospital	L222	Public
Tottenham Hospital	L223	Public
Trundle Multi-Purpose Centre	L219	MPS
Tullamore District Hospital	L224	Public

Far West Area Health Service (X450)

Facility Name	Code	Type
Balranald District Hospital	M202	Public
Bourke District Hospital	K201	Public
Brewarrina District Hospital	K202	Public
Broken Hill Base Hospital	S201	Public
Collarenebri District Hospital	K204	Public
Goodooga District Hospital	K214	Public
Ivanhoe District Hospital	S202	Public
Tibooburra District Hospital	S203	Public
Walgett District Hospital	K220	Public
Wentworth District Hospital	M216	Public
Wilcannia Multi-Purpose Centre	S204	MPS

Greater Murray Area Health Service (X460)

Facility Name	Code	Type
Albury Base Hospital	M201	Public
Barellan Hospital	R212	Public
Barham and Koondrook Soldiers' Memorial Hospital	M203	Public
Batlow District Hospital	R202	Public
Berrigan War Memorial Hospital	M204	Public
Coolamon-Ganmain Hospital	R210	Public
Cootamundra Hospital	R221	Public
Corowa Hospital	M206	Public
Culcairn Multi-Purpose Centre	M205	MPS
Deniliquin Hospital	M207	Public
Finley Hospital	M208	Public
Griffith Base Hospital	R205	Public
Gundagai District Hospital	R206	Public
Hay Hospital	R207	Public
Henty District Hospital	M209	Public
Hillston District Hospital	R208	Public
Holbrook District Hospital	M210	MPS
Jerilderie District Hospital	M211	Public
Junee District Hospital	R209	Public
Leeton District Hospital	R211	Public
Lockhart and District Hospital	R213	Public
Mercy Hospital, Albury	M212	Public
Narrandera District Hospital	R215	Public
Temora and District Hospital	R216	Public
Tocumwal Hospital	M214	Public

Tumbarumba Multi-Purpose Centre	M215	MPS
Tumut and District Hospital	R218	Public
Urana Multi-Purpose Centre	M213	MPS
Wagga Wagga Base Hospital	R219	Public
Wyalong and District Hospital	L226	Public

Southern Area Health Service (X470)

Facility Name	Code	Type
Bateman's Bay Hospital	N201	Public
Bega District Hospital	N202	Public
Bombala District Hospital	N203	Public
Boorowa District Hospital	N204	Public
Braidwood Multi-Purpose Centre	N205	MPS
Cooma Hospital	N206	Public
Crookwell District Hospital	N207	Public
Delegate Multi-Purpose Centre	N208	MPS
Goulburn Base Hospital	N209	Public
Kenmore Hospital	N101	Psyc
Mercy Care Centre	N210	Public
Moruya District Hospital	N211	Public
Murrumburrah-Harden District Hospital	N213	Public
Pambula District Hospital	N214	Public
Queanbeyan District Hospital	N215	Public
St John of God Hospital	N216	Public
Yass District Hospital	N217	Public
Young District Hospital	N218	Public

- **Data Items to be Reported**

3.1 From 1 July 2001 the Inpatient Statistics Collection covers all data items reported to the HIE for admitted patients. Some data items are mandatory for every patient while other data items are mandatory for some patient groups only. Some data items are optional and only reported where collected as a matter of course.

3.2 In the table of data items below "Mandatory" indicates a valid value must be reported for every admitted patient. Where the value is unknown or unable to be determined, the code for "unknown" must be reported. "Conditional" indicates a valid value must be reported where the information is required for a particular type of patient (defined in the associated instruction), or only where the data is collected for a local requirement and thus available to report.

3.3 The data items listed for the collection include those required to derive a State standard data item, or comply with a Statewide policy, but not required for any other purpose by the Department. These data items, while included in the scope of the collection, may only need to be stored on the Area's Patient Administration System or the Area's Health Information Exchange (HIE). In the table of data items to follow (see section 3.5) data items that must be stored on the Area's Patient Administration System only are flagged with "PAS", data items that must be stored on the Area Area's HIE are flagged with "Area" and data items that must be submission to the Department's HIE are flagged with "DoH".

3.4 The table below shows the codes used to describe the nature of any change to a data item since the previous collection year in the table of data items presented in section 3.5.

Code	Indicates Y
L	Data Item Label Change - The data item has had a label (i.e. name) change. Label changes may occur to align with national standards, improve user understanding or respond to recommendations from specialist groups. **Example:** "Indigenous Origin" has changed to "Aboriginal and Torres Strait Islander Origin"
B	Business Rule Changes - The data item instructions contain a business rule related to this data item that has changed. This change is usually required to align with national reporting requirements or standardise business practice. **Example:** Business rules for "Urgency of Admission" have changed to reflect national reporting requirements for obstetric admissions.
A	Annual Update - The data item has new or retired codes and this occurs each collection year. **Example:** "Reporting Facility" code set has new codes for private facilities that have opened in previous year, facility name changes, and closures.
U	Updated Classification - The data items that have a classification that differs from the previous year. Such a change occurs to standardise information across collections and align with national reporting requirements. **Example:** "Country of Birth" will change to align with national standards, which are used in NSW Health community data collections.
O	Other Change - The data item instruction has changed in another way, such as a change in the recommended local code/display values, or the data item should be reported using a different field length or set of fields. **Example:** "Client's Name" has increased in length and must be reported in 3 separate fields.

3.5 The list below identifies the data items covered by the Inpatient Statistics Collection from 1 July 2001.

Data Item Label	Status	New Item	Change Type	HIE
Record Identifiers				
Reporting Facility	Mandatory	No	A, L	DOH
Admitted Patient Stay Identifier	Mandatory	Yes	Nil	DOH
Admitted Patient Episode Identifier	Mandatory	Yes	Nil	DOH
Admitted Patient Record Update Date	Mandatory	Yes	Nil	DOH
Stay Record Dates and Times				
Formal Admission Date and Time	Mandatory	No	L	DOH
Formal Discharge Date and Time	Mandatory	No	L, B	DOH
Patient Identifiers				
Client's Name	Mandatory	No	L, O	DOH
Client's Alias Names	Conditional	Yes	n.a.	DOH
Medical Record Number	Mandatory	No	Nil	DOH
State Unique Identifier	Conditional	Yes	n.a.	DOH
Medicare Card Number	Conditional	No	Nil	DOH
Department of Veterans' Affairs Card Colour	Conditional	No	L, B	DOH
Department of Veterans' Affairs Card Number	Conditional	No	B	DOH
Health Fund	Conditional	No	O	DOH
Health Fund Membership Number	Conditional	No	Nil	DOH
Ambulance Client Number	Conditional	No	B	DOH
Client's Address of Usual Residence	Mandatory	No	A, O	DOH
Centrelink Client Number	Conditional	Yes	n.a.	Area
Client's Telephone Number Home/Work	Conditional	Yes	n.a.	Area
Name of Client's Next of Kin	Conditional	Yes	n.a.	Area
Name of Client's Mother and Father	Conditional	Yes	n.a.	Area
Maiden Name of Client's Mother	Conditional	Yes	n.a.	Area
Patient's Fixed Demographics				
Date of Birth	Mandatory	No	Nil	DOH
Estimated Date of Birth Flag	Conditional	Yes	n.a.	DOH
Sex	Mandatory	No	Nil	DOH
Country of Birth	Mandatory	No	U	DOH
Patient's Variable Demographics, Status and Elections				
Aboriginal and Torres Strait Islander Origin	Mandatory	No	L	DOH
Medicare Eligibility Status	Mandatory	Yes	n.a.	DOH
Marital Status	Mandatory	No	U	DOH
Preferred Language	Mandatory	No	L	DOH
Hospital Insurance Status on Admission	Mandatory	No	U	DOH
Private Health Insurance Claim	Mandatory	No	Nil	DOH
Consent for General Practitioner	Mandatory	Yes	n.a.	PAS

Data Item Label	Status	New Item	Change Type	HIE
Formal Admission Items				
Urgency of Admission	Mandatory	No	L, U	DOH
Intended Length of Stay	Mandatory	No	L	DOH
Readmission within 28 Days	Mandatory	No	n.a.	DOH
Contract Status	Mandatory	No	B, U	DOH
Source of Referral	Mandatory	No	n.a.	DOH
Facility Referred From	Mandatory	No	A	DOH
Previous Specialised Treatment	Conditional	Yes	n.a.	DOH
Year Last Admitted to Designated Psychiatric Unit	Conditional	No	B	DOH
Type of Accommodation	Conditional	No	n.a.	DOH
Formal Discharge Items				
Mode of Separation	Mandatory	No	n.a.	DOH
Facility Transferred To	Conditional	No	A	DOH
Referred to on Separation	Mandatory	No	n.a.	DOH
Event History Items				
Event Start/End Date and Time	Conditional	Yes	n.a.	DOH
Financial Class - Master	Mandatory	No	Nil	DOH
Financial Class -Local	Mandatory	No	Nil	DOH
Bed Type - Master	Mandatory	No	L	DOH
Mental Health Financial Sub-Program	Conditional	No	Nil	DOH
Attending Medical Officer - Local	Mandatory	Yes	n.a.	DOH
Ward - Local	Mandatory	Yes	n.a.	DOH
Legal Status	Mandatory	No	L, B, U	DOH
Patient Location	Conditional	Yes	n.a.	DOH
Facility Contracted To/From	Conditional	Yes	n.a.	DOH
Leave Period Start/End Date and Time	Conditional	No	L	DOH
General Episode Items				
Episode Start Date and Time	Mandatory	No	L	DOH
Episode End Date and Time	Mandatory	No	L	DOH
Service Category - Master	Mandatory	No	Nil	DOH
Service Category - Local	Conditional	Yes	n.a.	DOH
Mode of Separation for Episode	Mandatory	No	L	DOH
Palliative Care Status	Mandatory	No	Nil	DOH
Total Hours on Mechanical Ventilation	Mandatory	No	Nil	DOH
Unplanned Visit to Theatre	Mandatory	No	Nil	DOH
Neonate Admission Weight	Conditional	No	Nil	DOH
Source of Referral to Episode	Mandatory	No	Nil	DOH

Data Item Label	Status	New Item	Change Type	HIE
Clinical Episode Items				
Principal Diagnosis	Mandatory	No	Nil	DOH
Additional Diagnosis	Conditional	No	Nil	DOH
Procedures	Conditional	No	Nil	DOH
Date of First Listed Procedure	Conditional	No	Nil	DOH
Procedure Locations	Conditional	No	L, B	DOH
External Causes of Injury or Poisoning	Conditional	No	Nil	DOH
Place of Occurrence of External Cause of Injury	Conditional	No	Nil	DOH
Activity When Injured	Conditional	No	Nil	DOH
Clinical Coding Audit Flag	Conditional	Yes	Nil	DOH
Cancer Notification Items				
Primary Site of Cancer	Conditional	Yes	n.a.	DOH
Morphology of Primary Site of Cancer	Conditional	Yes	n.a.	DOH
Date of Diagnosis of Primary Cancer	Conditional	Yes	n.a.	DOH
State of Residence at Time of Diagnosis of Primary Cancer	Conditional	Yes	n.a.	DOH
Name of General Practitioner	Conditional	Yes	n.a.	DOH
Mailing Address of General Practitioner	Conditional	Yes	n.a.	DOH
AMO Registration Number of Treating Doctor	Conditional	Yes	n.a.	DOH
Laterality of this Primary Cancer	Conditional	Yes	n.a.	DOH
Pathology Laboratory	Conditional	Yes	n.a.	DOH
Best Basis for Primary Cancer Diagnosis at this Episode	Conditional	Yes	n.a.	DOH
Degree of Spread of Cancer at this Episode	Conditional	Yes	n.a.	DOH
Attending Medical Officer Items				
Local Code of Attending Medical Officer	Mandatory	Yes	n.a.	DOH
Local Name of Attending Medical Officer	Conditional	Yes	n.a.	DOH
Local Address of Attending Medical Officer	Conditional	Yes	n.a.	DOH
NSW AMO Registration Number	Mandatory	No	Nil	DOH
Medicare Provider Number	Mandatory	No	Nil	DOH
Local Specialty	Mandatory	No	Nil	DOH
Master Specialty	Mandatory	No	Nil	DOH
Ward Items				
Local Code of Ward	Mandatory	Yes	n.a.	DOH
Local Name of Ward	Conditional	Yes	n.a.	DOH
Master Bed Type Default	Conditional	Yes	n.a.	DOH
Institution Type Default	Conditional	Yes	n.a.	DOH

3.6 The data items listed below are covered by the collection but are data items that will be derived from the collected data items listed above.

PAS/HIE Derived Event History Data Items

- Payment Status
- Election Status
- Financial Program
- Unqualified Baby Bed Days during Episode of Care

- Hours in Intensive Care Unit during Episode of Care
- Total Involuntary Days Under *Mental Health Act* during Episode of Care
- Days in Designated Psychiatric Unit during Episode of Care
- Total Leave Days for Episode of Care

HIE Derived Age Data Items

- Age at Time of Formal Admission (Days, Months, Years)
- Age at Time of Formal Discharge (Days, Months, Years)
- Age at Start of Episode (Days, Months, Years)
- Age at End of Episode (Days, Months, Years)

HIE Derived Data Items for National Reporting

- NHDD: Area of Usual Residence - Version 3 (Statistical Local Area)
- NHDD: Health Insurance Status - Version 3
- NHDD: Department of Veterans' Affairs Patient - Version 1
- NHDD: Compensable Status - Version 3
- NHDD: Hospital Insurance Status - Version 3
- NHDD: Inter-Hospital Contracted Patient - Version 2
- NHDD: Mode of Admission - Version 4
- NHDD: Mode of Separation - Version 3 #
- NHDD: Number of Qualified Days for Newborns - Version 2
- NHDD: Source of Referral to Public Psychiatric Hospital - Version 3
- NHDD: Mental Health Legal Status - Version5 #
- NHDD: Funding Source for Hospital Patient - Version 1
- NHDD: Number of Leave Periods - Version 3
- NHDD: Care Type - Version 4
- NHDD: Establishment Identifier - Version 3
- NHDD: Establishment Type - Version 1
- NHDD: Medicare Eligibility Status - Version 1
- NHDD: Person Identifier - 1

Note: "NHDD" means "National Health Data Dictionary", # Indicates item is required for AR-DRG V4.1 derivation.

HIE Derived Episode Funding Data Items

- Service Related Group - Version 4.1
- Emergency Department Status
- Intensive Care Unit Status
- Enhanced Service Related Group 2000
- High Costs Complexity Case
- Surgery/Medical/Procedure Indicator
- Casemix Policy Class
- Episode Type
- Length of Stay Trim Point
- Outlier Days 1 - Days above Trim Point to Step Down Point
- Outlier Days 2 - Day Step Down Point to 365 Days
- Cost Weight A1 - Cost Weight, All Costs - 2000 Policy

- Cost Weight D1 - Cost Weight, Excluding ED and ICU - 2000 Policy
- Cost Weight E1 - Cost Weight, All Costs, No Discount - 2000 Policy
- Cost Weight A2 - Cost Weight, All Costs - Original Policy
- Cost Weight D2 - Cost Weight, Excluding ED and ICU - Original Policy

DOHRS Admitted Patient Activity Measures - Monthly Totals

- Number of Formal Admissions
- Number of Formal Discharges
- Number of Admitted Patients at Start
- Number of Admitted Patients at End
- Number of Sameday Episodes
- Number of Transfers In from Another Financial Program
- Number of Transfers Out to Another Financial Program
- Number of Occupied Bed Days
- Number of Never Qualified Births
- Number of Live Births
- Number of Unqualified Baby Bed Days
- Number of Patients Reclassified as a Nursing Home Type Patient
- Number of Formal Admissions for Overnight Renal Dialysis Treatment
- Number of Formal Admission for Overnight Sleep Disorder Treatment

3.7 The reporting of these data items must comply with instructions provided in the ISC Instruction Manual and updates to the manual that may be made from time to time (available on-line on HealthNet and HealthWeb).

3.8 “First Admission to Designated Psychiatric Unit” will cease to be included in the scope of the Inpatient Statistics Collection for separations dated from 1 July 2001. This concept will be captured by “Previous Specialised Treatment” for separation dated from 1 July 2001.

3.9 For separations dated from 1 July 2001, ICD10AM - Version 2 will continue to be the required classification for the reporting clinical codes and the Diagnosis Related Group (DRG) will be Version 4.1.

4. Methods of Reporting

4.1 All public sector facilities must use the HOSPAS, WinPAS, PiMS or Cerner patient administration system to report to the Inpatient Statistics Collection for formal discharges dated from 1 July 2001.

4.2 Facilities with low inpatient activity that do not have HOSPAS, WinPAS, PiMS or Cerner installed at the site may collect ISC data on paper forms for data entry and correction at another site within the Area Health Service that has one of these systems installed, provided due dates can be met.

4.3 Templates of the ISC forms developed by the NSW Health Department are available on Healthnet and HealthWeb. Carbon copy forms will no longer be supported by the Department for public sector sites as photocopies are more legible and last longer. Only forms for 2001/2002 may be used for reporting. Forms for prior years are not suitable as they do not capture the event history required for the 2001/2002 reporting requirements. Areas are responsible for designing and producing their own forms if they find the form supplied by the Department inadequate for their needs.

4.4 The NSW Health Department does not supply clinical coding, data entry, data correction or error report distribution services to public facilities.

5. Data Resubmission

5.1 It is an underlying principle of data warehousing that there should only be one version of information. For this reason, records that are updated in the source system (the patient administration system) must be resubmitted to both the Area HIE and the Department HIE. By default, HIE extracts will capture all new and updated records that occurred between the previous extract and the new extract date.

5.2 As standard practice, coded records may be submitted to the HIE, pass all data quality checks, then be updated and resubmitted at a later date when further relevant information become available (such as pathology reports and coroners reports). This practice allows due dates to be met without compromising data quality or integrity in the HIE.

6. Data Quality

6.1 The quality of data submitted to NSW Health for the Inpatient Statistics Collection will be determined using a standard suite of data quality (input edit) checks in the HIE. A list of the data quality checks is available in the ISC Instruction Manual and on-line through HealthNet at HealthWeb.

6.2 The Area Health Services will need to ensure that data is extract from the patient administration systems and loaded into the Area HIE well in advance of the due date so that error reports can be distributed, corrections can be made in the source system and the Area HIE can be updated with those corrections all before the due date. The Department recommends that data be first loaded in the Area HIE at least 8 to 15 days before the due date.

7. Reporting Requirements

7.1 The due dates for admitted patient dated from 1 July 2001 have been brought forward due to the increased need for accurate data available close to the event to which the information relates. Timely supply of quality data is required to increase the efficiency and effectiveness of business processes throughout NSW Health, reduce costs, and improve patient care.

Reporting Requirement	Reason
For all sites 100% admission, separation and administrative event data (excluding clinical coding and cancer notification items) must be loaded into to the Department HIE, and pass all associated data quality checks by the 14th day of the month after the month of the admission, separation or administrative event. **Note:** To support this requirement, HIE extracts have been specified to include every new and updated record since the last HIE extract date.	DOHRS admitted patient activity will be automatically calculated by the HIE from July 2001. DOHRS figures must be reported monthly to the Performance and Finance Committee, and to NSW Treasury. Up-to-date records for currently admitted patients are required for "census" reporting (e.g. census of long stay mental health patients) to support different funding methods for long stay patients
For remote rural sites 100% of clinical coding and cancer notification items for DVA patients admitted patient must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.	NSW Health Department reports to DVA on behalf of each Health Service. NSW Health has a contract with DVA and this contract requires data to be supplied by due dates. Casemix funding is used by DVA and failure to submit data on time results in lost casemix payments.
For remote rural sites 100% of clinical coding and cancer notification items for non-DVA admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 56th calendar day after the day of separation.	Timely casemix data is required by NSW Health in the Department and in the Health Service to support: • episode funding • budget holdings • flow reversals • capped interstate flow services It is acknowledged that remote rural sites require additional time to submit coded data due to a limited coder workforce in remote rural areas.
For all other sites 100% of clinical coding and cancer notification items for all admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.	

Note: "Administrative Events" are status changes that occur during the patient admission and recorded as transactions on a patient administration system. These events include changes in bed, ward, doctor, financial class, service category, legal status, and leave periods.

7.2 Where additional information relating to a record becomes available (such as additional diagnosis codes obtained from a coroners reports, or a morphology code obtained from a pathology report), or a change is made to a record after the due date, the record must be resubmitted to the HIE with the additional information added. This update may occur after the due date without incurring a fine however any errors associated with that update must be corrected before the next compliance measurement date to avoid a fine.

7.3 To support these due dates Area Health Services will need to:

- create extracts from the patient administration system and submit that extract to the Area HIE at least once per week
  (**Note:** this will support regular and timely data correction processes and evenly distributed error correction work loads.)

- supply data from the Area HIE to the Department HIE by 8pm every Friday, and by 8pm every 14th calendar day of the month
  (**Note:** the method for supply data from the Area HIE to the Department HIE changes from file loading to table loading with Version 3.0 of the HIE).

Failure to follow these recommended procedures increases the risk of missed due dates.

8. Fines

8.1 Fines are applied for failure to comply with reporting requirements outlined in this policy. The fines are designed to reflect importance of timely supply of high quality data, and the high cost of non-quality/untimely information, to the NSW Health System.

8.2 An exemption from fines will apply until January 2002 because:

- the new reporting requirements listed in this document mean changes to current work practices and a temporarily increase in resources in medical record departments to clear information backlogs;
- the HIE extracts from PiMS and Cerner supporting the full scope of data required to meet the requirements of the Inpatient Statistics Collection will not be delivered by I-soft and Cerner until October/November 2001;
- the data warehouse functionality required to identify errors, and age errors when corrections are received, are unlikely to be delivered in a production version of the HIE until September 2001;
- after the full HIE extract and error check functionality has been delivered there may be a backlog of errors that needs to be cleared by sites - the extent this backlog will vary by Area Health Service because the investment in staff to monitor data quality and ensure standard correct work practices varies considerably.

8.3 The table below shows the proposed fines for failure to meet the reporting requirement to apply from January 2002.

Reporting Requirement	**Penalty**
For all sites 100% admission, separation and administrative event data (excluding clinical coding and cancer notification items) must be loaded into to the Department HIE, and pass all associated data quality checks by the 14th day of the month after the month of the admission, separation or administrative event. **Note:** To support this requirement, HIE extracts have been specified to include every new and updated record since the last HIE extract date.	$2 per record per day
For remote rural sites 100% of clinical coding and cancer notification items for DVA patients admitted patient must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.	$2 per record per week
For remote rural sites 100% of clinical coding and cancer notification items for non-DVA admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 56th calendar day after the day of separation.	$2 per record per week
For all other sites 100% of clinical coding and cancer notification items for all admitted patient records must be loaded into the Department HIE, and pass all admitted patient data quality checks, by the 28th calendar day after the day of separation.	$2 per record per week

8.4 It is proposed that from January 2002 there will be no exemptions from fines. This means there will be no exemptions when facilities migrate to new patient administration systems and that Health Services must manage their migrations in a manner that avoids delays to the data supply and any drop in data quality.

8.5 From January 2002, fine revenue will not be able to be accessed by sites that consistently fail to meet due dates - instead the fine revenue will be used to reward sites that meet due dates and to implement Statewide data quality and timeliness improvement initiatives determined by the Department.

8.6 While exemptions from penalties will not be available from January 2002, applications to exclude a data quality check from the list used to measure compliance with the requirement to "pass all admitted patient data quality checks" may be made where the data quality check is incorrect, is not applicable to admitted patients, or the data item is unable to be collected due to system limitations. System limitations exclude situations where functionality in the system is available and included in HIE extracts but the Area Health Service did not set-up the system in a manner that facilitates the collection of that data. Submissions of requests for data quality check exclusions must be directed to Manager, Patient Data Management Unit, NSW Health Department.

8.7 Area Health Services may review these fines and provide feedback or alternative recommendations to the Department by 31 October 2001. Correspondence should be directed to the Chief Information Officer, and copied to the Manager, Patient Data Management Unit.

8.8 Following review of the feedback and submissions, the proposed fines and exemption policies listed in this section will become policy from January 2002 unless this circular is superseded by another circular outlining alternative levels of fines and alternative exemption policies.

9. Access to Penalty Payment Revenue

9.1 The Department will use penalty payment revenue to reward sites that consistently meet due dates. This policy has been introduced because:

- sites that consistently meet due dates will be "best practice" sites and thus offer a good training environment for new staff, which may later flow to other sites in other Health Services - they should therefore have access to fine revenue to train more staff in that "best practice" environment;
- sites that consistently meet due dates are likely to have more time to spend on training and coaching than sites that are consistently failing to meet due dates and are likely to share "best practice" procedures with other sites for their benefit;
- there should be an incentive to invest additional resources to meet due dates before the due date, rather than an incentive to miss due dates and incur the fine so to retrospectively compensate for a lack of timely resourcing.

9.2 Sites eligible for the reward may submit fully costed projects proposals that have an outcome of improving data quality and timely reporting of admitted patient. Proposals should be submitted to the Manager, Patient Data Management Unit, Information Management and Support Branch. The Patient Data Supplier Advisory Committee will have an opportunity to advise the Department on the merit of proposals and the Department will ultimately decide how fine revenue will be distributed.

10. Compliance Monitoring

10.1 The NSW Health Department will monitor compliance with the reporting requirements set in this circular. The compliance will be based on the data in the NSW Health Department's HIE by the due date.

10.2 The Data Management Unit will distribute compliance reports to Area Health Service Chief Executive Officers at least once a month, and to the Department's Performance Monitoring Branch at least once a quarter. Between July and December 2001 the compliance reports will show the Health Service's progress towards meeting the new due dates and the associated fine that would have been incurred had fines been applied in that period.

11. Roles and Responsibilities

11.1 It is the responsibility of the Health Service to assign a staff member as the Health Service's ISC Coordinator. This position is key person for ensuring timely accurate data for the Health Service and it needs to be adequately resource. The role of the ISC Coordinator is to:

- contact sites in advance of each due date to remind them about the reporting requirements (if this is required);
- monitor each facility's progress towards meeting the reporting requirements in the days leading up to the due date and contact sites who do not appear to be on target;
- monitor data quality including the coordination of output editing of data;
- coordinate the correction of errors that may be identified by knowledge workers;
- coordinate the extraction of data from patient administration systems and coordinate the uploading into the Area HIE in collaboration with the HIE Coordinator;
- continue to pursue hospitals who failed to meet a reporting requirements until such time that the reporting requirements is met;
- coordinate the distribution of information from the Department to the sites, and coordinate the reply return of information to the Department by the due date set;
- implement work practice changes to eliminate errors at point of first entry and consistently correct work practices at all sites;
- coordinate the migration of paper sites reporting via ISCOS to reporting via a patient administration system, including the coordination of any support that those staff involved in the migration may require;
- coordinate the updates to mapping tables in patient administration systems and check that mappings are correct;
- coordinate distribution of error reports, error correction and data resubmission.

11.2 It is the responsibility of the Health Service to assign a staff member as the Health Service's HIE Coordinator. In relation to the Inpatient Statistics Collection this person's role is to:

- Ensure admitted patient data is sent to the Department HIE from the Area HIE by the due dates given in this circular.
- Ensure all extract files from patient administration systems sent for loading into the Area HIE have loaded successfully by the due data.

- Ensure the ISC Coordinator or site is aware of any late, missing or failed extracts.
- Establish processes (automated where possible) and timetables for submissions from the patient administration system to the Area HIE.
- Ensure access to the HIE is available at each site in the medical records department, and that any site without access has an alternative method for accessing HIE error reports in a timely and convenient manner.
- Ensure test environments are available for HIE extract testing where the Area is participating in testing of patient administration system functionality.

11.3 It is the role of the Data Management Unit, NSW Health Department, to provide Statewide management and support for the collection. It is this unit's role to:

- publish and maintain information about the collection on-line;
- provide advice to Area ISC Coordinators about coding rules, classification definitions, and business rules relating to ISC data items where published information does not adequately address the issue being raised;
- ensure a full range of input data quality checks are available in the HIE and the HIE data quality check functionality meets the business requirements;
- coordinate changes in patient administration systems and the HIE to support Statewide/ national reporting requirements and accurate/timely reporting of data at the time of entry;
- issue collection policy, including due dates and penalties, and ensure these policies are appropriate for the business;
- ensure reference tables on the HIE are maintained and distributed in a timely manner to support accurate data quality checks;
- audit patient administration system setups, including mappings from local/display values to Statewide master values;
- ensure data received from Area Health Services has successfully loaded into the Department's HIE and liaise with the Area HIE and ISC coordinators if a failure has occurred;
- report on data collection compliance to the Executive of the Area and Department, and to the Performance Management Branch.

12. Security of Data

12.1 The Privacy Manual for Health Information (March 2015) must be observed for all data relating to the Inpatient Statistics Collection. Any other related security policy issued by the Department must also be observed.

12.2 Data sent between sites via electronic mail over an open network such as the Internet, or on media such as a diskette between hospitals (or between hospitals and Health Services) must be encrypted and password protected using a self-extracting encryption and compression package. The password must be provided separately. Commercial encryption programs are available from sellers of PC software.

12.3 Data sent in a hard copy (paper) format must be kept secure at all times. This means records must be transported in securely locked cases or be sent by secure post (or courier) using a service that records the name of persons handling the data.

13. Collection Resources

13.1 The NSW Health Department maintains the most up-to-date information about the Inpatient Statistics Collection, and other data collections, on-line on HealthNet and HealthWeb (the NSW Health Intranet and Internet sites). At least one staff member of each hospital's medical record department should have access to either HealthNet or HealthWeb. The sites are located at the URLs below:

- HealthNet: **http://internal.health.nsw.gov.au/im/ims/ap/index.html**
- HealthWeb: http://www.health.nsw.gov.au/policies/PD/2005/PD2005_198.html

14. Tools and Access Required

14.1 To meet due dates medical record department staff must have at least one e-mail account and access to the HIE. This is required for the efficient and direct distribution of information relating to the Inpatient Statistics Collection, including compliance reports and data quality reports.

14.2 Medical records department staff will also require business objects for standard reports, and a tool to perform adhoc queries on the HIE.

15. Contact Information

15.1 For further information about this circular or the Inpatient Statistics Collection, contact:

Nora Etmekdjian Phone: (02) 9391 9097; E-mail: **netme@doh.health.nsw.gov.au**
Roman Leszczynski Phone (02) 9391 9995; E-mail: **rlesz@doh.health.nsw.gov.au**

15.2 Requests for further information about this circular may also be faxed to the Patient Data Management Unit on (02) 9391 9070.

CLIENT REGISTRATION POLICY (PD2007_094)

1. Introduction

1.1 What is client registration?

Client registration is the process of identifying and collecting data on an individual and recording of that data within an Area Health Service-wide client registration database for the purpose of uniquely identifying that individual. The allocation of an Area Health Service unique patient identifier, to be used as a unique key for that client/patient, is a product of this process.

The intent of client registration is to be able to link information held on a client/patient and thereby, support the delivery of services to that client/patient and the management and understanding of services and service needs.

Client registration involves all of the following:

- **Gathering minimum standard information** about a client/patient of a health service to ensure that the client/patient is properly identified.
- **Searching** the Area Health Service-wide client registration database to determine if the client/patient has already been registered.

- **Recording mandatory information** about the client/patient or **updating existing information** in the Area Health Service-wide client registration database, and populating any other copies of this information with the updated information, ensuring that information held by the health service is correct and up-to-date.
- **Allocating an Area Health Service unique patient identifier** to new clients/patients.

Registration is for the purpose of providing health care to the client/patient or other related functions.

1.2 Purpose of this policy directive

The purpose of this policy directive is to specify NSW Health policy in relation to the registration of clients, patients and other related people.

Standardised client registration leads to more effective health care in that it enables information relating to any previous care, including screenings, tests, medications, and alerts, to be readily accessible by health professionals, allowing them to provide the best possible care to each client/ patient. This includes improving the quality and safety of health care by better targeting tests, investigative procedures and prescriptions, and reducing any duplication of these that may occur.

Standardised client registration also reduces the costs associated with disparate holdings of client/ patient registration details within an Area Health Service.

1.3 Target audiences

This policy directive applies to all NSW public sector health services as follows:
Public hospitals
- Multi-purpose services
- Residential care facilities
- Supported living services
- Outreach services
- Community health services
- Public psychiatric hospitals
- Pathology, imaging, pharmacy and other support services located in a public health facility
- Ambulance Service of New South Wales
- Justice Health services

The policy covers health care provided by these services in any mode (e.g., telehealth) and any location (e.g., outreach).

Services that are not part of NSW Health and are not delivered in NSW Health facilities (e.g. Aboriginal Medical Services, the Royal Flying Doctor Service) are not subject to this policy.

The staff for which this policy is intended includes any staff involved in registering clients/patients, including:
- client services or registration staff
- support staff such as medical record staff, ward clerks or secretarial staff
- intake officers
- admission managers
- health information managers
- Area information system departments
- clinicians.

1.4 Replaced policy directives

This policy replaces the following policy directives:

- Client Registration Policy (PD2007_094)

2. Client Registration Process

2.1 Which services must register clients/patients?

The following NSW Health services must register clients/patients:

1 Public hospitals and public psychiatric hospitals, including:
   - admitted patient services
   - outpatient services
   - residential and transitional aged care services
   - emergency department services
   - allied health services
   - outreach services
   - confused and disturbed elderly services

2 Residential care facilities, including:
   - residential aged care services
   - brain injury rehabilitation/transitional living services
   - hostel services
   - group home services
   - supported living services

3 Community health services, including:
   - centre/campus based services
   - home based services
   - mobile services
   - outreach services

4 Multi-purpose services

5 Ancillary health services, including pathology, radiology and pharmacy

6 Community acute and post acute care services (including hospital in the home)

7 Ambulance Service of New South Wales

8 Justice Health services

9 HealthOne NSW services.

2.2 Who must be registered?

Mandatory registrations

The following clients/patients who **receive** a health care service, or who are **booked to receive** a health service, including those **added to a waiting list**, must be registered:

- Patients who are admitted or are planned to be admitted to a health facility, including hospital-in-the-home patients.
- Patients who receive services or are planned to receive services in an outpatient department of a hospital.
- Patients who present to an emergency department, including those who do not wait to receive the service and those who are dead on arrival.
- Community health clients or those that are planned to receive these services, including those receiving services off-campus, e.g., at home.

- Clients receiving pathology, radiology or pharmacy services from a public health service, including those who receive a service as a result of a request from an external and/or private health service provider.
- All babies born in public hospitals or a NSW Health birthing facility. Each baby in a multiple birth must be registered separately.
- Stillborn babies of 20 weeks gestation or more, or, if the period of gestation cannot be determined, with a body mass of 400 grams or more. This applies regardless of the delivery location of the stillborn (that is whether it occurs in hospital or prior to arrival).
- Babies up to 9 days old accompanying their mother during her admission to hospital, even if they are well. For this purpose, determine the baby's age at the time of admission of the mother, calculating the day of birth as zero (0). If the baby's age is less than or equal to 9 days old at this time, then the baby must be registered. Babies older than 9 days accompanying their mother to hospital who do not require clinical care should be classified as boarders. See 'Optional registrations' below for guidelines relating to boarders.
- Organ donors (dead or alive), but only within the Area Health Service in which the organ is harvested.
- Clients/patients who are residents in NSW Health facilities, including but not limited to: residential aged care, hostels, group homes, transitional and assisted living, brain injury rehabilitation, and facilities for confused and disturbed elderly.
- Clients/patients receiving respite care.

  Clients/patients receiving a service within a group situation where clinical notes need to be recorded in the individual client's/patient's health record, including clients/patients who may join the group for one or a limited number of sessions. Clients/patients who are located in one Area Health Service but who are provided a service by staff in another Area Health Service using telecommunication service contact modes, such as telehealth. In these instances, clients/patients should be registered at each health service.
- Clients of call-centre based services where identification and/or registration would not inhibit participation in the service. (See 'Optional registrations' below for call-centre based services where registration may inhibit participation in the service.) People receiving individual immunisation or screening services, e.g., breast screening.
- Clients/patients whose identity is unknown at the time of receiving a health care service. (See Section 2.3 for further guidance on this.)
- Clients/patients who wish to have their identity restricted. (See Section 2.3 for further guidance on this.)
- People who are certified as dead prior to arrival to hospital taken directly to the hospital morgue. (See section 3.5 for minimum data requirements for dead people.)

Optional registrations

It is not mandatory to register the following clients, patients and other people who have contact with NSW Health services:

- People receiving group immunisation or screening services (though a record including details of the people receiving these services needs to be kept for medico-legal and follow-up purposes).
- Recipients of health promotion services.

- Clients/patients of the NSW public health system receiving a service that has been contracted out to a private sector or non-government organisation.
- Clients of a needle exchange service or a supervised injecting room.
- Clients of a service where identification and/or registration may inhibit participation in the service and where it is lawful and practicable to provide the service without identifying the client (e.g., crisis counselling, sexual health).
- A family member, carer or support person who receives a service directly related to a client/patient, but who is not deemed clinically as being a client/patient in his/her own right.
- A family member, carer or support person with whom the health service provider communicates regarding the client/patient.
- People making general enquiries of a health service, e.g., about a health condition or about the nature of services available.
- Boarders or other people receiving food and/or accommodation by the health service but who are not receiving treatment (e.g., a parent accompanying their sick child during a hospital admission). While there is no requirement under this policy directive to register these people, individual Area Health Services may set local policies that require registration for purposes such as delivery of meals or for accounting for hospital occupants in disaster or emergency situations.

2.3 Special circumstances

Unidentified clients/patients: Unidentified clients/patients are people for whom no registration details can be collected because the client/patient is unable to provide those details (e.g., the person is unconscious) and there is no other person (such as a relative or carer) who can provide this information. Unidentified clients/patients must be registered and assigned an Area Health Service unique patient identifier. Procedures for registering unidentified clients/patients detailed in the *Client Registration Guideline* (GL2007_024) must be followed, and attempts should be made to obtain the client/patient registration details from alternative sources, such as relatives or carers, where possible. People in Justice Health under a witness protection program are considered to be unidentified clients/patients for the purpose of this policy but in these instances no attempts should be made to obtain the client/patient registration details from alternative sources.

Identity-restricted clients/patients: An identity-restricted client/patient is one whose identity can be ascertained but there is a requirement to mask it in the registration system because the client/patient requests it, or for legal or other reasons. Identity-restricted clients/patients may include staff of a service; Very Important Persons (VIPs); or people receiving services of a sensitive nature. Clients/ patients who wish to have their identity restricted or are required to have their identity restricted must still be registered and allocated an Area Health Service unique patient identifier. This should be managed by policies developed by the Area Health Service. See *Client Registration Guideline* (GL2007_024) for further guidance on the registration of identity-restricted clients/patients. Also, see the Privacy Manual for Health Information (March 2015).

Telephone information, assessment and intake: Clients/patients may or may not be registered in these instances, depending on the nature of the call. For example, if the call is purely a request for publicly accessible information (e.g., opening times or contact details for a service), registration is not required. However, if the call involves intake (e.g., screening or assessment for the provision of a service), or for an appointment for a service, client registration needs to occur and at least the minimum registration data items recorded (see section 3.2). See Section 2.2 for guidelines on crisis-lines.

2.4 When to register

Client registration must occur at the first point of contact with a health service, or as early as possible in the process of providing a service. The first point of contact may be at the time of booking or, in the case of drop-in services, at the time of first presentation. For people who are certified as dead prior to arrival to hospital, the first point of contact is when the hospital takes responsibility for the body.

If it is not possible to obtain all client registration details at the time the client/patient is being booked for a service, effort should be made to obtain as many of the mandatory registration items as possible and then to record the remaining mandatory items at the time that the service is actually provided. This practice also applies in instances when the Area Health Service-wide client registration database is not accessible, in which case local policies should be developed and followed to ensure that the minimum mandatory data items are collected and the remainder followed up later. See Section 3 for a listing of mandatory client registration data items.

2.5 How to register clients/patients and update details

Client registrations must be recorded electronically in a single Area Health Service-wide client registration database. Each client/patient must be assigned an Area Health Service unique patient identifier.

Prior to adding a new client/patient to the Area Health Service-wide client registration database, it is mandatory to search for an existing registration of the client/patient within that database using a variety of search criteria. The search criteria should be defined in an Area Health Service policy and should align with the criteria described in the *Client Registration Guideline* (GL2007_024) and section 3.1 of this policy directive.

Updates to client registration details must always be made in the Area Health Service-wide client registration database.

Where client registration details are required in applications other than the Area Health Service-wide client registration database, an electronic HL7 message should flow outbound from Area Health Service-wide client registration database to the other system when a client's details are added, updated or requested by that system. For systems that are not compliant with HL7 messaging standards, the registration details will need to be entered manually into both the Area Health Service-wide client registration database and the non-HL7 compliant system - both sources must be kept consistent and up-to-date.

All alternative local identifiers (e.g. medical record numbers) assigned to the patient by other electronic systems, or by manual methods, must be stored in the Area Health Service-wide client registration database. This is required so that information from all source systems can be linked. Where functionality is available, the Area Health Service unique patient identifier must also be stored in the other source systems that hold a copy of client registration details, and transcribed onto all paper based medical records.

A 'Privacy leaflet for patients', as described in the *NSW Health Privacy Manual*, or similar, must be made available to clients/patients at every site performing client registration. This information should be prominently displayed (e.g. in admission areas, community health and hospital outpatient reception areas, emergency departments and hospital wards) and readily accessible to patients.

2.6 When to update client registration details

Client/patient details should be checked and confirmed or updated, as appropriate, each time a client presents for a new phase of treatment.

A phase of treatment may involve a number of service events that occur within weeks or months. Where a phase of treatment goes beyond three months, the currency of client registration details should be checked and confirmed with the client/patient every three months at minimum.

On re-presentation, or at the time a new service is booked or scheduled, special consideration must be given to the currency of:

- Address of usual residence
- Mailing address
- Telephone number(s)
- Preferred language
- Interpreter required
- Medicare eligibility and Medicare number (if eligibility for Medicare is a factor in service provision or billing)
- Health fund and health fund membership number (if a claim is to be made for the client/patient)
- General practitioner details
- Person to contact

Under privacy laws it is a requirement to keep personal health information up-to-date and accurate. Corrections or updates to client registration details made following a request by a client/patient, or his/her authorised representative, must be actioned in the Area Health Service-wide client registration database and in all copies of that information. For further guidance on clients' requests to make changes to their personal health information, see section 12.7 of the *NSW Health Privacy Manual.*

2.7 Area Health Service responsibilities

It is a mandatory requirement that each Area Health Service defines standard criteria for searching for client registrations that align with those described in the *Client Registration Guideline* (GL2007_024) and section 3.1 of this policy directive and to distribute them to all staff responsible for registering clients.

Area Health Services must ensure that all staff responsible for registering clients are trained in all aspects of registration (e.g., gathering of information from the client/patient, searching, recording information and assigning an Area Health Service unique patient identifier) before they are allowed to register clients/patients. Training should cover relevant policies and procedures, consequences and risks to patient health care and health service liability arising from duplicate registration and incorrect identification and matching of individuals.

Follow up training and education should be available for all relevant staff and procedures implemented to monitor the quality of registrations. Staff identified as having issues meeting the expected client registration standards, e.g., creating duplicate registrations or incorrectly matching clients/patients, should undergo structured remedial training and further monitoring to ensure that the training has been effective. Subsequent ongoing issues with registration should be addressed in accord with the local performance management framework and the staff member's continued involvement in client registration examined.

Area Health Services should have a client registration policy that addresses the following:

- standard methodology for searching for existing registrations in the Area Health service-wide client registration database

- training staff prior to allowing them to register clients
- follow-up training for client registration staff
- material to be covered in client registration training
- methods used to reduce duplicate registrations
- procedures to resolve potential duplicates
- how to register identity-restricted clients

2.8 When to implement

It is recognised that implementation of this policy directive may require changes to local business processes and, as such, will be introduced in a staged manner across NSW. The policy should be implemented across all services by 1 September 2008.

3. Client Registration Data to Collect

There are four groups of client registration data:
1. minimum data for searching for an existing registration;
2. minimum data for booking or scheduling the first service within the Area Health Service;
3. minimum data for provision of the first service within the Area Health Service;
4. additional data mandated for specific encounter types.

The *NSW Health Data Dictionary* is the authoritative source for data and classification standards for NSW Health. It also provides some business rules. Compliance with the dictionary is mandatory.

3.1 Information required to search for an existing registration

A search of the Area Health Service-wide client registration database must be conducted prior to registering a new client. This applies regardless of whether or not the patient states that they have previously been a client/patient of the service.

The priority information to be used for searching and matching is:
- Family name
- Initial of given name/given name
- Date of birth
- Sex

Highly desirable information for searching and confirming identity when results for a search have been returned are:
- Middle name(s).
- Alias name(s) (including maiden name and any other name used at any time).
- Address of usual residence.

Where only part of the information above can be obtained (e.g., in emergency situations), the search should use what information is available and reviewed at a later time when further information is available.

3.2 Information required for booking the first service

When a booking is made for the first service it is mandatory that the following information is recorded in the Area Health Service-wide client registration database:
- Family name
- Given name

- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Address of usual residence
- Mailing address (if different from Address of usual residence)
- Telephone number(s) - home, work and/or mobile
- Preferred language
- Interpreter required

This information is required to enable the client/patient to be contacted when a planned service needs to be rescheduled, and for scheduling interpreter services if required.

In addition to these items, services may choose to record the extra items in section 3.3 to save having to enter them at the time of first service provision.

3.3 Information required at time of service provision

At the time the first service is provided, it is mandatory that the following information is recorded in the Area Health Service-wide client registration database:

- Family name
- Given name
- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Address of usual residence
- Mailing address (if different from Address of usual residence)
- Telephone number(s) - home, work and/or mobile
- Preferred language
- Interpreter required
- Country of birth
- Aboriginal or Torres Strait Islander origin
- Medicare eligibility and Medicare Number (if eligibility for Medicare is a factor in service provision or billing)
- Department of Veterans' Affairs (DVA) file number and card type (if a DVA card holder)
- Health fund and health fund membership number (if the health service intends to make a claim against a private fund for services provided)
- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients under 16 years of age

It is highly desirable that the following information is also recorded in the Area Health Service-wide client registration database:

- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients 16 years of age or older.
- General practitioner name, address, telephone, email and facsimile numbers (for the purpose of corresponding with general practitioner about the client's/patient's ongoing care).

3.4 Additional data mandated for newborns

A baby born at or on the way to the hospital/birth centre must be registered as soon as possible after the birth. The information required for newborns is the same as the information required for other clients/patients, however the following additional information is also mandatory:

- Full name of mother.
- Mother's medical record number/Area Health Service unique patient identifier.

It is also highly desirable to record:

- Full name of father.

Some details, such as address of usual residence, may be inherited (copied) from the mother's registration details. However, Aboriginal or Torres Strait Islander origin of the baby should not be assumed to be the same as that of the mother. Staff should especially not assume that the newborn baby is not of Aboriginal or Torres Strait Islander origin when the mother has not identified as being Indigenous. The mother should be asked as to the status of the baby.

3.5 Information required for dead people

All hospitals must register, in the Area Health Service-wide client registration database, all people who die in hospital and those who are already dead who are brought to hospital. Specific information, outlined below, is required for the management of deceased people, and an additional register will need to be maintained where the Area Health Service wide client registration database does not accommodate all that information.

With respect to deaths, this policy directive should be read in conjunction with the following Acts and Policy Directives:

- *State Records Act 1998*
- PD2010_054 *Coroners' Cases and the Coroners Act 2009*

Hospitals should ensure that proper procedures are followed at all times with respect to the identification of dead people as well as the subsequent removal of bodies from hospital premises.

When the body of a person who dies outside the hospital is brought to the hospital, the Area Health Service-wide client registration database should be searched in the same way as for all other clients/ patients of the health service.

Information about the person's identity and other details should, if possible, be obtained from the next of kin, other family members or friends. If this is not possible, then information should be obtained from the person bringing the body to the hospital and any documentation in relation to the person (e.g., death certificate).

Where only part of the information required for searching is available, the search should use what information is available and reviewed when further information is available.

If the person has not been registered in the Area Health Service-wide client registration database, data items that must be recorded for them in that database are as follows:

- Family name
- Given name
- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Country of birth
- Aboriginal or Torres Strait Islander origin
- Person to contact (name, address, telephone numbers, relationship to client/patient)

Other mandatory information required specifically for the management of dead people includes:

- Where the body came from
- Whether a death certificate was issued or the death has been reported to Coroner
- Whether an autopsy has been authorised
- Who the body is claimed by
- That an authority for removal of the body has been sighted
- Date and time of removal
- Signature of the person removing the body

If this additional mandatory information cannot be accommodated in the Area Health Service-wide client registration database, an additional register to record this information must be maintained. The Area Health Service unique patient identifier must be used in that register to enable the information in that register to be linked to the record in the Area Health Service-wide client registration database.

When a person is dead, it is also important to record this on the Area Health Service-wide client registration database. This is necessary for people that die in hospital, for people who die outside of hospital and are brought to the hospital (e.g., to the emergency department or to the morgue), and for other people when the health service obtains notice and confirmation of their death.

Recording that a person is dead will ensure that any outstanding appointments across the Area Health Service can be cancelled, and can prevent further activity in relation to the client/patient (such as automatically generated letters) where information systems check the deceased flag in the Area Health Service-wide client registration database before initiating such activity.

If the death of a client/patient is known, the following information fields must be updated on the client's/patient's registration record:

- Date of death.
- Date of death estimation flag.

Standards for recording date of death where it is unknown are described in the *NSW Health Data Dictionary*.

4. Related Documents and Definitions

4.1 Related policies

This policy directive should be read in conjunction with NSW information privacy policies, legislation and other relevant policy directives to ensure the proper collection, storage, use and disclosure of health information. Such policies and legislation currently include:

1 Privacy Manual for Health Information (March 2015).
2 *Health Records and Information Privacy Act 2002* (NSW).
3 *Privacy and Personal Information Protection Act 1998* (NSW).
4 PD2010_054 *Coroners' Cases and the Coroners Act 2009*, and
5 *State Records Act 1998.*

4.2 Related standards

The following standards and guidelines have been referenced in developing this policy directive:

1 NSW Health Client Registration Standard, NSW Health, 2004.
2 NSW Health Data Dictionary, NSW Health, Version 1.2, 2006.
3 Australian Standard Health Care Client Identification (AS 5017-2006), Standards Australia, 2006.
4 Australian Standard Interchange of Client Information (AS 4590-2006), Standards Australia, 2006.

Information contained in the Area Health Service-wide client registration database should be maintained according to guidelines in the current General Retention and Disposal Authority - Public Health Services: Patient/Client Records (GDA 17), NSW Department of Health Information Bulletin 2004/20.

4.3 Definition of a health service

In the context of this policy directive a health service is defined as a service that provides any of the following:

- Initial health care needs identification
- Comprehensive or specialist health assessment
- Therapy or clinical intervention, symptom control
- Pain management
- Palliative care
- Spiritual, personal and/or social support or care
- Case management and/or care coordination
- Follow up, monitoring, evaluation, review
- Provision of aids and appliances (including in the home)
- Preventative care
- Radiology, pharmacy or pathology services
- Supported living
- Education about health issues

4.4 Definition of an Area Health Service unique patient identifier

A unique identifier within the Area Health Service assigned to a client/patient to distinguish them from other clients/patients.

For The Children's Hospital at Westmead, The Ambulance Service of New South Wales, and Justice Health, the Area Health Service unique patient identifier is the unique client/patient identifier assigned by those organisations respectively.

CLIENT REGISTRATION GUIDELINE (GL2007_024)

Background and instruction on the What, Why, Who, When and How of clients/patients registered within the NSW Public Health System. The Guideline can be accessed at http://www.health.nsw.gov.au/policies/gl/2007/GL2007_024.html

IDENTIFYING THE CARER AT PATIENT REGISTRATION (IB2019_031)

PURPOSE

The purpose of this Information Bulletin is to advise of changes to the NSW Health patient administration system (PAS) to record when a patient/client/consumer has a carer or is a carer.

Identifying a carer leads to safer and better quality care as health staff can involve them in discussions and decisions about the patient's care and treatment. Patients and their carers have a better experience when they are acknowledged and able to talk to and work with health staff. Health staff can also provide support, referrals and information to the carer as needed.

This Information Bulletin is to be used in conjunction with the Client Registration Policy Directive (PD2007_094) which specifies NSW Health policy in relation to the registration of clients, patients and other related people, such as carers.

KEY INFORMATION

From July 2019, at the time the first service is provided, it is mandatory to record in the PAS if a patient has a carer or is a carer. It is highly desirable that the information is recorded when booking or scheduling the first service. The information should be recorded in the iPM and Cerner PAS or appropriate location if another PAS is used. When the Client Registration form (SMR005.001/SMR005.002) is used the carer information should also be recorded.

On re-presentation, or at the time a new service is booked or scheduled, special consideration must be given to the currency of the carer information.

The information recorded in the PAS will be displayed in the electronic Medical Record (eMR).

Patients registered to a mental health service may nominate a Designated Carer/s. See Attachment 3 for more details, and the Nomination of Designated Carer/s form (SMR025.170).

Who is a carer?

A person is a carer if they provide unpaid, ongoing care and support to a family member or friend who needs it because of:

- disability,
- chronic (long term) illness e.g. diabetes, arthritis
- terminal (life limiting) illness,
- mental illness e.g. depression, anxiety, or
- frailty and ageing.

Many carers don't recognise themselves as a carer. A carer will have a relationship with the patient. For example, the carer may also be the patient's husband, sister or friend. However, as a carer, they will have additional ongoing responsibilities because the patient is unwell, frail or has a disability.

The patient may not be sure if they have a carer or, if they are a carer. Whether the person has a carer, or is a carer, is based on the patient's point of view.

The carer may be the Person to Contact for a patient/client/consumer.

The carer may help a family member or friend with daily needs such as feeding, bathing, dressing, toileting, taking medications or moving. The carer may support a person who is fairly independent but needs someone to check in to make sure they are safe and looking after themselves, or to help them with banking, transport, shopping or housework.

The carer of a **person being registered for mental health care** may be nominated as a Designated Carer and/or identified as a Principal Care Provider under the *NSW Mental Health Act 2007*. See Attachment 3 for more details, and the Nomination of Designated Carer/s form (SMR025.170) and Identification of Principal Care Provider form (SMR025.107).

Why ask if the patient has a carer or is a carer?
When health staff know that the patient has a carer they can involve that person in discussions and decisions about the patient's care and treatment. Patients and their carers have a better experience when they are able to talk to and work with health staff. Involving the carer can ensure a better outcome for the patient, reduce the risk of avoidable admissions and a longer stay in hospital.

Carers are more likely to experience physical and mental ill health and disability than the general population. When health staff know the patient has a carer or is a carer they are able to provide support, referrals and information, as needed.

Health staff can ensure that alternative care and support is arranged while the carer is in hospital or unable to provide care for another reason.

The NSW Carers (Recognition) Act 2010 requires staff to take action to reflect the principles of the NSW Carers Charter. The Charter states that carers should be recognised and supported and the relationship between a carer and the person for whom they care should be respected.

SUPPORTING INFORMATION

Health and Social Policy Branch, Ministry of Health and eHealth NSW are developing communication and education materials to assist in recording when a patient/client has a carer or is a carer. Quick User Guides and other materials will be found at:
https://www.health.nsw.gov.au/carers/Pages/default.aspx

NSW Health GL2007_024: Client Registration Guideline
http://www0.health.nsw.gov.au/policies/gl/2007/pdf/GL2007_024.pdf

Mental Health Act Guidebook
https://www.health.nsw.gov.au/mentalhealth/resources/Pages/mhact-guidebook-2007.aspx

For additional information please contact Health and Social Policy Branch, NSW Ministry of Health on 9391 9843.

Attachments listed below can be accessed at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2019_031

1. Instruction Sheet - Carer Identification
2. Attributes of Data items
3. Role Information

REGISTRATION OF NSW HEALTH ESTABLISHMENTS (PD2017_038)

PD2017_038 rescinds PD2008_001

PURPOSE

The purpose of this Policy Directive is to update and describe the mandatory requirement for Local Health Districts (LHDs), Specialist Health Networks (SHNs) and Health Pillars to register health establishments including organisations, locations and service units within NSW, and record the registration details within the NSW Ministry of Health's Health Establishment Registration Online application (HERO).

The information gathered will also be used to provide regular updates for the population of the Health Direct Australia – National Health Service Directory, as well as staffing and incident management systems.

Note: The population of the Human Services Network (HSNet's) ServiceLink will occur from information provided to Health Direct Australia's National Health Service Directory.

This Policy Directive supports the existing registration practices, extends registration requirements beyond the hospital setting, and mandates the registration of service units within hospitals and community health services. It also describes the mandatory information that must be provided when registering health entities and locations. It is to be read in conjunction with the latest HERO Information Bulletin and replaces PD 2008_001.

MANDATORY REQUIREMENTS

Registration of health services is necessary to:

- support rapid access by staff and clients to services
- support referrals of clients to appropriate services
- rationalise requirements to report information about health services
- manage data collections and performance reporting
- uniquely identify the source of data messages and data extracts for data collection management purposes
- support better planning of health services across NSW
- support activity target setting and activity modelling
- support activity based funding as set out in the Service Agreements.

Each LHD / SHN / Shared Service Entity must assign a staff member as the establishment registration manager. This staff member is the point of contact for the NSW Ministry of Health and Service Directory regarding any matter related to the registration of health establishments within the LHD / SHN catchment, or for the entities required by Shared Services, and will have the highest level HERO registration approval rights within the LHD / SHN / Shared Service entity, i.e. Jurisdiction Administrator.

IMPLEMENTATION

Entry of registration details in HERO is restricted to staff working within the NSW public health system. HERO maintains information about establishments and services that are essential for internal information management processes and messaging interfaces, target modelling and reporting.

A subset of the HERO registration details may be used within information systems where lists of particular services are required – this may include some systems used in the private health sector.

A limited set of information from HERO may be published for use by the general public and staff on the NSW Ministry of Health, LHD / SHN websites. Registration made in HERO will be used to populate and maintain the NSW Ministry of Health Services Directory located at the following URL: http://internal.health.nsw.gov.au/services/

The NSW Ministry of Health may provide a selection of information from registrations in HERO to the National Health Service Directory maintained by Health Direct Australia.

Health Direct Australia will populate information from the National Health Service Directory into the HSNet ServiceLink for the use by staff and the public. This information can be accessed at the following URL: **https://www.hsnet.nsw.gov.au/**

eHealth will extract information from HERO locations registered for the purpose of identifying locations of staff in their Lookup application.

Clinical Excellence Commission will extract information from HERO location establishment types registered for the purpose of identifying locations of incidents in their incident management system application.

Registration of NSW Health Establishments: Procedures.

1 BACKGROUND

1.1 What Is Health Establishment Registration?

For the purpose of this Policy Directive, 'Health Establishment Registration' is defined as the process of recording a core set of mandatory information about a health service entity in the HERO application.

For the purpose of this policy an entity can be:

- A location where health services are provided i.e. clinical or support
- A service unit
- A hospital
- A community health centre
- A diagnostic service outlet eg pathology collection

The process of registering a health establishment in HERO will result in the automatic assignment of a state-wide identifier for that entity, unique within the context of NSW Health.

1.2 Definitions and Abbreviations relating to this Policy Directive

- HERO: Health Establishment Registration Online
- LHD: Local Health District
- SHN: Specialist Health Network
- Shared Services: Devolved organisations affiliated with NSW Health, such as eHealth, Pathology, NSW Ambulance Services, Cancer Institute of NSW, etc.
- HDA (HealthDirect Australia): National Health Service Directory vendor
- HIE: Health Information Exchange data warehouse, legacy system
- EDWARD: Enterprise Data Warehouse for Analysis, Reporting and Decision Support
- FaMER: Facility Metadata Registry database to assign facility identifiers for HIE
- NGO: not-for-profit organisations, previously known as non-government organisations
- HSIPR: Health System Information and Performance Reporting Branch
- Service Unit: is defined as a team of people that come together to deliver health services to patients/clients with a specific set of problems or issues. Service units are part of an organisational structure.
- Establishment: Institutions, organisations or the community from which health services are provided. The term establishment covers conventional health establishments and also organisations which may provide services in the community.
- Location: The physical area where services are delivered, but not the organisations or service units that deliver the services at that location.
- Person Identifier Issuing Authority: Nominated organisation responsible for the assignment of a client identifier record number within the LHD / SHN.

2 HERO DATA SPONSOR

The executive sponsor of the HERO data collection is the Executive Director, Health System Information Performance Reporting (HSIPR) Branch and Deputy Secretary, System Purchasing Performance Division.

Within the division, the Executive Director, HSIPR Branch is the primary contact for authorising new health organisations, as well as significant amendments or closures of existing health organisations.

3 WHICH HEALTH ESTABLISHMENTS MUST BE REGISTERED?

It is mandatory for all establishments that report data to any mandated NSW Health data collections or are required for commonwealth reporting requirements, to be registered in HERO.

The types of health establishments that must be registered include:

- all NSW health public sector establishments / organisations;
- all NSW board-governed statutory health corporations. For example, the NSW Ambulance Service, Cancer NSW clinical services;
- all NSW health service units/teams/clinics under NSW public sector establishments/organisations, board governed statutory health corporations and affiliated health organisations including intake services;

- all NSW private sector health care establishments; this may include some if not all of their service units/teams /clinics, as deemed necessary for disease notifications;
- all interstate establishments that have high levels of inbound and outbound referrals or contractual arrangements. However this does not include their service units/teams/clinics;
- all NSW Health locations as requested to support the use of eHealth applications such as the StateWide Infrastructure Services Health Lookup system and the Incident Management System. This may also include administrative service locations, staffing and asset management locations;
- all Person Identifier issuing authorities to enable identification of such authorities in the EDWARD data warehouse.

3.1 Health Service Units

For the purpose of this Policy Directive and registrations within HERO, a 'service unit' is defined as a team of people that come together to deliver health services to or on behalf of patients / clients with a specific set of problems or issues. Service units are part of an organisational structure, and are distinct from the physical locations where they are based at and/or provide services from. Under certain circumstances, LHDs may wish to register both the service unit and the physical location for entities that possess both attributes, e.g., an admitted patient physical ward location and the associated admitted patient service unit.

The registration of service units within HERO is mandatory.

Service units within NSW public sector LHDs, SHNs, hospitals, community health services and state-wide networks must be registered as 'child' establishments (services) of the relevant higher level organisation.

Service units have one or more roles / positions within them, and there may be one or more incumbents working within those roles / positions. Where source systems are used to schedule or record activity, service units are clearly established and defined within those source systems as hospital outpatient clinics or community health centre service teams.

Examples of service units include:

- Intake services
- Emergency department teams
- Public hospital outpatient service units
- Public hospital admitted patient service units
- Public hospital outreach service units
- Public hospital pathology laboratory / radiology / pharmacy services
- Public sector community health service units
- Public sector client information services / call centres
- Public sector patient transport services
- Public health unit service teams.

All health service units that deliver services on NSW Health campuses must be registered in HERO, even if they only deliver services on a privately referred non-admitted basis.

Service units that report directly to a state-wide network or program, such as oral health, immunisation, screening and needle exchange services may have a parent health establishment of a state network rather than an LHD / SHN. However, they should be recorded in HERO as being located within the jurisdiction boundary of a LHD.

3.2 Service Point Locations

Registration of all service point locations is also mandatory. This is to support the use of HERO 'location' entities by StateWide Infrastructure Services Health applications, the Clinical Excellence Commission Incident Management System and other system applications. Registering these types of entities allows the association of relationships between entities in HERO, specifically the relationship between service units and the locations at which they deliver services, and the hospitals and community health services that are located within each LHD / SHN.

3.3 Other Establishments Reported via a Mandated Data Collection

Any health entity that is not listed above and which reports to a NSW Ministry of Health data collection must also be registered in HERO.

3.4 Establishment Identifiers

When an establishment is registered in HERO, it will be assigned a unique identifier within the context of NSW Health.

Alternative identifiers, such as the HIE facility identifier, should be recorded in HERO to support the continued interim use of those existing identifiers in legacy applications such as the HIE data warehouse for cross-referencing and aliasing in source system applications. It assists in the process of reconciling legacy systems to the replacement system. This cross-referencing is also used as an interim mapping for transition of WebNAP to EDWARD via the mLoad application.

3.5 Use of Hero Identifier versus Other Facility Identifiers

The HERO identifier must be used as the identifier for the entity in all new data collections or new applications where an identifier for an entity is required.

The HERO identifier must replace the existing HIE facility identifier at the next logical change over point.

Logical change over points includes:

- Data collection re-design
- Data collection extract modification
- Source system change, upgrade or migration
- Migration of a data collection to a new data repository.

Prior to the logical change-over point, the four-character HIE facility identifier may continue to be used.

Some new establishments may be assigned both a new HERO identifier and a HIE facility identifier upon initial registration if they are covered by a reporting requirement that is still using the HIE facility identifier.

The HSIPR Branch will assign any HIE facility identifiers and record them in HERO against the relevant entity.

3.6 Other Entities That May Be Registered In HERO on a Needs Basis

HERO will support the registration of a broad range of health service establishments, reporting entities, and service point locations that are beyond the minimum mandatory registration requirements described in this Policy Directive. This allows for the recording of relationships between each entity, including the range of locations at which services may be delivered.

Establishments, reporting entities, and service point locations that are not mandatory for registration may be registered where an LHD / SHN or other business unit identifies a requirement to do so. For example, an LHD / SHN may wish to register a specific outpatient service within a private hospital or interstate health services to facilitate the recording of referrals to or from that service.

4 WHICH HEALTH ENTITIES MUST NOT BE REGISTERED?

4.1 Virtual Wards

Under the Location hierarchy within HERO, wards reflect actual physical locations where a patient is accommodated. A virtual ward that is established in one hospital for the purpose of accommodating a patient who spends part or all of their stay within a different hospital contradicts the intent of HERO.

With the exceptions of (i) Hospital in the Home virtual wards and (ii) MoH approved Collaborative Care wards, HSIPR will not be endorsing these types of entities, and will seek written submissions from the LHD / SHN explaining the necessity for the initial request, allowing HSIPR to provide appropriate advice.

5 WHO WILL ACCESS ESTABLISHMENT REGISTRATION DETAILS?

Entry of registration details in HERO is restricted to authorised staff working within the NSW public health system. HERO maintains information about establishments and services that are essential for internal information management processes and messaging interfaces, purchasing and reporting.

As it is important that all staff have ready access to information about other Government services that will assist clinicians with appropriate referral pathways for clients, LHDs/SHNs should ensure that the relevant information technology support units of an LHD / SHN, eHealth, NSW HealthShare, and the NSW Ministry of Health have provided general access to all staff with intranet access to the HERO website (https://hero.health.nsw.gov.au)

A subset of the HERO registration details may be used within information systems where lists of particular services are required – this may include some systems used in the private health sector.

A limited set of information from HERO may be published for use by the general public and staff on the NSW Ministry of Health, LHD / SHN websites. Registrations made in HERO will be used to populate and maintain the NSW Ministry of Health Services Directory located at the following URL: **http://internal.health.nsw.gov.au/services/**

eHealth will extract information from HERO locations registered for the purpose of identifying locations of staff in their Lookup application.

The Clinical Excellence Commission will extract information from HERO location establishment types registered for the purpose of identifying locations of staff in their incident management system application.

6 ROLES AND RESPONSIBILITIES

6.1 HSIPR Branch

The NSW Ministry of Health's HSIPR Branch has the responsibility to perform the ***initial*** registration of any new higher level establishments, and to amend or maintain details over time. These include:

- Local Health Districts, Specialist Health Networks, Shared Services and other Affiliated Health Organisations;
- Public Hospitals, including Third Schedule Hospitals (affiliated) and Public Psychiatric Hospitals, including interstate;
- Public or private Residential Aged Care Facilities, including interstate;
- Public or private Hospices;
- Multi-Purpose Services (MPS);
- Community Health Centres;
- Community Residential Facilities / Supported Accommodation Services / Group Homes;
- Not for Profit organisations (ie Non-Government organisations)
- Freestanding pathology laboratories / radiology suites / pharmacy locations

The HSIPR Branch is responsible for monitoring the openings and closures of all the above entities. Initial registration of these entities will only occur following a written request from the LHD / SHNs Chief Executive.

It is the role of the HSIPR Branch to provide state-wide management and support for the registration system. HSIPR is responsible for:

- Developing, updating and publishing all information, including policy directives, guidelines, data standards and instructions that support health establishment registration.
- Training of a nominated LHD / SHN representative who in turn will provide training to other responsible LHD / SHN staff to register and manage health service establishments within HERO.
- Establishing and maintaining HERO user accounts.
- Maintaining HERO code value reference tables.
- Coordinating changes to the HERO application.

6.2 LHDs/SHNs

6.2.1 Registration of Health Establishments

For lower level entities, it is the responsibility of the LHD / SHN to perform the initial registration of the following NSW health establishments:

- Ambulatory / hospital / community health services, including mental health service units/teams;
- Mothercraft services;
- Public health units;

- HealthOne services;
- Person Identifier issuing authorities;
- Service point locations including mental health service delivery locations;
- Incident area locations.

It is the responsibility of the LHD / SHN to maintain the details of these entities over time. However, the HSIPR Branch reserves the right to update attributes and/or identifier information as required for reporting purposes.

Also, it is the LHD / SHNs responsibility to advise HSIPR of any new service contractual arrangements between the LHD / SHN and other organisation(s). The Ministry's HERO Administrator will create the initial registration of the 'contracted' establishments and has the right to maintain the details over time such as:

- Private residential aged care facilities;
- Private hospices
- Private organisations with public contracted services

Interstate private and public sector establishments must be registered if there are high levels of referrals with NSW health establishments, or contracts established to provide health services on behalf of NSW Health. This is necessary for planning purposes, to identify and monitor inbound or outbound referral patterns, and to monitor purchased activity.

The types of interstate public and private sector establishments (if the LHD / SHN has a contract with the private sector organisation to provide health services) that must be registered include the following:

- Hospitals
- Day procedure centres
- Residential aged care facilities
- Non-government organisations (either for-profit or not-for-profit) providing health services under a contract with the Ministry of Health.

The LHD / SHN must notify the MOH HERO Administrator who will create these interstate establishments.

6.2.2 Additional responsibilities and processes

In addition, the LHD / SHN establishment registration manager is required to:

- Manage completion of the initial and ongoing reviews, verification or correction of details relating to previously registered establishments.
- Ensure the health establishment identifier is provided back to the source system administrator, health service and any staff that use related data within the LHD / SHN.
- Conduct an audit/review every six months of HERO using data and information for that service available for a minimum of the previous 18 months, or for the length of time the service has operated, whichever time period is the shorter. Suggested reviews are conducted by 31 March and 30 September each year to ensure that the information is accurate and up-to-date, in consultation with the service unit manager and relevant executive personnel, e.g. Clinical Director.

- Establish and manage a process of approval for registration of new health service establishments within the LHD / SHN.
- Manage a process of mergers and closures of services.
- Notify the Ministry in writing, via the Executive Director of the HSIPR Branch, of any creations of new or closures of existing health organisations, such as hospitals or LHD wide community health services, including an assessment on the impact of the change on their performance activity targets.
- Contribute to the ongoing development of the standard classifications within HERO, and provide advice about any system refinement required.

Changes of establishment type are only permitted in the case of genuine errors, not as a result of a change in the service delivered by a service unit. As a general principle, it is therefore recommended that where a service has changed their establishment type, this is sufficient to justify a closure of the existing service unit and the creation of a new service unit. Refer to guideline related to this policy for more detailed information.

For the ongoing registration of new services and new establishments, a HERO registration must be completed prior to providing services to clients/patients and prior to being activated within any source system. Source systems must have the HERO identifier aliased for all data warehouse extracts.

Registration details of entities must be updated and confirmed by the LHD / SHN establishment registration manager when there is a significant change to a service. This includes opening or closing, temporary closures of a location/service, or change of establishment type. Continuity of activity reporting is essential for target setting and activity based funding.

6.3 Private Health Care – Regulation and Compliance Unit

The NSW Ministry of Health's Private Health Care – Regulation and Compliance Unit (PHC) is responsible for licensing the private sector hospital and day procedure centres, including details about the openings and closures, addresses and other contact details, as well as the licenses and parent companies.

Currently, the registrations of the following are the joint responsibility of HSIPR and PHC:

- Private hospitals; and
- Private day procedure centres

6.4 Other Ministry of Health branches

Where other branches within NSW Health have elected to utilise LHD / SHN HERO data for their own requirements, it is that branch's responsibility to manage the requisite content and liaise with the LHDs/SHNs to ensure that the establishment data they are requesting meets that branch's requirements. Prioritisation and ongoing maintenance of that work by the LHD / SHN is to be negotiated directly between that branch and the LHD / SHN, and that branch is to liaise with the LHD / SHN to address any shortcomings of the content within HERO.

Under these circumstances, HSIPR's role is to act as system administrator, ensuring that any new or changed data follows HERO classification hierarchy principles, and to provide extracts of the data upon request. Management of any other work, including verification of content, is not part of HSIPR's remit with respect to its role as HERO administrator.

6.5 Shared Services and Affiliated Organisations

The initial registration of new entities for other purposes will be the responsibility of the Shared Services / Affiliated Organisation introducing the requirement to identify them within HERO. Post-implementation and ongoing maintenance will be the responsibility of the LHD / SHN or Shared Service / Affiliated Organisation where the entity is managed.

7 MANDATORY MINIMUM DATA ITEMS FOR REGISTRATION

There are mandatory fields in HERO via the Quick Registration option that must be completed prior to submitting a registration request to the MOH HERO administrator.

The following data items comprise the minimum data set for health establishment registration in HERO. *Note:* fields that show an asterisk * are mandatory for the quick registration process.

- Establishment name – official standardised name*

  Note: the standardised name will appear in all Ministry and Executive reports. Please refer to the guideline related to this policy directive for the preferred naming convention standard.
- Establishment name – abbreviated name*
- Health sector*
- Management Authority (i.e. LHD / SHN)*
- Jurisdiction Boundary (i.e. LHD / SHN Boundary location)*
- Hierarchical parent establishment*
- Establishment group (derived field)*
- Establishment type*
- Open date*
- Telephone number (where applicable)
- Physical and Postal address details i.e. Street address and Suburb/Locality*

Additional details via the ‘More Details’ button can be added, if available, during the quick registration process to ensure the registration is fully completed and submitted for final approval.

- Close date (where applicable)
- HIE/FaMER identifier (for previously registered establishments only and services/locations still providing extracts to HIE data warehouse).

Note: If the additional details are not immediately available for the initial approval, then this requires ‘checking out’ the HERO entity, updating and re-submitting for final approval.

For each data collection that the health organisation reports to, the following can be recorded in HERO (this ‘optional’ requirement may change in the future):

- Data collection (via Reporting Details tab)
- Reporting start date (via Reporting Details tab)
- Method of reporting (via Reporting Details tab)
- Identifier used for reporting (via Identifiers tab)
- Source system and version (via Reporting Details tab)

- Contact position
- Contact address
- Contact telephone number
- Contact email address.

8 NATIONAL HEALTH SERVICES DIRECTORY

The NSW Ministry of Health has an agreement with Health Direct Australia to provide an extract with an agreed selection of information from registrations in HERO to populate the National Health Service Directory with services in New South Wales. This directory is available to all staff via the URL: **http://www.nhsd.com.au**.

The HERO extract will supply the following fields for all open entities (excluding physical locations, Justice Health entities and any entities deemed not for release by the LHDs/SHNs):

- Establishment ID
- Standardised Name
- Establishment Type
- Physical Address fields

Note: Health Direct Australia will provide information from the National Health Service Directory to populate the state-wide service directory HSNet ServiceLink for use by staff and the public. This information can be accessed at the following URL: **http://www.hsnet.nsw.gov.au**.

Maintenance of additional service directory details including:

- Description of service;
- Opening hours;
- Telephone numbers;
- Fax numbers

will occur through an application maintained by Health Direct Australia which will be accessed and updated by health facility service managers. All other details will be maintained through the HERO application.

LHDs / SHNs are to ensure that any changes to services and service structures have taken the potential impact on the National Health Services Directory into account prior to making changes within HERO.

9 METADATA REPOSITORY

The metadata for classifications used in HERO will be maintained in the Health Information Resources Directory (HIRD), which is accessible through the NSW Ministry of Health Intranet. Within HIRD, the HERO resource will be referred to as the 'Health Establishment Registration Online Data Dictionary' and is accessible via the following URL:
http://hird.health.nsw.gov.au/hird/view_data_resource_description.cfm?ItemID=9040

10 HOW TO ACCESS HERO

Each LHD / SHN and their designated personnel who are required to register establishments must apply for HERO user accounts via **http://internal.health.nsw.gov.au/data/hero/web-forms/hero-account-application-form.html** and nominate the required user class. HERO is available via the NSW Ministry of Health Intranet (**http://hero.health.nsw.gov.au**).

The following types of accounts are available to LHDs/SHNs:

- Jurisdiction Administrator: view, create, modify, and rejection/approval rights at the LHD / SHN level after any lower level approvals have been made.
- Local/business unit administrator: view, create, modify, and rejection/approval rights at any level below LHD / SHN
- Local requester: view and create/modify rights but no rejection/approval rights.

Note: The Ministry administrator can view, create, modify, and has final rejection/approval rights after lower level approvals have been obtained.

A user account is not required to search and view HERO data. The data can be viewed by any staff member with access to the NSW Health Intranet.

The role of the Ministry HERO Administrator will reside in the Ministry's HSIPR Branch.

11 LIST OF RELATED DOCUMENTATION

- HERO Business Information Bulletin
- HERO Guideline Document

12 ATTACHMENT 1: IMPLEMENTATION CHECKLIST

Purpose: This checklist includes a list of critical requirements that are essential to the consistent, accurate and complete reporting of health service entities. The checklist should be used at the commencement of the local HERO Project and may be used periodically to measure progress.

Where the user of this checklist has ticked "Not commenced" or "Partial compliance", further details relating to planned action in this area must be provided in the "Notes" section and translated into the LHD implementation plan.

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Register all relevant service entities including locations in HERO	❑	❑	❑
	Notes:		
2. Ensure source systems are structured to record the HERO identifiers to enable compliance with reporting of activity for relevant data collections	❑	❑	❑
	Notes:		
3. Conduct a periodic review that source systems are cross-referenced with HERO identifiers to ensure extracts are correctly mapped	❑	❑	❑
	Notes:		
4. Conduct analysis of establishment types for each HERO service entity is current as per standards and alignment with how services are physically being delivered.	❑	❑	❑
	Notes:		
5. Establish policy and processes to record HERO identifiers in source systems, particulary those source systems providing extracts or direct data feeds to EDW	❑	❑	❑
	Notes:		
6. Ensure LHD have the appropriate human resources assigned to fulfil the requirements and responsibilities outlined in the Policy and Procedure. For example: a) HERO Co-ordinator b) Source System Administrators	❑	❑	❑
	Notes:		

NON-ADMITTED PATIENT CLASSIFICATION PRINCIPLES (GL2017_014)

PURPOSE

The purpose of the Non-Admitted Patient (NAP) Classification Principles is to provide a set of rules for determining what constitutes a non-admitted patient service unit and how to classify it to the appropriate Establishment Type. Each class is defined in terms of a specified range of activities, usual providers, potential inclusions and exclusions, and other descriptive information.

KEY PRINCIPLES

The NAP Classification Principles are rules for determining what constitutes a non-admitted patient service unit and how to classify it to the appropriate Establishment Type. Each class is defined in terms of a specified range of activities, usual providers, potential inclusions and exclusions, and other descriptive information.

USE OF THE GUIDELINE

Each non-admitted service unit must be classified to a single Establishment Type class. Every non-admitted patient service provided by that service unit is reported against that Establishment Type class.

NSW Health Establishment Types are mapped to a national Tier 2 class for the purposes of reporting to the Commonwealth and national ABF and costing.

This document should be read in conjunction with the:
- Non-admitted Patient Establishment Type Definitions Manual
- Non-admitted Patient Classification Reporting Rules
- Non-admitted Patient Care Data Set Specifications.

The Guidelines can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_014

306(16/08/17)

NON-ADMITTED PATIENT REPORTING RULES (GL2017_017)

PURPOSE

The purpose of the Non-Admitted Patient (NAP) Reporting Rules is to provide exhaustive guidance on the reporting of NAP activity.

KEY PRINCIPLES

Every non-admitted patient service must be reported against a non-admitted patient service unit, which must be classified to a single Establishment Type class.

Every non-admitted patient service must be reported with a modality of care reflecting the service provided.

306(29/08/17)

USE OF THE GUIDELINE

This Guideline supplements existing NAP resources and should be read in conjunction with the:
- Non-Admitted Patient Establishment Type Definitions Manual
- Non-Admitted Patient Classification Principles
- Non-Admitted Patient Care Data Set Specifications.

The intended audience for this document includes:
- NSW Health and affiliated health organisations;
- LHD/SHN chief executives;
- LHD/SHN Non-admitted Patient data collection co-ordinators;
- Hospital general managers and community health service managers;
- Managers of NSW Health non-admitted patient service units;
- Non-Admitted patient source system administrators; and
- Chief Information Officers.

The Guidelines can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_017

306(29/08/17)

HERO: NSW HEALTH SERVICE LOCATION REGISTRATION REQUIREMENTS FOR EDWARD COMPLIANCE (IB2017_044)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and source system support staff of the minimum NSW Health service locations that must be registered in HERO in order to comply with EDWARD extract format specifications.

KEY INFORMATION

LHDs/SHNs and private sector health organisations contracted by NSW Health to provide NSW Health public patient services, are to have the following locations registered in HERO:

- NSW Health campuses (*registered by Ministry of Health's (MOH) HERO Administrator only*)
- Private sector health care campuses on which services are provided to public patients on behalf of NSW Health (*registered by MOH HERO Administrator only*)
- Admitted patient wards
- Residential care wards and supported living accommodation buildings
- Emergency Department Locations
- Mental Health Service Locations (admitted, non-admitted and residential)
- Operating Theatre Suites
- Operating Theatre Rooms

306(07/11/17)

Note that excepting mental health services, **all other non-admitted patient service locations are optional for registration in HERO**.

It is a requirement that:

- Each location is accurately classified by location type so as to accurately indicate the principal use of the location. The location type must not be changed except to correct an original data entry error.
- New locations are registered during the initial planning or development period, and well before services are provided at those locations and activity data has begun flowing through to EDWARD. The late registration of a location in HERO and subsequent aliasing/mapping of the local location identifier within the source system will not cause any previous activity records to be triggered to be resent.
- Locations that cease to be used, or where the space is repurposed, reconfigured or becomes a different type of location, must be registered as closed and the close date must be recorded in HERO.
- Locations cannot move physically. For example, if a ward moves from one building to another, resulting in a reconfiguration of the service areas, the original ward should be closed and a new service location of the same type registered in the new building.

IMPLEMENTATION

The registration of locations is to be implemented and maintained in HERO. HERO issues the NSW Health state standard service location identifier.

HERO location identifiers are used in aliasing locations in source systems in order to report those locations to the EDWARD enterprise data warehouse. The aliasing process “maps” the local location identifiers within a source system to the state standard identifiers as issued by HERO.

Each LHD / SHN must have a HERO Coordinator and all registrations in HERO must be directed through, and approved by, the LHD / SHN HERO Coordinator, before being submitted for approval by the MOH HERO Administrator.

LHD / SHN HERO coordinators are the single point of contact between LHD / SHN and the Ministry of Health’s HERO administrator for all matters relating to the clarification of HERO data entry, use and the registration requirements.

In complying with this Information Bulletin, HERO coordinators are to ensure that the registration of new locations does not adversely affect existing location entities that have been established to support the implementation and continued use of the Statewide Infrastructure Services Health application or the Clinical Excellence Commission Incident Management System.

External parties, such as private sector services providers, are required to liaise directly with the MOH HERO Administrator on HERO data entry and entity registration matters. With agreement of the MOH HERO Administrator, emails, load sheets and/or forms may be used by external private sector parties that are not within the NSW Health IT network.

CLARIFICATION ADVICE

Registration of service locations in HERO is managed by the Ministry of Health's Information Management and Quality Unit of the Health System Information and Performance Reporting Branch. The NSW Ministry of Health's HERO Administrator will provide clarification advice regarding the changed reporting requirements outlined in this information bulletin.

Primary Contact:
Contact: Jasmine Klammer
Position: Senior Metadata Support Officer / MOH HERO Administrator
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Escalation Contact:
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EMERGENCY DEPARTMENT DATA DICTIONARY (PD2009_071)

PURPOSE

One of the key functions of the Emergency Department Data Collection is to gather data on Emergency Department activity across the state.

The purposes of collecting Emergency Department (ED) data in NSW are:
- To assist clinicians in the management of patients; and
- To enable comparisons of performance in respect to access to services, quality clinical outcomes, patient management, customer satisfaction and cost effectiveness.

The *Emergency Department Data Dictionary (Version 4) (refer to Attachment section below)*, provides definitions for key ED data items, including the mandatory extract for the NSW Health Information Exchange (HIE), which are outlined in the extract layout formats.

MANDATORY REQUIREMENTS

All facilities providing data to the Emergency Department Data Collection are required to comply with standards outlined in the *Emergency Department Data Dictionary (Version 4)* by **1 July 2010**.

IMPLEMENTATION

Area Health Service Executive and Emergency Department Management, in conjunction with software vendors, are to ensure relevant staff are advised and consulted with on implementation of this policy.

Continued improvement in Emergency Department Performance remains a high priority for NSW Health. Consequently, the frequent provision of Emergency Department data to enable regular monitoring of Emergency Department performance and evaluation of strategies to address the issue is considered a high priority.

For this reason, Greater Metropolitan Emergency Departments are required to supply weekly data. The reference period for weekly data is 12:00am Monday to 11:59pm Sunday. The deadline for submission of data for loading to the Department's Health Information Exchange is 5pm Wednesday following the reference week. All Rural and Regional Emergency Departments with electronic source system are required to submit data monthly, by the 5th working day in the month following the reference month.

All data submissions must comply with the *Emergency Department Data Dictionary (Version 4).*

The Emergency Department Data Dictionary is available from the Emergency Department Data Collection web page at **http://internal.health.nsw.gov.au/data/collections/edc/**

NON-ADMITTED PATIENT DATA COLLECTION TRANSITION FROM WEBNAP TO EDWARD REPORTING (GL2015_012)

PURPOSE

The purpose of this Guideline is to advise NSW Health non-admitted patient service providers and non-admitted patient activity source system support staff of the changes in requirements involved in the transition from reporting via WebNAP to reporting via the EDWARD.

An understanding of these differences, and the three phases of implementation, is required to reconfigure source system builds and patient level activity extracts, and redesign nonadmitted patient activity reporting business processes.

KEY PRINCIPLES

In line with NSW Health's strategic direction and the significantly increased volumes of non-admitted patient services being reported at the patient level by NSW Health services the Non-Admitted Patient Data Collection will transition to be reported via EDWARD rather than the interim system WebNAP.

The migration of the data collection to EDWARD will have significant benefits for Local Health Districts (LHDs) / Specialist Health Networks (SHNs) and other NSW Health agencies. LHDs / SHNs should expect higher data availability, more efficient data loading and resubmission processes, significantly improved data error reporting functionality and appropriately secured access to activity data.

When reported via EDWARD the non-admitted patient, admitted patient and emergency department activity data will be automatically allocated the appropriate National Weighed Activity Unit (NWAU) and integrated into a single data mart that supports full patient journey analysis utilising the Enterprise Patient Registry unique identifier.

USE OF THE GUIDELINE

In order to minimise the transition burden, requirements have been prioritised across three phases:

- **Phase 1**: Report current scope via EDWARD and decommission WebNAP
- **Phase 2**: Convert source system extracts and classifications to the EDWARD format
- **Phase 3**: Integrate additional reporting requirements for specific clinical streams The EDWARD Business Implementation (EBI) Program collaborating with the NSW Ministry of Health's Health Systems Information and Performance Reporting (HSIPR) Branch will establish a small project team to support transition, testing and address queries as they arise during the migration period.

Phase 1

Implementation of phase 1 requires LHDs/SHNs to load WebNAP patient level and summary level extracts into EDWARD and to cease reporting to WebNAP. To support the transition to EDWARD reporting during Phases 1 and 2, a file upload, conversion and transfer tool, the EDWARD mLoad Tool, will be available for LHDs/SHNs to upload patient level and summary level data extracts from source systems in either the WebNAP extract format, or the EDWARD extract format.

The tool will apply the necessary file format conversions to WebNAP extracts compliant with the 2015/16 WebNAP reporting requirements and file format. It will also produce a container header file (based on user inputs) for both WebNAP and EDWARD flat file formats, and transfer files to the EDWARD drop zone where they will be automatically loaded into EDWARD.

During this phase LHDs / SHNs:
1. Must build EDWARD extracts for non-admitted patient source systems that are not yet reporting at the patient level
2. Must commence the reconfiguration of WebNAP extracts such that the source system can report activity directly in the EDWARD extract format
3. May cease reporting summary level data for services reporting at the patient level once reporting through the EDWARD mLoad Tool
4. May commence (or fully implement any) transition steps outlined in later phases. Phase 1 must be completed by **30 June 2016**, to enable the decommissioning of WebNAP.

Phase 2
Implementation of Phase 2 requires LHDs / SHNs to complete the reconfiguration of WebNAP source system extracts into the EDWARD extract format and source systems to be fully aligned with the EDWARD classification standards.

During this phase any changes effective from 1 July 2016 will also need to be incorporated into the EDWARD extracts. During this phase LHDs/SHNs may implement Phase 3 implementation steps. Phase 2 must be completed **by 30 June 2017**, to enable the decommissioning of the WebNAP patient level file conversion functionality, compliance with 2016/17 reporting requirements and to establish the foundations required for implementation of Phase 3.

Phase 3
Phase 3 involves reporting the additional data elements set aside in the EDWARD extract file format for the integration of other non-admitted patient data collections for specific clinical streams. It will involve decommissioning the legacy extracts and legacy data repositories (such as HIE and other disparate databases).

This phase may only impact selected source systems. For example, radiotherapy sources system would add data elements required for the integration of radiotherapy waiting times and non-admitted patient cancer notifications, while source systems used by Hepatitis, HIV/AIDS and sexually transmissible diseases services would add data elements pertaining to communicable diseases.

Phase 3 is expected to be completed **by 30 June 2018**, to enable the decommissioning of the HIE and other legacy data repositories and to establish a single comprehensive non-admitted patient data collection.

FURTHER INFORMATION

The NSW Ministry of Health will provide advice and clarifications regarding the requirements for reporting non-admitted patient activity via EDWARD. Requests for advice should be directed to the Health System Information & Performance Reporting Branch, NSW Ministry of Health.

Primary Contact:

Position:	Data Integrity Officer, Information Management & Governance
Unit Contact:	Jill Marcus
Email:	jmarc@moh.health.nsw.gov.au
Telephone:	(02) 9391 9897

Escalation Contact:

Position:	Manager, Information Management and Governance
Unit Contact:	David Baty
Email:	dbaty@moh.health.nsw.gov.au
Telephone:	(02) 9391 9828

A full copy of these guidelines can be downloaded at:
https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2015_012

COVID-19 DATA COLLECTION AND REPORTING REQUIREMENTS NSW HEALTH INTRANET PAGE (IB2020_012)

PURPOSE

Advise all NSW Health Districts and Networks of the 'COVID-19 Data Collection and Reporting Requirements' NSW Health intranet page.

KEY INFORMATION

Data collection and reporting, source system and business process changes must be implemented to facilitate the identification, recording and reporting of impacts of the COVID-19 pandemic on the NSW Health system.

IMPLEMENTATION

Data collection and reporting requirements relating to COVID-19 are evolving frequently in response to different and more complex information needs identified at State and Commonwealth levels.

Data collection and reporting requirement changes impacting on business processes, source systems and data collections will be published by Information Bulletin.

Advisory documents are also being regularly produced to provide advice to the NSW Health system on the management and monitoring of the COVID-19 pandemic.

A NSW Health intranet page has been established to provide a 'one-stop shop' for all COVID-19 related updates to core NSW Health patient focused activity data collections.

This intranet page is located at:
http://internal.health.nsw.gov.au/data/collections/covid19

The intranet page will be updated as changes to data collection and reporting requirements are determined. Staff should visit the intranet page **regularly** to appraise themselves of the latest COVID-19 related data collection and reporting requirements for the relevant data collections.

CLARIFICATION ADVICE

The System Information and Analytics Branch, NSW Ministry of Health will provide clarification advice regarding these data collection and reporting requirements. Requests for advice should be directed to the Data Integrity and Governance Team of the System Information and Analytics Branch.

Advisory documents developed to support state-wide advice on data collection and reporting requirements to the NSW Health system may be submitted to the Data Integrity and Governance Team, System Information and Analytics Branch, NSW Ministry of Health for publishing on the NSW Health intranet page.

Contact: Patrick Fleming
Position: Data Governance Support Officer
Email**:** **MOH-DataGovernance@health.nsw.gov.au**
Telephone: 02 9391 9710

COVID-19 DATA COLLECTION SUMMARY ADVISORY (IB2020_043)

IB2020_043 rescindes IB2020_011

PURPOSE

To provide advice to all NSW Health services, private hospitals and day procedure centres, regarding data collection and reporting of COVID-19 (2019 novel coronavirus) for the Emergency Department, Admitted Patient and Non-Admitted Patient data collections.

KEY INFORMATION

A summary of data collection and reporting requirements to facilitate the identification, recording and reporting of impacts of the COVID-19 pandemic is outlined below.

Compliance with this Information Bulletin is essential in ensuring the identification, surveillance and monitoring of services provided to persons in response to COVID-19 and the identification of activity eligible for funding under the National Partnership on COVID- 19 Response and to meet national reporting requirements.

Detailed information can be found on the **NSW Health COVID-19 Data Collection and Reporting Requirements intranet page** covering the topics listed below, as well as at the associated links:

- Emergency Department
  - Diagnosis Codes
  - Presenting Problem
- Admitted Patient
  - Coding rules and values
  - Transfer of a patient with suspected COVID-19
  - Supplementary Guidance (**IHPA How to Classify COVID-19 Webpage**)
- Non-Admitted Patient
  - Service Units
  - **Non-Admitted Service Type Code**
  - **Service Setting Type Code**
- Admitted Patient and Non-Admitted Patient
  - **Legal Status Code**
- Emergency Department, Admitted Patient and Non-Admitted Patient
  - Request Source Type

The above provisions relate to all services and activity in scope of reporting for the listed data collections.

The classification changes must be implemented into all relevant sources (capture) systems, including user interfaces and reference tables. Extracts for data submission to the relevant data collections must also be updated, as required. Local Health Districts and Speciality Health Networks are responsible for ensuring their information system developers or support providers implement the changes as required to the new reporting requirements.

CLARIFICATION ADVICE

The NSW Ministry of Health will provide clarification advice regarding the changed reporting requirements. Requests for advice should be directed to the Data Integrity and Governance Team, System Information and Analytics Branch, NSW Ministry of Health via the appropriate data collection contact set out on the **NSW Health COVID-19 Data Collection and Reporting Requirements intranet page.**

COVID-19 WARDS SET UP ADVICE (IB2020_013)

PURPOSE

To advise all NSW Health Districts and Networks about setting up new wards and repurposing existing wards for COVID-19 in the Health Entity Registration On-line (HERO)., NSW Health Bed Reporting System (BRS), Patient Flow Portal and Electronic Record for Intensive Care (eRIC)

KEY INFORMATION

In response to the COVID-19 pandemic, several additional and/or re-purposed wards have been implemented across NSW Health. These must be registered in the Patient Administration System (PAS) and HERO **first**, then set up in the BRS, PFP, eRIC and other applicable downstream systems.

Details are available in the Information Bulletin at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2020_013

328(17/04/20)

SEXUALLY TRANSMISSIBLE INFECTIONS AND HUMAN IMMUNODEFICIENCY VIRUS DATA SET FROM 1 JULY 2023 (IB2023_008)

PURPOSE

This Information Bulletin informs Local Health Districts and Specialty Health Networks of the change in requirements for reporting Sexual Health and Human Immunodeficiency Virus (HIV) services to the Non-admitted Patient and Supplementary Services Data Collection's Sexually Transmissible Infection (STI) and HIV Data Set Extension from 1 July 2023.
This Information Bulletin must be read in conjunction with the NSW Health Information Bulletin *Sexually Transmissible Infections and Human Immunodeficiency Virus Data Set* (**IB2020_046**).

KEY INFORMATION

Background

The Sexually Transmitted Infection (STI) and Human Immunodeficiency Virus (HIV) Data Set Extension is a set of reporting requirements that must be captured and reported by STI and HIV services in addition to the Client Characteristics Minimum Data Set, Individual Service Provider Data Set, and the Non-admitted Patient and Supplementary Services Core Minimum Data Set.
The data elements in scope of the data set extension pertain to services provided by staff working in non-admitted patient service units that are classified to the following establishment types:

- 32.16 - HIV / AIDS Allied Health / Nursing Unit
- 32.26 - Sexual Health Allied Health / Nursing Unit
- 32.47 - HIV / AIDS Medical Consultation Unit
- 32.48 - Sexually Transmissible Infections Medical Consultation Unit
- 32.49 - Infectious Diseases - Other Medical Consultation Unit
- 32.52 - Infectious Diseases - Other Allied Health / Nursing Unit
- 39.10 - Immunology Medical Consultation Unit.

346(03/04/23)

Changes to reporting requirements

There are changed reporting requirements that apply to services provided from 1 July 2023.
The following data elements have changed classifications:

- Sexual health and HIV service unit contact type code
- Gender identity code
- Sexual contact risk code.

The following data elements have changed data element names and changed classifications:

- Client sex with cis males in last 3 months code (previously "client male sex partners in last 3 months code")
- Client anal sex condom use (previously "Client Male Partner Anal Sex Condom Use Code).

The following data elements are new for reporting from 1 July 2023:

- Client sex with cis females in last 3 months code
- Client sex with trans men in last 3 months code
- Client sex with trans women in last 3 months code
- Client sex with non-binary people in last 3 months code
- Client pregnancy status code
- Syphilis treatment commencement date.

The following data element is no longer in scope of the data set extension and is no longer recommended for data capture:

- Client substance misuse flag.

Implementation

For services using the Cerner eMR, eHealth NSW has developed a modified Sexual Health/ HIV PowerForm, and EDWARD extract, that incorporates the changed reporting requirements. It is the responsibility of Local Health Districts and Specialty Health Networks to test and implement the modified Cerner eMR PowerForm and the EDWARD data warehouse extract into their production environment between 1 July 2023 and 31 December 2023.
Local Health Districts and Specialty Health Networks that are not using the eHealth NSW Cerner eMR state base build PowerForm are responsible for the implementation of the changes into their alternative source system, reporting the data via an EDWARD data extract. The Hunter New England Local Health District will lead the implementation of the reporting requirements in SHIP.
Staff responsible for implementation and testing of the source system and data extract solution should refer to the detailed reporting requirements information provided in the data governance documentation set and the data dictionary published in the Health Information Resources Directory (HIRD). The data dictionary outlines the detailed category definitions and mandatory, conditional mandatory, and optional reporting status for each data element.

Interim reporting arrangements

Existing data reporting arrangements, which include the reporting of summarised data tables to the Centre for Population Health, and reporting Syphilis Notifications via Public Health Units, must continue until such time the patient unit record level reporting via EDWARD is in place for all NSW Health services.

Further information

Detailed information about the foundation reporting requirements for STI and HIV Data Set Extension are described on the following intranet pages:

- **Client Characteristics Minimum Data Set**
- **Individual Service Provider Minimum Data Set**
- **Organisation Service Provider Minimum Data Set**
- **Non-Admitted Patient and Supplement Services Data Collection: Core Minimum Data Set.**

Detailed information about the reporting requirements specific to STI and HIV services from 1 July 2023 can be found on the **NSW Non-Admitted Patient and Supplementary Services Data Collection: STI and HIV Data Set Extension from 1 July 2023** intranet page. The following data governance documents are published on this page:

- Changes to reporting requirements from 1 July 2023
- Data elements reportable from 1 July 2023
- Scope, coverage and business rules from 1 July 2023
- Classification and code standards from 1 July 2023
- SNOMED CT diagnosis short list from 1 July 2023.

Clarification Advice

Requests for clarifications pertaining to data supply or data elements that are within the scope of the core minimum data set or core extended data set should be directed to the Data Integrity and Governance team within the Systems Information and Analytics Branch, NSW Ministry of Health.

- Position: Data Integrity Officer, Non-Admitted Patient & Supplementary Services Data Collection
- Email: **MOH-NAP@health.nsw.gov.au**

Requests for clarifications pertaining to data elements that are specific to sexually transmissible infections and HIV should be directed to the Blood-Borne Virus (BBV) & Sexually Transmitted Infection (STI) Unit, Centre for Population Health, NSW Ministry of Health.

- Position: Senior Policy Analyst
- Email: **MOH-BBVSTI@health.nsw.gov.au**

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters Manual

CHAPTER 23 – AIDS AND APPLIANCES

TABLE OF CONTENTS

	PD/IB/GL NUMBER
Care of the Person following Amputation: Minimum Standards of Care	ACI Guideline
Assistive Technology	PD2020_026

CARE OF THE PERSON FOLLOWING AMPUTATION: MINIMUM STANDARDS OF CARE

(Advised under IB2017_030) (Rescinds PD2008_015 and GL2008_006)

The NSW Agency for Clinical Innovation (ACI) now has responsibility for clinical matters related to amputee care. Guidance should now be sought from the updated *Care of the Person following Amputation: Minimum Standards of Care* produced by the ACI Rehabilitation Network, available on the ACI's website at:

https://aci.health.nsw.gov.au/__data/assets/pdf_file/0004/361687/ACI034-Interactive-PDF-of-care-standards-for-amputees-2.0.pdf

The person with an amputation may present to the NSW Health System across the care continuum and require support on their lifelong care journey. The document outlines the minimum standards that are expected of services in NSW in the provision of care to the person with an amputation or limb loss.

ASSISTIVE TECHNOLOGY (PD2020_026)

PD2020_026 rescinds PD2011_027.

POLICY STATEMENT

NSW Health provides assistive technology, primarily loaned to support health needs, to NSW residents who are not eligible for support through other schemes. NSW Health primarily loans assistive technology to support health needs.

This Policy Directive outlines the governance framework, eligibility criteria and the roles and responsibilities of NSW Health organisations for assistive technology provision across NSW Health. The approach to the provisions of assistive technology for NSW Health organisations, including EnableNSW and district equipment loan pools. All NSW Health organisations are expected to develop their own supporting guidelines.

SUMMARY OF POLICY REQUIREMENTS

Assistive technology is provided throughout NSW Health *(Local Health Districts, Specialty Health Networks and HealthShare NSW (EnableNSW)).*

Assistive technology provided by NSW Health is standardised equipment, primarily loaned to people who are not eligible for aids and equipment through other schemes.

NSW Health provides appropriately prescribed, timely, cost effective and clinically necessary assistive technology to:

- Support health needs.
- Reduce or prevent risk of injury or illness that would result in admission or readmission to hospital.
- Facilitate timely and safe discharge from hospital.

The Assistive Technology Policy and Procedures can be downloaded from:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2020_026

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters Manual

CHAPTER 24 – SURGICAL CARE

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	PD/IB/GL NUMBER
Accountable Items Used for Surgery and Other Procedures	PD2023_002
Register of Surgical Operations	PD2014_049
Clinical Procedure Safety	PD2017_032
Extended Day Only Admission Model	GL2020_023
The Perioperative Toolkit	GL2018_004
NSW Emergency Surgery Guidelines and Principles for Improvement	GL2021_007
Intravascular Access Devices (IVAD) - Infection Prevention & Control	PD2019_040
High Volume Short Stay Surgical Model Toolkit	GL2012_001
Patient Identification Bands	PD2021_033
Work Health and Safety – Controlling Exposure to Surgical Plume	GL2023_018

ACCOUNTABLE ITEMS USED IN SURGERY AND OTHER PROCEDURES
(PD2023_002)

PD2023_002 replaced PD2013_054

POLICY STATEMENT

NSW Health requires that health workers, involved in the managing and counting of accountable items used during surgery and other procedures, must ensure accountable items are not unintentionally retained in the patient.

SUMMARY OF POLICY REQUIREMENTS

This Policy applies to surgery/ procedures performed in NSW Health settings, including but not limited to, perioperative settings, interventional radiology suites, cardiac catheter laboratory, biopsy clinics and birthing units.

Each NSW Health service in which surgery/ procedures are performed is to have a multi-disciplinary perioperative management committee which reviews and oversees compliance with this Policy.

An incident involving the "*unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death"* is to be managed as an Australian Sentinel Event as per the NSW Health Policy Directive *Incident Management* (**PD2020_047**).

The instrument nurse/ midwife is responsible for ensuring the count sheet is complete and accurate. The circulating nurse/ midwife is responsible for documenting the count.

The count sheet and documentation of the instrument count must be part of the patient's medical record.

A minimum of two counts must be performed. When the initial count starts all accountable items and waste must remain in the operating/ procedure room.

A pharyngeal pack is an accountable item. When a pharyngeal pack is used, it must be documented on the count sheet.

Where multiple and complex instrument trays are used, the patient may be transferred from the operating/ procedure room before the final count is complete. The final count must be completed before the patient leaves the post-surgical/ procedural area. The next patient must not enter the operating/ procedure room until the final count is complete.

When an accountable item is intentionally retained in a patient, the accountable item and its location must be documented on the count sheet.

When an instrument tray/ separate instruments/ loan set is considered incorrect post operatively/ post procedure by the Sterilizing Services Department, the Department is to notify the nurse/ midwife in charge of the operating theatre/ procedural area, in a timely manner, who is to initiate an immediate investigation including checking the count sheet and instrument list documentation.

Disposable accountable items involving incorrect packaging and/ or inadequate quality are to be reported to the **Therapeutic Goods Administration** (TGA).

The entire Accountable Items used in Surgery and Other Procedures policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_002

REGISTER OF SURGICAL OPERATIONS (PD2014_049)

PD2014_049 rescinds PD2009_078.

PURPOSE

A register of surgical operations is required to be maintained for all surgical operations and procedures performed in operating suites in all public hospitals in NSW.

MANDATORY REQUIREMENTS

The Register of surgical operations can be documented manually or digitally (electronically). The register shall document the following data items:

- Full name of the patient
- Patient's facility medical record number
- Anaesthetic start and finish time
- Name of the Anaesthetist (if applicable)
- Procedure(s) performed
- Name of the Surgeon
- Name of the Surgical Assistant (if applicable)
- Name of the Registered Nurse in Charge of the surgical operation (case).

Where the register is maintained digitally (electronically) appropriate security arrangements must be in place to ensure that once entered, data must not be altered without the creation of a clear audit trail.

Additionally requirements for digital record keeping are outlined in *IB2009_027 NSW Standard on Digital Record Keeping* - **http://www.health.nsw.gov.au/policies/ib/2009/IB2009_027.html**

Surgical Operations Registers must be retained in accordance with The General Retention and Disposal Authority (GDA17) Section 2.1.8 – Surgical procedures, Operation or Theatre register

http://www.records.nsw.gov.au/recordkeeping/rules/retention-and-disposal-authorities/general-retention-and-disposal-authorities/public-health-services-patient-client-records-gda17/part-1-the-general-retention-and-disposal/2.0.0-patient-client-registration-and

Private Hospitals and Health Care Facilities should maintain a register of surgical operations in accordance with the *Private Health Facilities Regulation 2010* Schedule 2, clause 76. For information on suppliers of hard copy *Register of Surgical Operations* please contact the System Relationship and Performance Branch.

IMPLEMENTATION

- This policy directive is effective immediately and applies to all operating theatre departments at NSW public hospitals.
- Local Health District and Special Health Network Chief Executives are responsible for the implementation of this policy directive.
- Hospital Operating Theatre Managers are responsible for the operationalization of this policy directive and monitoring to ensure compliance.

CLINICAL PROCEDURE SAFETY (PD2017_032)

PD2017_032 rescinds PD2014_036

PURPOSE

The purpose of this policy directive is to address clinical care and patient safety risks associated with clinical procedures; improve matching of the patient to the correct procedure; improve communication within the procedural team, and between the patient and the procedural team; and reduce the number of clinical procedure related incidents.

The principles of the **World Health Organization (WHO) Surgical Safety Checklist** and the **Royal Australasian College of Surgeons' Surgical Safety Checklist** have been used in the development of this policy directive.

This policy directive aligns with the **National Safety and Quality Health Services Standards** requirements for correctly matching patients with their intended care.

MANDATORY REQUIREMENTS

All staff involved in clinical procedures must adhere to the requirements of this policy directive regardless of the location where the procedure is performed.

Each health service undertaking clinical procedures must have systems and processes in place to enable compliance with this policy directive. This includes educating and training staff, documenting incidents associated with procedures, monitoring compliance with this policy directive, and reporting outcomes to the appropriate committee/s within the health service and to relevant external agencies such as the NSW Coroner's office.

IMPLEMENTATION

Chief Executives are responsible for:

- Assigning responsibility for implementing and complying with this policy directive and reporting on the implementation of this policy document as required.

Clinicians are responsible for:

- Complying with this policy directive.

Clinical Excellence Commission responsible for:

- Reviewing and ensuring the currency of this policy directive.

1 BACKGROUND

1.1 About this document

The purpose of this policy directive is to address clinical care and patient safety risks associated with clinical procedures; improve matching of the patient to the correct procedure; improve communication within the procedural team and between the patient and the procedural team; and reduce the number of clinical procedure related incidents.

1.2 Principles

The following principles apply to clinical procedures.

1. The policy directive applies to the full age range of patients. Where issues are specific to children these are raised by way of exception for children.
2. The manager / departmental head is responsible for ensuring the processes for clinical procedure safety are followed.
3. Every clinician involved in a procedure whether as an individual proceduralist or as a member of a procedural team is responsible for ensuring the processes for clinical procedure safety are followed.
4. Active involvement and effective communication between the proceduralist (and procedural team members where appropriate) and the patient or their person responsible should occur.
5. Use age appropriate communication techniques when communicating with children. A staff member experienced in communicating with children should provide an explanation of the procedure, in consultation with the person responsible, in language that can be understood by the child. The use of toys such as dolls or teddy bears may assist with explanations as may the opportunity to see and touch any non-dangerous equipment prior to the procedure such as a stethoscope and the anaesthetic mask.
6. In general, for Level 1 and Level 2 procedures, the person responsible is encouraged to stay with their child where clinically appropriate and where the child is conscious, and agreed between the senior proceduralist and the person responsible; for Level 3 procedures up to when the child is sedated / anesthetised and then following the procedure as the child wakes up as the clinical situation allows.
7. Valid consent must be obtained for the procedure.[1]
8. The proceduralist (and procedural team members where appropriate) is responsible for confirming patient identification, procedure verification and where appropriate the correct site / side / level for the procedure. The proceduralist carries ultimate responsibility for the patient identification and procedure verification.
9. Patient identification, and verification of the correct procedure and correct site (where appropriate) must occur prior to the procedure commencing.
10. To the extent possible involve the patient, or their person responsible, at all points in the patient identification and procedure verification processes, including marking of the procedure site, where appropriate.
11. Site marking is essential where there is the potential for error involving multiple structures (fingers, toes, or lesions), left / right distinction, or levels (spine).
12. Confirm the patient's known allergies / adverse reactions to substances. Ensure substances the patient has a known allergy / adverse reaction to are not used during the procedure.
13. If pre-procedure imaging data are to be used, the data must be available and correctly identified before the patient receives procedural sedation / anaesthesia.
14. If prostheses, implants, sterile equipment, or special equipment are required, they must be available and, where appropriate, confirmed they are functional and appropriate for use e.g. left / right, before the patient receives procedural sedation / anaesthesia.

1.3 Key definitions

Airway management	Includes oxygen therapy via face mask, management of airways obstruction including the use of common devices such as oro -pharyngeal and naso - pharyngeal airways, single handed and two handed mask ventilation using Bag and Mask, insertion and management of Laryngeal Mask Airways and intubation of the trachea using standard laryngoscopy equipment and monitoring of the patient for the effects of hypoxia with basic monitoring such as ECG (electrocardiogram), NIBP (non-invasive measurement of blood pressure), Pulse Oximetry and CO_2 waveform analysis for deep sedation.
Anaesthesia and sedation	Refer to definition - Sedation and anaesthesia.
Assisting clinicians	Staff engaged in assisting the proceduralist as part of the procedure.
Clinical handover	The effective transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[2]
Clinician	A person authorised by a facility to provide clinical care to a patient.
Clinician airway monitor	A dedicated clinician (who is not the proceduralist) with appropriate competency-based training, whose primary responsibility is to monitor the patient's level of consciousness and to monitor and provide the initial management of cardio-respiratory status of the patient during the procedure.
Incident	Any unplanned event resulting in, or with the potential for, injury, damage or other loss. This includes a near miss.[3]
Must	Indicates a mandatory action required that must be complied with.
Patient	A person receiving health care. Also known as consumer or client.
Patient identification	The active process of confirming a patient's identity through the use of approved patient identifiers to ensure the correct patient is matched to their planned procedure.[4]
Person responsible	For the purposes of this policy directive a *person responsible* is a person who can provide consent for a patient's clinical procedure to be performed.[1]
Proceduralist	A clinician who is performing or assisting in the procedure. There may be more than one proceduralist involved in a procedure. The senior proceduralist takes overall responsibility for the case.
Procedural Team	Includes all clinicians participating in the delivery of care during the procedure.

Procedure	For the purposes of interpreting this policy directive *procedure* is defined as follows. Level 1 procedure • Usually requires a single proceduralist • Usually does not require written consent • Does not involve procedural sedation or general / regional anaesthesia. **Exception** - Dental procedures involving dental nerve blocks are classified as Level 1 procedures. • Usually performed in wards, emergency departments, clinics and imaging departments. Level 2 procedure • Requires a proceduralist, often supported by an assisting proceduralist/s • Usually requires written consent • Does not involve procedural sedation or general / regional anaesthesia • Usually performed in wards, emergency departments, clinics, imaging departments and interventional suites. Level 3 procedure • Requires at least one proceduralist and a procedural team • Always requires written consent • Involves procedural sedation or general / regional anaesthesia • Usually performed in formal procedural suites such as operating theatres, emergency departments, endoscopy suites, interventional imaging suites, birthing suites and cardiac catheterisation laboratories.
Procedure verification	The active process of verifying the procedure by confirming the planned procedure and the site / side / level for the procedure.

Sedation and anaesthesia[5]	**Procedural sedation** implies that the patient is in a state of drug-induced tolerance of uncomfortable or painful diagnostic or interventional medical, dental or surgical procedures. • **Conscious sedation** is defined as a drug-induced depression of consciousness during which patients are able to respond purposefully to verbal commands or light tactile stimulation. • **Deep levels of sedation**, where consciousness is lost and patients only respond to painful stimulation, are associated with potential loss of the ability to maintain a patent airway, inadequate spontaneous ventilation and / or impaired cardiovascular function. Deep levels of sedation may have similar risks to general anaesthesia, and may require an equivalent level of care. For the purposes of interpreting this policy directive: • **Use of opioids** The use of opioids for analgesia is not considered procedural sedation. • **Use of nitrous oxide** – If the primary intent is analgesia then it is not considered procedural sedation. – If the primary intent is sedation then it is considered procedural sedation and these procedures must be classed as Level 3 procedures. Procedural sedation does **NOT** include premedication to reduce anxiety or provide pain relief. **Regional anaesthesia** includes major nerve blocks, epidural blocks and spinal blocks. Excludes dental nerve blocks. It involves the injection of local anaesthetic in the vicinity of major nerve bundles supplying body areas. Regional anaesthesia may be used on its own or combined with sedation or general anaesthesia. **General anaesthesia** is a drug-induced state characterised by absence of purposeful response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes. General anaesthesia is sometimes indicated during diagnostic or interventional medical or surgical procedures and requires the exclusive attention of an anaesthetist, or other appropriately trained and credentialed medical specialist within their scope of practice.
Should	Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.
Sign In	The period **immediately before preparing the patient** for their procedure by the procedural team.
Sign Out	The period after the procedure and before the patient / procedural team leaves the procedural area.

Team Time Out	The period **immediately before commencing the procedure** to undertake a final verification of the patient's identity and the procedure. Team Time Out applies to Level 2 and Level 3 procedures.
VTE prophylaxis	Treatment, either pharmacological or mechanical, provided to a patient in order to reduce the risk of **venous thromboembolism** (deep vein thrombosis and pulmonary embolism).[6]

2 LEVEL 1 PROCEDURES

Definition	**Examples**[1]	**Requirements**	
		Pre-procedure	**Post procedure**
- Single proceduralist - Usually does not require written consent - Does not involve procedural sedation or general/regional anaesthesia, except for dental procedures involving dental nerve blocks - Usually performed in wards, emergency departments, clinics, imaging departments	- Insertion IV cannula - Insertion IDC - Insertion NGT - Taking blood samples - Diagnostic Radiology - Diagnostic Nuclear Medicine - Routine dental procedures e.g. dental extraction, fillings - Dental procedures involving dental nerve blocks - Superficial skin lesions/biopsies - Non operative obstetrics e.g. fetal scalp blood sampling, perineal repair with LA, Artificial Rupture of Membranes, fetal scalp electrode2	**STOP and confirm the following before commencing the procedure** − Patient identification − Procedure verification – procedure + site/side/level, where appropriate, matches consent − Allergy/adverse reaction check − Anticipated critical events	− Document procedure in patient's health care record or Radiology Information System − Advice for clinical handover − Label specimen/images − Post procedure tests where clinically relevant

2.1 Pre procedure

Procedures **not** involving procedural sedation / anaesthesia are either Level 1 or Level 2 procedures. Refer to the definition and examples for guidance in classifying procedures as Level 1 or Level 2.

For Level 1 procedures the proceduralist, and assisting proceduralist/s, where relevant, must **STOP** and confirm the following minimum requirements immediately before commencing the procedure. Where two or more staff members are involved they must introduce themselves to each other and the patient, as appropriate, by their preferred names and roles before the procedure commences.

[1]The examples provided do not cover all possible procedures and the examples may be escalated to a higher level (ie Level 1 procedures may be classified by a health service as Level 2 or Level 3 procedures). Health services should consider development of local lists of examples for Level 1, Level 2 and Level 3 procedures consistent with the requirements of this policy directive.

[2] Where the procedure is a non operative obstetric procedure and patient identification has occurred at the commencement of labour, the obstetric team that has cared for the patient during labour should confirm the patient's identification immediately before commencing the procedure if appropriate e.g. if the patient is moved to a new room or a new member joins the obstetric team caring for the patient during the procedure.

2.1.1 Patient identification

- The patient's identity must be confirmed before any procedure commences.
- Staff must confirm that they have the correct patient by asking the patient, or their person responsible, to state the patient's full name and date of birth. Staff should not state the patient's name or date of birth and then ask the patient, or their person responsible, if this information is correct.
- The response must be confirmed against the details on the request form / referral / treatment plan and patient identification band or other approved patient identification tool (including unique patient identifier), as appropriate.
- Where patient details on the request form / referral / treatment plan are incomplete or there is a discrepancy with the information received from the patient, or their person responsible, the correct information must be verified before commencing the procedure and actions taken documented in the patient's health care record.
- If the patient is unable to participate in the patient identification step, for example due to physical incapacity, language issues, or is a child, and their person responsible is not present, then the patient's identification band or other approved patient identification tool (including unique patient identifier) should be used to confirm the patient's identification.

2.1.2 Procedure verification

- Consent must be obtained for any procedure as required by the NSW Health policy directive on consent to medical treatment.[1]
- Consent must be documented for high risk radiology and nuclear medicine procedures for Diagnostic Imaging Accreditation Scheme accreditation.
- Signed consent forms are not required for minor procedures performed under local anaesthesia, e.g. insertion of IV cannula, urethral catheterisation, or suture of minor lacerations.
- Request forms / referrals / treatment plans for procedures must include the patient's name, date of birth, sex, unique patient identifier (where appropriate), reason for the procedure, details of the test/s required, the date the test/s were ordered, and the exact anatomical location for the test/s including the procedure site, laterality and level.
- The proceduralist must ask the patient, or their person responsible, to state what procedure they understand will be performed and to state the site / side / level for the procedure (where relevant) and verify this matches the planned procedure and consent / request form / referral / treatment plan.[7]
- Where procedure details on the request form / referral / treatment plan are incomplete or there is a discrepancy the requesting clinician or a member of their team must be contacted to clarify the information before commencing the procedure and the response documented.

2.1.3 Allergy/adverse reaction check

- Ask the patient, or their person responsible, if they have a known allergy / adverse reaction and if yes, what the allergy / adverse reaction was and what effect they experienced. The response should be documented.

2.1.4 Anticipated critical events

- The proceduralist must consider the planned procedure, critical steps, anticipated events and equipment requirements.

2.2 Post procedure

- The name of the proceduralist/s must be documented in the patient's health care record or Radiology Information System.
- Document the name of the procedure and outcome/s in the patient's health care record or Radiology Information System.
- Provide clinical handover advice (verbal and documented) to the staff caring for the patient or post procedure destination, as appropriate, and discuss with the patient and / or person responsible where possible.
- Specimens / images must be labelled correctly and labels checked with the patient or person responsible or checked with another clinician where possible.
- Arrange post procedure tests where clinically relevant.

3 LEVEL 2 PROCEDURES

Definition	Examples3	Requirements	
		Pre-procedure (including Team Time Out)	**Post procedure**
- Proceduralist often supported by an assisting proceduralist/s - Usually requires written consent - Does not involve procedural sedation or general/regional anaesthesia - Usually performed in wards, emergency departments, clinics, imaging departments, interventional suites	- Lumbar puncture - Insertion of chest tube - Ascitic tap - Stress test - Diagnostic interventional procedures - Nuclear Medicine therapies - Non-superficial biopsies - IV or IT administration of chemotherapy - IV administration of contrast - Centrally inserted central venous access device[8]	**STOP and confirm the following before commencing the procedure** – Proceduralist/assisting proceduralist/s introductions, where appropriate – Patient identification – Procedure verification - procedure + site/side/level, where appropriate, matches consent – Patient position – Essential imaging reviewed – Allergy/adverse reaction check – Special medication/s administered – Antibiotics – Implants and special equipment – Anticipated critical events	– Document procedure in patient's health care record or Radiology Information System – Advice for clinical handover – Equipment problems/issues – Specimens/images labelled correctly – Post procedure tests where clinically relevant eg. CXR post insertion of chest tube

3.1 Pre procedure (including Team Time Out)

Procedures **not** involving procedural sedation / anaesthesia are either Level 1 or Level 2 procedures. Refer to the definition and examples for guidance in classifying procedures as Level 1 or Level 2.

The proceduralist, and where present assisting proceduralist/s, must **STOP** and confirm the following minimum requirements immediately before commencing the procedure. Where two or more staff members are involved they must introduce themselves to each other, and the patient and their person responsible where appropriate, by their preferred names and roles before the procedure commences.

[3] The examples provided do not cover all possible procedures and the examples may be escalated to a higher level (ie Level 1 procedures may be classified by health services as Level 2 or Level 3 procedures). Health services should consider development of local lists of examples for Level 1, Level 2 and Level 3 procedures consistent with the requirements of this policy directive.

3.1.1 Patient identification

- The patient's identity must be confirmed before any procedure commences.
- Staff must confirm they have the correct patient by asking the patient, or their person responsible, to state the patient's full name and date of birth. Staff must not state the patient's name or date of birth and then ask the patient, or their person responsible, if this information is correct.
- The response must be confirmed against the details on the consent form / request form / referral / treatment plan and patient identification band or approved patient identification tool (including unique patient identifier), where appropriate.
- Where patient details on the consent / request form / referral / treatment plan are incomplete or there is a discrepancy with the information received from the patient, or their person responsible, the correct information must be verified before commencing the procedure and actions taken documented in the patient's health care record.
- If the patient is unable to participate in the patient identification step, for example due to physical incapacity, language issues, or is a child, and their person responsible is not present, then the patient's identification band or approved patient identification tool (including unique patient identifier) should be used to confirm their identification

3.1.2 Procedure verification

- Consent must be obtained for any procedure as required by the NSW Health policy directive on consent to medical treatment.1
- The consent form (where written consent obtained) must be completed as required by the NSW Health policy on consent.1
- Request forms / referrals / treatment plans for procedures must include the patient's name, date of birth, sex and unique patient identifier (if available), and should include the procedure site / side / level, reason for the procedure, details of the examination / test/s required, the date the test/s were ordered, and the exact anatomical location for the test/s.
- Consent must be documented for high risk radiology and nuclear medicine procedures for Diagnostic Imaging Accreditation Scheme (DIAS) accreditation.9 The level of risk associated with each imaging procedure should be determined locally based on the risk factors of the individual patient and the risk of the procedure.
- When contrast is used for procedures outside the operating theatre a patient checklist that is specifically designed for contrast administration must be used.
- The proceduralist must ask the patient, or their person responsible, to state what procedure they understand will be performed and to state the site / side / level for the procedure (where appropriate) and verify this matches the planned procedure and consent / request form / referral / treatment plan.[9]
- Where procedure details on the consent form / request form / referral / treatment plan are incomplete or there is a discrepancy the requesting clinician or a member of their team must be contacted to clarify the information before commencing the procedure and the response documented.

3.1.3 Site / side / level marking

- The site / side / level should be marked where there is the potential for error involving multiple structures (fingers, toes, or lesions), left / right distinction, or levels (spine).
- The site /side / level marking for radiotherapy treatments involve the following.
  - The mark should be on or near the incision site or radiotherapy site.
  - For certain treatments the immobilising device may be marked.
  - Site / side / level marking is not required in the following circumstances. For multiple fractions of radiotherapy, where the site is usually only marked before the first fraction and reapplied as necessary, and where markings are applied to the immobilisation device rather than on the patient's skin.

3.1.4 Patient position

- The positioning of the patient must be verified as correct for the planned procedure.
- The appropriate equipment for positioning and venous thromboembolism (VTE) prophylaxis must be working and available for use during the procedure.

3.1.5 Essential imaging available

If imaging data are to be used to verify the procedure or site/side/level of the procedure the proceduralist must verify in conjunction with the assisting proceduralist/s, where appropriate, that:

- The patient's identity, the site of the procedure and the date of the image in relation to the procedure all match.
- The images are for the correct side of the body, oriented correctly, and correctly labelled with the patient's name and date of birth.

3.1.6 Allergy/adverse reaction check

The proceduralist should:

- Ask the patient if they have a known allergy/adverse reaction and if yes, what the allergy/ adverse reaction was and what effect they experienced. The response should be documented.
- Check for any other source that may provide further information on allergies/adverse reactions the patient might have eg. treatment plan, progress notes.
- Check that allergies/adverse reactions are noted on the allergy/adverse reaction section of the National Inpatient Medication Chart or other relevant section of the patient's health care record.
- Note that when contrast is used for procedures the allergy/adverse reaction check must be included in a patient checklist that is specifically designed for contrast administration.
- Ensure the assisting proceduralist/s is aware of all identified allergies/adverse reactions.

3.1.7 Special medications administered

- The proceduralist should confirm that any special medications required have been administered.

3.1.8 Antibiotics

- Antibiotic prophylaxis may be indicated and should be given in accordance with current antibiotic therapeutic guidelines prior to the procedure commencing except when antibiotics are withheld in order to get specimens for microbial testing.

3.1.9 Anticipated critical events

- The proceduralist must consider, and discuss with the assisting clinician/s, the planned procedure, critical steps, anticipated events and equipment requirements.
- The proceduralist, and the assisting proceduralist/s, must verbally confirm sterility, implants and equipment requirements.

3.2 Post procedure

3.2.1 Name of the proceduralist/s documented

- The name of the proceduralist/s must be documented in the patient's health care record or Radiology Information System.

3.2.2 Name of the procedure documented

- The proceduralist must confirm exactly what procedure was done, any expected or unexpected adverse events and patient outcomes, and ensure this is documented in the patient's health care record or Radiology Information System. Where a procedure has varied from that planned the rationale must be documented with reason/s why.

3.2.3 Advice for clinical handover

- Provide clinical handover advice (verbal and documented), including the patient's management plan post procedure, for the clinicians to post procedure destination and discuss with the patient where possible.
- Document and communicate any altered calling criteria on the relevant observation chart.

3.2.4 Equipment problems/issues documented and advised to relevant staff

- Malfunctioning equipment and instruments should be accurately identified to prevent them from being used again until the problems are resolved. Any equipment or instrument problems arising during the procedure must be documented, and raised with the relevant staff so they can be resolved as soon as possible. If an adverse event has occurred as a result of equipment / instrument malfunctions then this should be notified in the incident management system.

3.2.5 Specimens/images labelled correctly

- The proceduralist, and assisting proceduralist/s, must ensure the correct labelling of any pathology specimen/images obtained during the procedure by verifying the patient's name, specimen/image description and any orienting marks.

3.2.6 Tests required

- Referral for test/s post procedure should be discussed with the patient and their person responsible where clinically appropriate, and arranged.

4 LEVEL 3 PROCEDURES

<table>
<tr><th>Definition</th><th>Examples4</th><th colspan="2">Requirements</th></tr>
<tr>
<td rowspan="2">- At least one proceduralist and a procedural team
- Always requires written consent
- Involves procedural sedation or general/regional anaesthesia
- Usually performed in formal procedural suites such as operating theatres, emergency departments, endoscopy suites, interventional imaging suites, birthing suites, cardiac catheterisation laboratories</td>
<td rowspan="2">- Surgical procedure (OR)
– ECT
– Colonoscopy
– Bronchoscopy
– Interventional imaging procedure, including:
• Angiography
• Cardiovascular
• Coiling
• Stenting
• Interventional Neuroradiology</td>
<td>1. Pre-procedure
– Patient identification
– Procedure verification – planned procedure + site/side/level, where appropriate, matches consent
– Site/side/level marking, where appropriate</td>
<td>2. Sign In
SIGN IN ONE
– Patient identification
– Procedure verification – planned procedure + site/side/level, where appropriate, matches consent
– Allergy/adverse reaction check
– Sedation/anaesthetic equipment checked
– Patient sedation risk/anaesthetic assessment
– Significant airway or aspiration risk
– Clinician airway monitor identified
– Clinician skilled to manage airway identified
– Pulse oximeter working
– Risk of major bleeding
SIGN IN TWO
– Essential imaging available
– Site marking (exemptions)
– Implants and special equipment
– Proceduralist available to complete procedure</td>
</tr>
<tr>
<td>3. Team Time Out
– Team member introductions
– Patient identification
– Procedure verification - planned procedure + site/side/level, where appropriate, matches consent
– Patient position
– Essential imaging reviewed
– Allergy/adverse reaction check
– Special medication/s administered
– Antibiotics
– VTE prophylaxis
– Anticipated critical events</td>
<td>4. Sign Out
– Name of procedure recorded
– Counts/tray list checks correct
– Specimens/images labelled correctly
– Blood loss documented; ongoing blood loss discussed
– Equipment problems/issues documented/relevant staff member avised or equipment / instrument labelled.
– Advice for clinical handover</td>
</tr>
</table>

[4] The examples provided do not cover all possible procedures and the examples may be escalated to a higher level (ie Level 1 procedures may be classified by health services as Level 2 or Level 3 procedures). Health services should consider development of local lists of examples for Level 1, Level 2 and Level 3 procedures consistent with the requirements of this policy directive.

Procedures involving procedural sedation / anaesthesia must always be classified as Level 3 procedures.

4.1 Pre procedure requirements

The following must be undertaken before the patient is transferred to the procedural suite.

4.1.1 Patient identification

- The patient's identification must be confirmed before any procedure commences.
- Staff must confirm they have the correct patient by asking the patient, or their person responsible, to state the patient's full name and date of birth. Staff must not state the patient's name or date of birth and then ask the patient, or their person responsible, if this information is correct.
- The response must be confirmed against the details on the consent form/request form/referral/ treatment plan and patient identification band (including unique patient identifier).
- Where patient details on the consent form / request form / referral / treatment plan are incomplete or there is a discrepancy with the information received from the patient, or their person responsible, the correct information must be verified before commencing the procedure and actions taken documented in the patient's health care record.
- If the patient is unable to participate in the patient identification step, for example due to physical incapacity, language issues, or is a child, and their person responsible is not present, a member of staff from the preceding location of the patient (e.g. ward or emergency department) must act as the patient's advocate to confirm the patient's identity.
- Patients undergoing Level 3 procedures must be wearing a patient identification band. [5]

4.1.2 Procedure verification

- Consent must be obtained for all Level 3 procedures as required by the NSW Health policy directive on consent to medical treatment.6
- The consent form must be completed as required by the NSW Health policy on consent
- Request forms / referrals / treatment plans for procedures must include the patient's name, date of birth, sex and unique patient identifier and should include the procedure site / side / level, reason for the procedure, details of the examination / test/s required, the date the test/s were ordered, and the exact anatomical location for the test/s.
- Staff must ask the patient, or their person responsible, to state what procedure they understand will be performed and to state the site / side / level for the procedure (where appropriate) and verify this matches the planned procedure and consent form / request form / referral / treatment plan
- Where procedure details on the consent form / request form / referral / treatment plan are incomplete or there is a discrepancy the requesting clinician or a member of their team must be contacted to amend or complete a new document before the procedure commences and actions taken documented in the patient's health care record.
- Verify x-ray and other imaging data are for the correct patient and are the correct images, where appropriate.
- Other relevant clinical information including documentation recorded electronically must be available prior to the planned procedure.
- Verification should be documented in the patient's health care record, including a record of individuals involved in the verification process.

[5] *Patient Identification Bands, PD2014_024 at* **http://www.health.nsw.gov.au/policies/pd/2014/PD2014_024.html**
[6] *Consent to Medical Treatment - Patient Information*, PD2005_406 at **http://www.health.nsw.gov.au/policies/PD/2005/PD2005_406.html**

4.1.3 Site/side/level marking

Site/side/level marking
Site / side / level marking is essential in cases where there is the potential for error involving multiple structures (fingers, toes, or lesions), left / right distinction, or levels (spine). In these cases, where appropriate, the site / side / level should be marked.
The site / side / level must be marked by one of the proceduralists (except for intra-ocular surgery):

- As a minimum, all cases involving multiple structures (fingers, toes or lesions), laterality or levels (spine) must be marked.
- Non-procedure sites / sides / levels must not be marked.
- Marking occurs before the patient enters the procedural room, except in an emergency.
- The method of marking should be consistent throughout the organisation. Initials must not be used in marking.
- Marking takes place with the patient involved, awake and aware, where appropriate. Note some paediatric, psychiatric and intellectually impaired patients may find this distressing and marking may be done after these patients are anaesthetised. For this group of patients it may be appropriate to have a person responsible present.
- The mark should be on or near the incision site.
- The mark should be visible and sufficiently permanent so it remains visible following skin preparation and draping.
- The marking must be documented in the patient's health care record by the person marking the site / side / level.

  Exception: For **intra-ocular surgery** where pre-operative mydriatic drops have been ordered, the correct side may be marked by a registered nurse, and the marking checked by a second registered nurse before the drops are given, in conjunction with confirmation of the patient's identity, checking of the consent, and verbal confirmation by the patient, or their person responsible, of the side to have surgery. The mark must be subsequently checked as the correct side for the procedure as required by Sign In One, Sign In Two and Team Time Out.

Site/side/level marking exemptions
Site / side / level marking is **not required** in the following circumstances (although it can be used):

- To avoid confusion e.g. if a procedure requires a regional anaesthetic then only the procedure site should be marked.
- For single organ cases e.g. cardiac surgery, caesarean section.
- Where the site of surgical entry is unambiguous e.g. midline incisions, cystoscopies, laparoscopies.
- If the site is obvious e.g. open trauma wound, large tumour.
- For endoscopies.
- For procedures where the catheter / instrument site is not predetermined e.g. cardiac catheterisation, epidural / spinal analgesia / anaesthesia.
- For radiology procedures where marking the site could add to the ambiguity of subsequent procedures.
- Where intra-procedure imaging for localisation e.g. radiological, MRI, stereotaxis, ultrasound, radiation detection will be used.

- Where the procedure site cannot be marked e.g. teeth, the site / side must be clearly recorded in the patient's health care record.
- For premature infants, and some oral and maxillofacial surgery, where marking may cause permanent marking of the tissues.
- Where the patient refuses marking. Such refusal must be documented in the patient's health care record.
- In a life-threatening emergency where the patient enters the procedural room directly. This must be documented in the patient's health care record.

4.2 Requirements for a Level 3 procedure checklist

There are three distinct stages to Level 3 procedure checklists with each stage corresponding to a specific time period in the patient's procedure.

Sign In	The period **before commencing procedural sedation or general / regional anaesthesia** that is, immediately before the procedural team prepares the patient for their procedure. Sign In is further divided into two parts - Sign In One & Sign In Two
Team Time Out	The period **immediately before commencing the procedure** to undertake a final patient identification and procedure verification
Sign Out	The period before the patient / procedural team leave the procedural area.

- A checklist must be used for every Level 3 procedure.
- A checklist must include Sign In, Team Time Out and Sign Out.
- Sign In One and Two may be combined with the agreement of sedationists / anaesthetists and proceduralists.
- The name of the clinician/s that completed each section of the checklist must be clearly documented.

Section	**Clinician responsible**
Sign In One	Sedationist / Anaesthetist
Sign In Two	Proceduralist Where Sign In One and Sign In Two **are combined the names of both clinicians responsible must be documented -** that is the name of the Sedationist / Anaesthetist and the name of the Proceduralist
Team Time Out	Senior proceduralist
Sign Out	Nurse / Midwife

- The checklist is part of the patient's health care record.
- The checklist must include confirmation of the patient's identification and the procedure verification.
- The checklist should comply with the requirements of Sections 4.3 to 4.6 of this policy.
- For procedures performed outside an operating suite, Local Health Districts / Specialty Health Networks (LHD / SHNs) may remove items included in a Level 3 procedure checklist, as set out in Sections 4.3 to 4.6, based on a risk management approach considering issues such as the type of procedure and the procedural setting. This would only apply when the items removed have no relevance to the procedure being performed (e.g. for electroconvulsive therapy (ECT) procedures the checklist might remove the items about blood loss or imaging). If modified checklists are created then they must be clearly labelled with the location the checklist will be used in or, if a procedure specific checklist, then the procedure must be included in the title (e.g. ECT Procedure Safety Checklist).
- Additional items not covered by this policy directive may be added as required.
- Checklists for Level 3 procedures must be approved by the LHD / SHN Chief Executive or their delegate/s (such as Executive Directors for Clinical Governance, Medical Services, Nursing & Midwifery) or the LHD / SHN's quality and safety committee. The approval must be documented.

4.3 Sign In One: Checklist completed by the sedationist / anaesthetist

Sign In One must be completed before commencing procedural sedation or general / regional anaesthesia.

Sign In One is completed by the sedationist / anaesthetist in conjunction with another member of the procedural team e.g. anaesthetic nurse / circulating nurse. Where there is no sedationist / anaesthetist then a proceduralist must complete this check.

In procedural suites where a formal, documented verification check is performed prior to entering the procedural suites e.g. in an airlock, theatre holding bay or reception area, the Sign In One is an additional step that must occur in a room or area immediately adjacent to the procedural room e.g. in the anaesthetic room if available, or in the procedural room.

Sign In One must be completed before the patient enters the procedural room, except in emergency situations, where an anaesthetic room does not exist or where the patient enters the procedural room directly. In these cases Sign In One should be completed inside the procedural room.

4.3.1 Patient identification

- Patient identification must occur before any treatment / intervention is initiated except if a life threatening or emergency situation exists.
- Staff must ask the patient, or their person responsible, to state their full name and date of birth. Staff must not state the patient's name or date of birth and then ask the patient, or their person responsible, if this information is correct.
- The answers to these questions must be confirmed against the details on the patient identification band. If there is a discrepancy between the details, the procedure must not proceed until this is resolved.
- If the patient is unable to participate in the final patient identification step prior to the planned procedure/s, for example due to physical incapacity, language issues, or is a child, then the patient's person responsible or the patient's identification band/s should be used to confirm the patient's identity.

4.3.2 Planned procedure matches consent

- The consent form is the primary source of information about the patient's planned procedure. The procedure to be performed must match what has been written on the patient's signed consent form. Details on the consent form must be clear and correct; and must match the health care record, the request / referral letter, the patient's or their person responsible's, understanding of the procedure to be undertaken and imaging data, where appropriate.
- A final consent check with the patient, or their person responsible, before sedating / anaesthetising the patient gives the patient the opportunity to identify any mistakes. If the planned procedure and consent do not match, the proceduralist must resolve the matter before the patient receives procedural sedation / anaesthesia.
- If the planned procedure information on the consent form is incorrect this should be documented in the patient's health care record as well as the actions taken to resolve the discrepancy.

4.3.3 Site/side/level matches consent

- The relevant team member should ask the patient, or their person responsible, to state their site / side / level for the planned procedure. The team member must not state the site / side / level for the planned procedure and then ask the patient, or their person responsible, if this information is correct.
- For some procedures (e.g. those that involve ovaries and fallopian tubes), side detection may be unreliable preoperatively.7 In these circumstances, side verification is not recommended.

4.3.4 Allergy/adverse reaction check

The relevant team member should:

- Ask the patient, or their person responsible, if they have a known allergy / adverse reaction and if yes, what the allergy / adverse reaction was and what effect they experienced.
- Check for any other source that may provide further information on allergies / adverse reactions the patient might have e.g. treatment plan, progress notes.
- Check that allergies / adverse reactions are noted on the allergy / adverse reaction section of the National Inpatient Medication Chart or other relevant section of the patient's health care record.
- Note that when contrast is used for procedures the allergy / adverse reaction check must be included in a patient checklist that is specifically designed for contrast administration or a Level 3 checklist.
- Ensure all team members are aware of all allergies / adverse reactions identified.

4.3.5 Sedation/anaesthetic equipment checked

- When procedural sedation or anaesthesia is planned a formal check of the necessary sedation / anaesthetic equipment must be completed prior to each procedure to ensure the equipment is available and working. Continuous pulse oximetry and blood pressure monitoring must be commenced on the patient prior to commencing procedural sedation or anaesthesia and continued until the patient is adequately recovered from this.

7 Gynaecology surgery for adnexal masses: it is not uncommon for a patient to be consented for a right sided procedure, based on clinical examination or imaging (usually ultrasound) and to find at operation that the pathology is left sided (and vice versa). This is due to the fact that the tubes and ovaries are lateral and posterior to the uterus and fall towards the midline of the pelvis, making it easy to get the wrong side.

4.3.6 Patient sedation risk/anaesthetic assessment done

- When procedural sedation or anaesthesia is planned a medical assessment must be completed prior to commencement of the procedure (except in a life threatening emergency). This must include documentation of the patient's medical condition/s and their sedation risk/anaesthetic assessment. When a non-anaesthetist plans to give procedural sedation an assessment must be made as to whether an anaesthetist is required to assess and manage the patient. This decision must be documented in the patient's health care record.

4.3.7 Significant airway risk

- When procedural sedation or anaesthesia is planned the sedationist/anaesthetist must formally assess the patient's airway and document this in the patient's health care record prior to commencing procedural sedation/anaesthesia. If this assessment indicates a significant airway risk then an anaesthetist must be present before sedation is given.
- When a significant airway risk is identified the procedural sedation/anaesthesia must not commence until all required special equipment needed is present and functional, and procedural team members needed are present.
- Functioning and clean suction equipment must always be immediately available when procedural sedation/anaesthesia is given.

4.3.8 Significant aspiration risk

- The risk of aspiration should also be evaluated and documented. If the patient has symptomatic active reflux or a full stomach, the sedationist / anaesthetist must consider what additional steps might be taken to reduce the increased risk of aspiration.
- When a significant aspiration risk is identified the procedural sedation / anaesthesia must not commence until all required special equipment needed is present and functional, and the appropriate procedural team members are present.
- Functioning and clean suction equipment must always be immediately available.

4.3.9 Identification of clinician airway monitor and availability of skilled personnel

- When procedural sedation is to be used, and where an anaesthetist is not present to care exclusively for the patient, a clinician airway monitor other than the proceduralist must be nominated whose primary responsibility is to monitor the patient's level of consciousness and to monitor and provide the initial management of cardio-respiratory status of the patient during the procedure. There must be present a clinician skilled in airway management and cardio-pulmonary resuscitation relevant to the patient's age.

4.3.10 Risk of major bleeding

Defined as the risk of bleeding more than:

- 500 ml of blood for adults
- 7 ml/kg of blood for children
- >750 ml of blood for maternity patients.[8]

If there is a risk of major bleeding:

- The procedural team should confirm there is a valid group and screening available. If antibodies are present and the blood bank indicates that this may delay the provision of cross-matched blood, then at least two units of compatible cross-matched blood should be available before proceeding.
- The patient should have large bore venous access.
- Intra-procedure blood loss should be measured and the patient monitored for signs of hypovolaemia.

[8] *WHO guidelines for safe surgery : 2009 : safe surgery saves lives* at **http://www.who.int/patientsafety/safesurgery/tools_resources/en/**

4.4 Sign In Two: Checklist completed/signed by the proceduralist

Sign In Two must be completed before commencing procedural sedation or general / regional anaesthesia.

Sign In Two must be completed by a proceduralist who is required to confirm the following.

4.4.1 Essential imaging available

If imaging data are to be used to verify the site or procedure, a proceduralist must confirm with another member of the procedural team that:

- Images are correct and properly labelled for the correct side of the body, oriented correctly, and labelled with the patient's name and date of birth.
- Patient's identity, the site of the procedure and the date of the image, in relation to the procedure, all match.

4.4.2 Site marked

A proceduralist must confirm that the site has been marked or marking is not required (Refer to **4.1.3 Site marking**).

4.4.3 Implants and special equipment

- If any implant (type / side / size / power) and / or special equipment is required, its availability and function where possible to check, must be checked by two team members.
- A proceduralist must be present prior to commencement of procedural sedation / anaesthesia to confirm that sterile instrumentation, implants and / or any special equipment required are present and functional.
- Where an implant is used the product's label, code reference and serial number should be recorded in the patient's health care record.

4.4.4 A proceduralist who can complete the procedure is immediately available

- Confirm that a proceduralist, who can complete the procedure, is immediately available before the patient receives procedural sedation/anaesthesia and before moving to the Team Time Out stage.

4.5 Team Time Out – Checklist signed by proceduralist

Team Time Out is the final patient safety check and must occur immediately before the procedure commences in the room where the procedure is to be conducted. Usually this will be after procedural sedation / anaesthesia has commenced. The senior proceduralist present must lead the Team Time Out. The proceduralist, sedationist / anaesthetist and other members of the procedural team must **ALL** confer and agree on all aspects of the Team Time Out section of the checklist.

Success of Team Time Out is reliant on active communication amongst all members of the procedural team. It is the responsibility of the senior proceduralist present to ensure that Team Time Out is completed. The procedure should not commence until all team members are satisfied that the patient identification and procedure verification processes have been completed and patient identification and procedure verification are correct.

Each and every member of the procedural team is responsible for ensuring Team Time Out occurs and for raising any concerns they may have during Team Time Out.

Where discrepancies are noted or disagreements occur at Team Time Out, the procedure must be delayed until the issues are resolved. Only for reasons of clinical urgency should the procedure commence. The justification for proceeding in the presence of such discrepancies must be documented by the proceduralist in the patient's health care record as soon as the procedure is completed and an incident report must also be completed.

Where previous identification / verification steps have occurred satisfactorily but a discrepancy in information or disagreement in identification / verification occurs at Team Time Out, an incident report should also be completed even if the issues are resolved satisfactorily.

If disagreement occurs in an extreme emergency situation, the senior member of the procedural team is responsible for the care of the patient and should decide the most appropriate course of action.

Only after Team Time Out has been completed should the procedure commence.

4.5.1 Procedural team member introductions

- All procedural team members must introduce themselves to each other by their preferred names and roles before the procedure commences. Team members may change frequently and it is important in effective management that all team members understand who each member is and their role.
- In situations where multiple patient procedures are undertaken consecutively and there is no change in team members during the list, then this action can occur at the commencement of the list.
- In addition, teams may adopt local strategies such as documenting the name and role of team members on a whiteboard.

4.5.2 Patient identity

- The patient's identity must be confirmed against approved patient identifiers, including the patient identification band/s, consent and documentation. The identification band/s used for confirmation must be accessible after positioning and draping.

4.5.3 Planned procedure matches consent

- The consent form is the primary source of information about the patient's planned procedure. The planned procedure must be matched against the patient's consent form and imaging data, where appropriate.
- The processes described in this policy directive should not preclude the use of discretion by the treating proceduralist to alter the procedure for reasons of clinical judgement. However, significant changes to the documented procedure must be communicated to all members of the procedural team and must be recorded in the patient's health care record.

4.5.4 Site/side/level mark matches consent

- The site/side/level mark must be consistent with the site/side/level documented in the consent and imaging.
- For some procedures (eg. those involving ovaries and fallopian tubes), side detection may be unreliable preoperatively. In these circumstances, side confirmation is not recommended (Refer to **4.3.3 Site/side/level matches consent**).

4.5.5 Patient position

- The positioning of the patient must be confirmed as correct for the planned procedure and site/ side/level.

4.5.6 Essential imaging reviewed

- One of the proceduralists must confirm that the essential imaging is in the procedural area and ready for use during the procedure. If imaging data are used to verify the site or procedure, the proceduralist must review and confirm the images are correct and properly labelled. If essential images are not available, the proceduralist must decide if it is safe to proceed and document this decision in the patient's health care record.

4.5.7 Allergies/adverse reactions

- Confirm any known allergies/adverse reactions. This will raise the team's awareness of precautions that may need to be taken during the procedure to avoid allergies/adverse reactions.

4.5.8 Special medications administered

- Confirm that any special medications required (eg. eye drops, steroids, mannitol) have been administered.

4.5.9 Antibiotics

- Antibiotic prophylaxis is considered best practice for a number of complex procedures. Where ordered, antibiotic prophylaxis must be given prior to the procedure (ideally within 60 minutes of the procedure commencing).12
- Antibiotics for caesarean sections may be given prior to the procedure or after the cord is clamped. This should be determined by local procedures or by the senior proceduralist. The senior proceduralist must decide the timing of antibiotic administration for a caesarean section and document this decision in the patient's health care record.
- An exception is when antibiotics are withheld in order to obtain specimens for microbial testing or to observe the patient.

4.5.10 VTE prophylaxis

- The need for VTE prophylaxis must be assessed on every patient. Where indicated, it should be commenced prior to the procedure. Methods include anticoagulants, compression stockings and foot / calf compressors. Indicators for use are outlined in the NSW Health policy directive on prevention of venous thromboembolism.6 Note that not all VTE prophylaxis methods will commence pre-procedure e.g. anticoagulants may commence post procedure.

4.5.11 Anticipated critical events

Effective team communication reduces error, prevents major complications and supports efficient teamwork. To ensure the procedural team has a common understanding of the planned procedure and expected outcomes / issues:

- The proceduralist must verbally brief the team on the planned procedure, critical steps, anticipated events and equipment requirements.
- The sedationist / anaesthetist must verbally identify any specific patient or procedure concerns they have.
- The nurse / midwife verbally confirms that
  - Any required equipment is available and, where possible to check, functional
  - Any required items or implants are available and, if necessary, sterilised / disinfected.

4.6 Sign Out – Checklist signed by the nurse/midwife

Sign Out should occur before the patient/procedural team leave the procedural area.

Sign Out is designed to ensure that all relevant patient documentation is completed and that appropriate clinical handover can be conducted. The nurse/midwife is responsible for Sign Out and should sign this section before the patient/procedural team leave the procedural area. The proceduralist or sedationist/anaesthetist could also complete this section.

Responsibility for documentation must be consistent with the requirements set out in the NSW Health policy directive on handling instruments and accountable items which says that "while documentation is primarily completed by the circulating nurse / midwife, the instrument nurse / midwife is ultimately responsible for ensuring the completion and accuracy of all documentation relating to the surgery/procedure. The anaesthetic nurse is responsible for documenting the anaesthetic nursing care provided."

The nurse/midwife confirms the following.

4.6.1 Name of the procedure recorded

- The proceduralist must document the procedure that was carried out in the patient's health care record. Where a procedure has varied from what was planned the rationale must be also noted in the health care record.

4.6.2 Count/tray list checks

- To ensure there are no instruments, accountable items or other items unintentionally retained in the patient, a count/tray list check must be performed as required by the NSW Health policy directive on handling instruments and accountable items.[9]
- This is usually attended prior to the patient leaving the procedure room. However, for the management of multiple or complex instrument trays, for example, the policy directive says that *the final instrument check may be completed immediately post procedure and before the next patient enters the operating or procedural room.*

4.6.3 Specimens/images labelled correctly

- The proceduralist and another member of the procedural team must ensure the correct labelling of any pathology specimen / images obtained during the procedure by verifying the patient's name, specimen / image description and any orienting marks.

4.6.4 Equipment problems/issues documented and advised to relevant staff

- Malfunctioning equipment and instruments need to be accurately identified, and if possible isolated from other equipment and instruments, to prevent them from being used again until the problem/s is resolved. Any equipment or instrument problem/s arising during the procedure must be documented, raised with the relevant staff or the equipment / instrument labelled so the problem/s can be resolved as soon as possible. If an adverse event has occurred as a result of equipment / instrument malfunction then this should be notified in the incident management system.

The procedural team confirms the following.

4.6.5 Blood loss documented, ongoing blood loss discussed

To ensure that early warning signs of blood loss can be assessed, the blood loss (if any) during the procedure should be documented and any anticipated post procedure bleeding discussed. If significant post procedure bleeding is anticipated, blood loss criteria for notifying medical staff must be documented. 304(22/09/17)

[9] *Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures, PD2013_054*
http://www.health.nsw.gov.au/policies/pd/2013/PD2013_054.html

4.6.6 Advice for clinical handover

The following advice for clinical handover (verbal and documented) must be provided to staff at the post procedure destination.

- The procedural team has discussed the patient management plan for recovery, post procedure investigations and communication. This is expected to include any key messages that should be relayed to the patient or their person responsible.
- Any altered calling criteria documented if patient is not being recovered in a Post Anaesthetic Care Unit (PACU) or Recovery.
- Post procedure VTE prophylaxis has been ordered, if required.
- Post procedure care should be discussed with the patient, or their person responsible, where possible.

5 INCIDENTS

In the event of an incident:

- If the patient's condition permits, an immediate plan to rectify the error/s should be made by the senior member of the procedural team. Wherever possible, the patient and their person responsible should be involved in the management plan
- Manage incidents as required by NSW Health policy directives on incident management and open disclosure.16
- Serious incidents must be discussed at appropriate patient safety or clinical review meetings. Local improvement strategies should be developed in response to these serious incidents
- Report to the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) even when anaesthesia / sedation did not contribute, regardless of cause of death.

6 AUDITING AND REPORTING

Auditing of compliance with this policy directive must be undertaken by each LHD/SHN.

Performance indicators may be included in quarterly reporting to LHD/SHN clinical councils.

7 RESOURCES

Resources to support implementation of this policy directive can be found at the following sites.

Clinical Procedure Safety

http://www.cec.health.nsw.gov.au/programs/clinical-procedure-safety

This site includes a checklist for Medical Imaging Departments (Radiology and Nuclear Medicine) which has been developed by clinicians of the Agency for Clinical Innovation's Radiology and Nuclear Medicine Networks.

Safe Sedation

https://www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care/sedation/safe-sedation-resources

8 ABBREVIATIONS

ECT	Electroconvulsive therapy	LA	Local anaesthetic
IDC	Indwelling catheter	MRI	Magnetic resonance imaging
IV	Intravenous	NGT	Nasogastric tube
IT	Intrathecal	VTE	Venous thromboembolism

9 REFERENCES

1. *Consent to Medical Treatment - Patient Information*, PD2005_406 at **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_406.pdf**

2. Clinical Handover is defined at **https://www.aci.health.nsw.gov.au/resources/acute-care**

3. Incident is defined in *Incident Management* Policy, PD2014_004 at **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_004.pdf**

4. *Client Registration Policy*, PD2007_094 (**http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2007_094.pdf**)

Client Registration Guideline, GL2007_024 (**http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2007_024.pdf**)

Patient Identification Bands, PD2014_024 (**http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_024.pdf**).

5. ANZCA, *PS09 – Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures, 2014* at **http://www.anzca.edu.au/resources/professional-documents** .

6. *Prevention of Venous Thromboembolism,* PD2014_032 at **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_032.pdf**

7. Refer to *Consent to Medical Treatment - Patient Information*, PD2005_406 for information about how long a consent remains valid and who should obtain consent at **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_406.pdf**

8. *Central Venous Access Device Insertion and Post Insertion Care*, PD2011_060 at **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_060.pdf**

9. *Diagnostic Imaging Accreditation Scheme: Practice Accreditation Standards*, Australian Government Department of Health http://www.health.gov.au/internet/main/publishing.nsf/Content/diagnosticimaging-accred2

10. *Patient Identification Bands*, PD2014_024 at **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_024.pdf**

11. WHO guidelines for safe surgery:2009 : safe surgery saves lives at **http://www.who.int/patientsafety/safesurgery/tools_resources/9789241598552/en/**

12. Bratzler DW, Houck PM. *Antimicrobial prophylaxis for surgery: an advisory statement from the National Surgical Infection Prevention Project. Clinical Infectious Diseases*, 2004;38:1706–15.

13. Refer to section 4.2 of *Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures*, PD2013_054 **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_054.pdf**

14. *Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures,* PD2013_054 **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_054.pdf**

15. Refer to section 5.5 of *Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures*, PD2013_054 **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_054.pdf**

16. *Incident Management*, PD2014_004
http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_004.pdf

Open Disclosure Policy, PD2014_028
http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_028.pdf

17. Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)
http://www.cec.health.nsw.gov.au/incident-management/mortality-review-committees/scidua

10 FURTHER READING

Agency for Clinical Innovation, *Anaesthesia Perioperative Care Resources*
http://www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care

Antibiotic Therapeutic Guidelines - available via the CIAP website ("Medications" then "Therapeutic Guidelines eTG") at http://www.ciap.health.nsw.gov.au/home.html or directly at accessible at
https://tgldcdp.tg.org.au.acs.hcn.com.au/topicTeaser?guidelinePage=Antibiotic&etgAccess=true

ANZCA, *PS09 – Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures, 2014* http://www.anzca.edu.au/resources/professional-documents.

Collaborating Hospitals' Audit of Surgical Mortality (CHASM)
http://www.cec.health.nsw.gov.au/incident-management/mortality-review-committees/chasm

Maternity – Breast Milk: Safe Management, PD2010_019
http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_019.pdf

National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care **https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/**

Infants and Children: Management of Acute and Procedural Pain in the Emergency Department, GL2016_009 **http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2016_009.pdf**

Royal Australasian College of Surgeons (RACS), *Surgical Safety Checklist*, October 2009
www.surgeons.org/media/12661/LST_2009_Surgical_Safety_Check_List_(Australia_and_New_Zealand).pdf

Royal Australian and New Zealand College of Radiologists. *Iodinated Contrast Media Guideline, 2016 Version*
http://www.ranzcr.edu.au/quality-a-safety/radiology/iodinated-contrast-media-guideline

World Health Organization, Surgical Safety Checklist, 2008
http://www.who.int/patientsafety/safesurgery/ss_checklist/en/

EXTENDED DAY ONLY ADMISSION MODEL (GL2020_023)

GL2020_023 rescinds PD2011_045

GUIDELINE SUMMARY

The Extended Day Only (EDO) admission model for elective surgeries provides Local Health Districts (Districts) and Specialty Health Networks (SHNs) with advice and the specific Diagnosis Related Groups (DRG) that are to be routinely considered for this service model.

All Districts and SHNs are expected to maximise the use of the EDO model to ensure that there is predictable access for surgical patients. The EDO model also supports quality and safety for patients by establishing protocolised care for patients undergoing commonly performed surgical procedures.

KEY PRINCIPLES

EDO surgery is defined as specified (by DRG) surgical treatments requiring admission up to 24 hours for elective surgery and includes Day Only surgery. Up to 80% of all surgical patients can be treated as Day Only and EDO admissions.

The concept of EDO model is to have a designated service alongside physical resources to ensure elective surgical procedures are undertaken safely and effectively.

Where the EDO Unit has historically been a dedicated and uniquely identifiable surgical unit, it more often incorporates dedicated beds within surgical wards in contemporary hospital systems.

The EDO Unit is ideally located close to the operating theatre suite for streamlined access and to minimise transportation.

To enhance predictability of surgery and maintain separation from emergency surgical services, the key elements of the EDO model include:

 Established clinical protocols to inform, direct and record the patient's clinical pathway, admission, discharge and post discharge management. These also streamline patient care processes and support quality clinical management of the patient.
 Clear, safety-based inclusion or exclusion *criteria for EDO admission*, including:
o Identification of procedures from DRG suitable for the EDO model in the facility;
o Selection of patients with an expected length of stay of less than 24 hours;
o Selection of patients with a predictable course of recovery for the surgical procedure being undertaken; and
o Assessment of patient comorbidities to ensure patients who are unsuitable for EDO are more appropriately managed.
 Compulsory screening2 of all admission notifications by the perioperative service for procedures suitable for admission to the EDO unit.
 Staggered admission times dependent on the timing of the patient's surgery.
 Designated beds and staff who are allocated to the EDO service only.
 Consultant-led procedures and with trainees under consultant supervision.
 Escalation pathways to resolve clinical uncertainty regarding a patient's suitability for Day Only or EDO admission. This may include referral to the relevant local Program Director of Surgery or equivalent.
 Communication pathways to handover patient care to their primary care provider or other relevant community services.

Paediatric patients

The classification of procedures for paediatric patients suitable for EDO differs considerably from the adult population. Paediatric patients frequently require a general anaesthetic to perform routine medical procedures e.g. endoscopy, CT/MRI scans and change of plaster. These may be appropriate for Day Only or EDO admission and the care model is to be routinely considered when requesting and scheduling procedures.

Selection of Procedures suitable for EDO

The DRG identified in Attachment 2 as suitable for EDO admission are not exhaustive. Other DRG may appropriately be admitted as EDO based on clinical judgement and specific facility care pathways. The DRG identified have been selected on the basis that over 50% of separations were either same-day or single overnight admissions during the 2019 calendar year.

While it is recognised that some DRG lack a precise clinical descriptor, they provide the best objective assessment of length of stay for the purpose of selecting procedures. Careful assessment of patients with significant clinical co-morbidities must be undertaken to ensure the patient's suitability for EDO Admission. Additionally, if a patient experiences any intra- or post-operative complication(s), they must be reassessed for EDO Admission suitability.

Key Performance Indicators

Eighty percent of all surgery from the DRG identified in Attachment 2 should be performed through a combination of a Day Only and EDO model, to maximise the utilization of bed occupancy and efficiency of operating theatres, and to provide patients with flexible admission times.

This target is measured for each Districts on a monthly basis and reported to the Surgical Services Taskforce and local Directors of Surgery to enable ongoing monitoring and action where appropriate.

The measurement for EDO patients is up to 28 hours, to accommodate those patients who are unable to be discharged within the 24-hour timeframe.

USE OF THE GUIDELINE

The implementation checklist and the list of DRG provide direction to NSW Health organisations to implement the EDO model.

Availabe with the full guideline at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_023

For further references;

- NSW Health Guideline *High Volume Short Stay Surgical Model Toolkit* (GL2012_001)
- NSW Health Guideline *The Perioperative Toolkit* (GL2018_004)

THE PERIOPERATIVE TOOLKIT (GL2018_004)

The Perioperative Toolkit is designed to aid in the continuous quality improvement of perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia. The Perioperative Toolkit applies evidence and clinical reasoning to risk stratification and directing resources to clinical need.

Shared decision making with patients, families and carers and integration with primary care are integral aspects of perioperative care.

The nine elements of perioperative care described in this Toolkit build upon the five in its predecessor – the Pre Procedure Preparation Toolkit (PPPT) (2007).

KEY PRINCIPLES

The perioperative team comprises of the patient, their family and carers, general practitioners, surgeons, proceduralists, anaesthetists, nurses, administrative and clerical staff, allied health professionals, primary healthcare providers, Aboriginal health, multicultural and diversity health workers.

The Perioperative Toolkit (2016) builds on the state-wide systems of the PPPT (2007). Significant inroads have been made in addressing elective surgery waiting times by reducing length of hospital stay in healthier patients having less major surgery.

The four new elements are directed towards measuring outcomes for quality improvement, pre-operative pre-habilitation and strengthening intra- and post-operative care for the high-risk complex patient with chronic multisystem disease having moderate to major surgery.

Recommendations for prioritising perioperative care

Standard care	Best practice (to be developed further over the next five years)
Elements 1,2,3,4,9	**Elements 5,6,7,8**

Effective perioperative care is reliant on the following key elements.

1. The perioperative process prepares the patient, family and carer for the whole surgical/procedural journey.
2. All patients require pre admission review using a triage process.
3. Pre procedure preparation (PPP) optimises and supports management of the patient's perioperative risks associated with their planned surgery/procedure and anaesthesia.
4. The multidisciplinary team collects, analyses, integrates and communicates information to optimise patient centred care.
5. Each patient's individual journey should follow a planned standardised perioperative pathway. 6. Measurement for quality improvement, benchmarking and reporting should be embedded in the perioperative process.
6. Integration with primary care optimises the patient's perioperative wellbeing.
7. Partnering with patients, families and carers optimises shared decision making for the whole perioperative journey.
8. Effective clinical and corporate governance underpins the perioperative process.

A range of tools are available on the Perioperative Toolkit page on the ACI website. These tools can be used and adapted to meet local needs.

USE OF THE GUIDELINE

To address the economic challenges of safe access to elective surgery each NSW Health facility should have an integrated service in place for perioperative care and invest in strengthening the model of care.

The perioperative service should be supported and led by a clinical champion. Ideally the medical clinical leader or Director, Perioperative Service is an anaesthetist. An anaesthetist's continuing professional development and experience with surgeons and proceduralists at the most critical time of treatment, informs this role.

The medical clinical leader, collaborating closely with the nurse clinical leader, is responsible for:

- facilitating the other's leadership role
- the coordination of integrated perioperative multidisciplinary care
- the identification, communication and management of perioperative patient risk
- the establishment of local guidelines
- measurement, benchmarking and reporting of outcomes.

The Perioperative Toolkit is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2018_004

304(07/02/18)

NSW EMERGENCY SURGERY GUIDELINES AND PRINCIPLES FOR IMPROVEMENT (GL2021_007)

GL2021_007 rescinded GL2009_009

GUIDELINE SUMMARY

Emergency surgery is an important and significant component of surgical service provision, accounting for up to 45% of surgery delivered in public hospitals each year.
NSW hospitals have a long history of delivering high-quality surgical services, and timely access to emergency care is key to supporting optimal outcomes for patients and communities.

This iteration of the NSW Emergency Surgery Guidelines support hospitals, local health districts (Districts) and specialty health networks (SHNs) to plan their emergency surgery services based on a predictable long-term workload. It aims to ensure capacity is sufficient to meet demand, minimise unwarranted variation in care, and facilitate monitoring for improvement to ultimately provide a supportive work environment for staff and a safe, caring service for patients.

A revised framework for prioritisation of clinical urgency, incorporating obstetric emergencies for the first time, is presented to support clinical decision-making.

Category	Priority	Maximum timeframe
A	Life threatening (including obstetric)	1 hour
B	Highly critical (including organ/limb threatening)	2 hours
C	Critical	4 hours
D	Urgent	8 hours
E	Semi-urgent	24 hours
F	Non-urgent	72 hours

338(18/05/21)

KEY PRINCIPLES

The key principles supporting a safe, responsive and high-quality emergency surgical service are further articulated.

1. Hospitals are designated for either elective or emergency surgery, or for specific components of each.
2. Emergency surgical workloads are measured and reviewed regularly to maximise predictability.
3. Emergency surgery capacity is matched to service demand, with consideration of caseload, case mix and balance with elective surgery demand.
4. Where clinically appropriate, emergency surgery is scheduled in standard hours.
5. Emergency surgery cases are scheduled based on clinical need, in line with a statewide urgency prioritisation framework and these guidelines.
6. Emergency surgery models of care are consultant-led.

7. Evidence-based protocols are used for the assessment and treatment of common acute surgical presentations.
8. Local escalation plans are established and agreed to facilitate delivery of best practice patient care, communication and conflict resolution.
9. A standardised set of indicators is applied to emergency surgery to facilitate service monitoring and continuous quality improvement.

USE OF THE GUIDELINE

The NSW emergency surgery guidelines and principles for improvement are a resource to support this planning across all specialties, allowing appropriate allocation of the necessary operating theatre time and resources to meet the expected demand. For emergency surgery, planning should also include immediate access to operating theatres for the most urgent emergency surgery patients; sufficient staffing and equipment for safe patient care; access to data and information to support planning; and effective leadership to foster high-performing surgical services. Future proofing and planning are required to plan for the predictable annual increase in emergency surgery workload.

These guidelines outline the key principles. The examples provided are drawn from surgical specialties where emergency caseloads are generally high (orthopaedics, general surgery, obstetrics and gynaecology and plastic surgery).

However, the principles are equally applicable to those specialties where emergency caseloads are less (neurosurgery, vascular surgery, oral and maxillofacial surgery) or where caseloads are relatively low (urology, cardiothoracic, ophthalmology and otolaryngology).

The guidelines detail each of these principles more fully, guiding hospitals to better align their services with the principles in order to deliver better, safer emergency surgical care to their communities.

The NSW emergency surgery guidelines and principles for improvement are available at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_007

INTRAVASCULAR ACCESS DEVICES INFECTION PREVENTION AND CONTROL INSERTION AND POST INSERTION CARE (PD2019_040)

PD2019_040 rescinded PD2011_060

PURPOSE

The purpose of the NSW Health Intravascular Access Device (IVAD) Infection Prevention and Control Insertion and Post Insertion Care Policy is to provide guidance to NSW Health Organisations (HO's) including Affiliated Health Organisations on the minimum standards for insertion, management and removal of IVADs, in order to minimise the adverse health impacts on patients and reduce burden of healthcare associated Infections (HAIs). This Policy is to be read in conjunction with NSW Health Infection Prevention and Control Policy.

MANDATORY REQUIREMENTS

All clinical staff who insert IVADs or care for a patient with an IVAD must comply with this Policy Directive. For each insertion a record of insertion must be completed.
Every IVAD insertion, management and removal must be documented at the time of care or as soon as possible afterwards.
HO's must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices for clinicians.
HO's must support clinicians to ensure adherence with this Policy Directive.
Aseptic technique must be adhered to during each IVAD insertion, management and removal to reduce the risk of local or systemic infection.

IMPLEMENTATION

NSW Health Organisations (HOs) and the governance structure for the implementation of this Policy Directive to reduce the risk of healthcare associated infections (HAIs).

Clinical Excellence Commission

- Provides tools to support the implementation, monitoring and evaluation of this policy.

Health Education and Training Institute (HETI)

- Compliance with the existing mandatory education components (Aseptic technique, Hand Hygiene and Infection prevention and Control Practices from HETI online) applies.

Chief Executive of Local Health District and Specialty Health Network

- Assigns leadership responsibility, personnel and resources to implement and comply with this Policy.

Directors of Clinical Governance

- Ensure that this Policy is communicated to all managers and health workers.
- Ensure local infection prevention and control programs and systems are in place to implement and monitor this Policy.
- Monitor and provide regular reports on the progress and outcomes of infections related to IVADs.
- Monitor, evaluate and address issues with compliance with this Policy.

Clinical leaders and senior managers

- Provide resources and equipment necessary for compliance with this Policy.
- Implement and evaluate local infection prevention and control systems.

Infection prevention and control professionals

- Provide leadership in infection prevention and control surveillance and reporting.
- Provide advice on compliance with the insertion, management and removal of IVADs policy within their health organisation.
- Provide leadership in the management of HAIs or other transmission risks and in the communication of these risks to health workers, patients, volunteers, carers and visitors.

Clinical Staff Inserting, Caring for, Managing and Removing IVAD Devices

- Comply with IVAD Infection Prevention and Control, Insertion and Post Insertion Care policy this Policy.
- Are trained, competent and assessed in the insertion, management and removal of an IVAD device in accordance with this Policy Directive.
- Ensure IVAD insertion and care is documented in the patient's health record.
- Assess and document daily the ongoing need for an IVAD device.

Intravascular Access Devices (IVAD) – Infection Prevention and Control Procedures

BACKGROUND

Background

Intravascular access devices (IVADs) are commonly used in a variety of settings. They are used to provide a route for administering intravenous medications, fluids, blood products and nutrients and may be used for haemodynamic monitoring, short to long term intravascular access, renal therapies and blood specimen collection.
Intravascular access devices provide direct access to the patient's bloodstream and therefore pose a serious risk for infection of microorganisms to be introduced either at the time of insertion or while the device is in situ. Device-related infections are associated with increased morbidity and mortality, prolonged hospital stay and additional healthcare costs.
Central Venous Access Devices (CVAD) pose a risk of air embolism in patients during insertion and removal (1).
Correct use and management of IVADs minimises the risks of device related infection to patients (2).
The health service organisation must have a process for the appropriate use and management of invasive medical devices (3).

About This Document

This Policy outlines the minimum infection prevention and control requirements for IVADs for NSW Health Organisations (HOs). It has been developed for clinicians who insert, use/manage and remove devices and for persons responsible for surveillance and control of infections in hospital, outpatient, and home healthcare settings. It is recognised that in a clinical emergency, the principles of insertion outlined in this Policy may be difficult to meet. In these situations a risk assessment should be undertaken and the intravascular device replaced as soon as clinically appropriate.

This Policy integrates evidenced-based knowledge with clinical expertise to:

- Support appropriate device management within NSW HOs
- Prevent device related infections
- Prevent adverse events
- Assist NSW HOs to meet the requirements for Standard 3 of the National Standards for Quality Healthcare Services

Scope

This Policy focuses on infection prevention and control (IP&C) for IVADs. Some aspects outside of IP&C are also included to assist in guiding the overall management of IVADs.
This Policy sets out the minimum standards to ensure the safe use of devices and should be used in conjunction with the manufacturer's instructions relating to individual catheters, connections, administration set dwell time, and compatibility with antiseptics, medications and other fluids. HO's who use these devices must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices.

The Policy is applicable to all patient care settings in which devices are inserted, managed or removed. This Policy is applicable across all patient populations (e.g. adults, ambulance, pre-hospital, hospital in the home, paediatrics and neonatology).

The following devices have been included in this Policy:

- Peripheral intravenous cannula (PIVC)
- Midline catheters
- Central venous access devices (CVAD)
    - Peripherally inserted central catheter (PICC)
    - Tunnelled cuffed and non-cuffed central venous catheter
    - Non-tunnelled central venous catheter
    - Implantable Venous Ports (Port)
- Umbilical catheters
- Peripheral artery catheters
- Pulmonary artery catheters
- Haemodialysis catheters

The following items are out of scope for this Policy:

- Technical or procedural aspects related to the above devices
- Sub-cutaneous devices
- Arteriovenous (AV) fistulas
- Anticoagulants
- Intraosseous devices

Key definitions

A detailed **glossary** of terms can be found at the back of the Policy

Central Venous Access Device (CVAD)	• A catheter inserted through an upper or lower peripheral or central vein where the catheter tip terminates in:
	  ○ For upper body access: superior vena cava/right atrial (SVC/RA) cavo-atrial junction.
	  ○ For lower body access: the common iliac vein or abdominal vena cava
	• These catheters are used for the administration of parenteral fluids and medications that are typically not suitable via a short peripheral catheter. They are also used for the measurement of central venous pressure in critical care setting.
	  ○ *Centrally*- inserted central venous catheters have a skin entry point in the neck or trunk.
	  ○ *Peripherally*- inserted central catheters have a skin entry point on a limb or the scalp.
	  ○ *Non-Tunnelled*- the catheter insertion and exit points are the same
	• *Tunnelled* - the catheter is inserted through one point and then "tunnelled" under the skin to a remote exit point**.**

Implantable Venous Port (port):	Long term CVAD, which is surgically placed under the skin from the insertion site to a separate exit site. The exit site is typically located in the chest, but can be located elsewhere for comfort and aesthetic reasons (e.g. inner bicep, abdomen and thigh). They can be multi lumen. Ports consist of two main parts: the portal reservoir and a catheter. The tip of the catheter resides in the cavo-atrial junction. Also known as a port-a-cath or a venous port.
Intravascular access device (device)	Catheters, tubes, or devices inserted into the vascular system, including veins, arteries, and bone marrow.
Midline Catheter	A long peripheral catheter inserted into the upper arm via the basilic, cephalic, or brachial vein, with the internal tip located at or near the level of the axilla and distal to the shoulder.
Non-tunnelled CVAD- Also known as Percutaneous CVAD	A device that enters the venous system. Non-tunnelled catheters are generally used for short term therapy and in emergency situations.
Peripheral Artery Catheter	An arterial line (also art-line or a-line) is a thin catheter inserted into an artery.
Peripheral intravenous cannula (PIVC)	A catheter (small, flexible tube) placed into a peripheral vein for intravenous access.
Peripherally inserted central catheter (PICC)	A catheter inserted through the veins of the upper extremities in adults and children; upper or lower extremities in neonates, catheter tip is located in the superior or inferior vena cava, preferably in the cavo-atrial junction
Health Organisation (HO)	For the purpose of this Policy a Health Organisation is: Local Health District, Speciality Health Networks, Statutory health corporation that provides inpatient services, or Affiliated health organisation in respect of its recognised establishments that provide inpatient services.
Pulmonary Artery Catheter	Also known as a Swan-ganz catheter, is a catheter inserted into a large central vein, with the tip residing in a pulmonary artery. Its purpose is diagnostic and therapeutic; it is used to detect heart failure or sepsis, monitor therapy, evaluate the effects of drugs, frequent blood sampling and to infuse medication.
Tunnelled CVAD	A central vascular access device (CVAD) with a segment of the catheter lying in a subcutaneous tunnel with the presence of a cuff into which the subcutaneous tissue grows to offer security for the catheter; indicates that the skin exit site and vein entry site are separated by the subcutaneous tunnel.
Umbilical Catheter	Catheter that is inserted into one of the two arteries or vein of the umbilical cord.

1 EDUCATION & DOCUMENTATION

1.1 Staff Education and Training

- All staff involved in the insertion, management and removal of IVADs must complete an educational program that is appropriate for the care being provided as determined by their HO.
- Clinicians are responsible and accountable for attaining and maintaining currency of skills for device insertion, management and removal within their scope of practice (4).
- HOs should have systems in place to recognise prior competence/skills assessment of the clinician from other HOs.
- The role, responsibilities and accountability for each type of clinician involved with these devices must be clearly defined in organisational policy or procedure (4).

1.1.1 Competency Assessment for Intravascular Access Devices (IVADs)

- Clinicians who insert, manage and remove IVADs must undergo training and formal competency assessment, as determined by the HO and is consistent with best practice.
    - Competency assessment must be conducted to establish proficiency to perform these skills independently and may be undertaken on an ongoing basis as necessary.
    - Competency validation must be documented in accordance with organisational policy.
- Clinicians working towards formal competency must be supervised by an experienced and competent clinician

1.2 Patient Education

- The level of the education program provided to the patient and/or caregiver should be determined by the:
    - criticality of the patient
    - cognition of the patient
    - ability to manage the IVAD
    - type and duration of the IVAD
- The clinician should educate the patient and/or caregiver while in hospital or hospital in the home and before discharge on:
    - the procedure and need for the device
    - signs and symptoms of infection
    - signs of air embolism
    - what to do if it becomes disconnected or accidentally removed
    - practice and principles of caring for the device
    - infection prevention strategies for their device
- **Patients and/or carers in the community must be provided with appropriate material that includes who to contact for advice or in the case of an emergency**

1.3 Documentation

- Documentation in health care records must provide an accurate description of each patient/client's episodes of care or contact with health care personnel NSW Policy Directive **Health Care Records - Documentation and Management (5)**.
- Each HO must determine where clinical information relating to devices is to be documented in the patient's health record and that this is applied consistently so that clinical information can be readily accessed as needed. This is particularly important for devices with a longer dwell time.
- All clinical incidents must be reported and documented as per the NSW Health, PD2014_004 Incident Management Policy (6).
- Follow Australian Commission on Safety and Quality in Health Care (ACSQH) guidelines for labelling requirements. NSW Health Policy Directive **User-applied Labelling of Injectable Medicines, Fluids and Lines (7)**

1.3.1 Insertion

- Minimum documentation requirements at insertion by the proceduralist/procedure assistant are: A Central Venous Line Insertion Record or equivalent must be completed by the proceduralist inserting the device or their assistant for all CVADs which should include the below information:
    - Patient education and consent, refer to **Consent to Medical Treatment** (8).
    - Date and time of insertion, number of attempts, reason for insertion, local anaesthetic (if used), and the technique used, including visualisation and guidance technologies.
    - Site preparation, infection prevention and safety precautions taken.
    - The type, length, and gauge/size of the device (for PIVC); including the lot number for all CVADs and implanted devices.
    - Identification of the insertion site by anatomical descriptors and landmarks.
    - Confirmation of the location of the catheter tip for all CVADs prior to initial use.
    - Confirmation of patency and ready for use.
- This Record must be placed in the patient's health care record.

1.3.2 Post-Insertion

While the patient is admitted to hospital the condition of every IVAD must be documented at least once per nursing shift. The documentation must detail (4):

- Condition of the site, dressing, catheter securement, dressing change details, site care, and any changes related to the device or site.
- Length of CVAD catheter from skin to hub (to assess potential migration).
- Patient reported symptoms.
- Device function (e.g. patency, lack of resistance when flushing, presence of a blood return upon aspiration).
- Equipment/infusion type used for administration of Intravenous (IV) therapy.
- The Visual Infusion Phlebitis (VIP) score if used or any signs of infection

1.3.3 Administration Sets

All labelling of administrations sets used in continuous infusion must be documented in accordance with NSW Health Policy Directive User-applied labelling of injectable medicines, fluids and lines (7). If the lumen has an indwelling lock solution, the lumen must be clearly labelled so that it is not inadvertently flushed into the patient (7).

1.3.4 Removal

Minimum documentation requirements on removal of devices is:

- Date and time of device removal, reason for removal, condition of the site, and whether the catheter length and/or tip were complete and intact.
- Dressing applied.

Any continuing management of complications including site observation and documentation post removal.

2.3.5 Infection

Incidents of infection/phlebitis at the insertion site must be reported to Incident Information Management System (IIMS) or as per other local reporting requirements (6).

If a catheter related site infection or Blood Stream Infection (BSI) is suspected or confirmed this must be documented clearly in the patient medical record, if cultures are obtained, document the source of culture(s). The documentation should include a management plan and actions taken.

If IVAD site infections are suspected to have progressed to a systemic infection (bacteraemia) then notify as a Safety Assessment Code (SAC 2; all staphylococcus aureus bacteraemia must be recorded as a SAC 2).

Compliance with reporting mandatory Key Performance Indicators (KPIs) including routine reports on IVAD associated infections should be communicated to relevant stakeholders, peak organisational, governing and executive committees (6, 9).

2 PRE-INSERTION

2.1 Considerations when Choosing a Device

The risk of infection can be dependent on device site and selection. The following should be considered (10) as contributing to this risk: (see Section 4.2 for more information).

- Comorbidities, prolonged use and sites with frequent movement.
- History of mastectomy, arteriovenous (AV) fistula or graft, haematological disorders, history of device complications, obesity, coagulopathy, previous surgery, failed or difficult device access or immunocompromised.
- Therapeutic purpose: the infusate characteristics, complexity of infusion regime, availability of peripheral access sites.
- Estimated length of time: long-term intermittent therapy, treatment anticipated for more than 3 weeks.
- Vein status: veins may be difficult to access, torturous, fragile, hidden or deep.

3.1.2 Bundles

Infection prevention and control bundles reduce the risk of healthcare associated infections (11, 12). Facilities should develop bundles that are both evidence based and include local clinical risks. The principles for developing a bundle include:

- A manageable list of interventions that are descriptive and meet local requirements.
- Processes for documentation and assessment that considers clinical judgment in decision making.
- Input from the multidisciplinary team in developing the bundle.
- Monitoring and communication to clinical teams.

3 INSERTION

3.1 Prophylaxis, antimicrobial impregnation, coating or bonding

- The following should not routinely be used for the prevention of infection when inserting an intravascular device:
    - Systemic antibiotic prophylaxis (13-17).
    - Antibiotic or antiseptic ointment (13, 18).
    - Antimicrobial-impregnated catheters may be considered for specific population based on patients' risk factors and clinical presentation (19-21).
- The use of bonded connections and valves are beneficial in reducing the risk of air embolism and infection (22).

1. Device Selection, Site Selection, and Device Securement

3.1.1 Peripheral Intravenous Cannula (PIVC)

Device Selection

- Clinicians should use the smallest gauge and shortest length PIVC that will accommodate the anticipated therapy to reduce the risk of phlebitis.
- See **Attachment 1 PIVC Device Selection Guide** more information.

Site Selection

- Optimal site selection for PIVC is the distal areas of the upper extremities (e.g. Forearms) (3, 13).
- Basilic or cephalic veins on the posterior (dorsal) forearm are the preferred site for catheterisation (3).
- The site selected should be accessible and functional during surgery and procedures.
- Veins should be selected on the non-dominant forearm if practical (especially if the catheter is to remain in position for any length of time) (3).
    - Avoid veins of the lower extremities unless necessary, due to risk of tissue damage, thrombophlebitis, and ulceration.
    - Rotate PIVC site and arm where possible for repeated cannulations.
    - Replace a catheter inserted in a lower extremity, to an upper extremity as soon as possible.
    - Avoid compromised areas, areas of flexion e.g. antecubital fossa and areas of pain on palpation.
- For paediatrics, preference should be given to sites that are long lasting for duration of therapy (e.g. hands, forearm and upper arm).
    - Upper or lower extremities or the scalp (last option) can be used as the catheter insertion site (13).
    - Avoid hand or fingers, or the thumb/finger used for sucking in infants.
    - Avoid the right arm of infants and children after procedures treating congenital cardiac defects that may have decreased blood flow to the subclavian artery.

Securement

- The catheter should be stabilised with a transparent dressing and sterile adhesive tape or sterile adhesive/wound closure strips, to prevent catheter dislodgement (13, 23).
- For paediatrics use of IV board/splints are recommended to secure PIVC placed in or adjacent to areas of flexion. Follow local policy or guidelines for strapping and securement of PIVCs.

3.1.2 Midline Catheters

Device Selection

- Use the smallest gauge of midline catheters that will accommodate the prescribed therapy to reduce the risk of phlebitis and thrombosis (24, 25).

Site Selection

- Vein selection should be based on the biggest and most superficial vein above or directly below the antecubital fossa to allow normal arm movement and function. The catheter should not be placed at the antecubital fossa crease/fold or pass the axillary crease/fold.

Securement

- A sutureless securement device is preferred to reduce the risk of infection (26).

3.1.3 Central Venous Access Device (CVAD)

Device Selection

- Use the smallest gauge of CVAD that will accommodate the anticipated therapy to reduce the risk of phlebitis (27).
- The minimum necessary number of lumens and add-ons (manifolds, stopcocks and multi-extension sets) should be used.
- Heparin-coated catheters are not recommended (28).

Site Selection

- For PICCs select the basilic (preferred), cephalic, and brachial veins (with sufficient size) of the antecubital space or brachial veins (29, 30).
- In neonates the upper and lower extremities have similar complication rates.
- Use a subclavian or internal jugular site rather than a femoral site where possible, in adult patients to minimise infection risk for non-tunnelled CVC placement (31).
    - If the patient has chronic kidney disease, consider the internal jugular vein or, secondarily, the external jugular vein, weighing benefits and risks for each access site due to the risk of central vein stenosis (32).
    - Subclavian vein should be avoided for temporary access in patients with chronic renal failure due to the risk of central vein stenosis (33).
    - In patients with chronic renal failure be aware if a limb is being preserved for future haemodialysis access.
- For internal jugular sites, the right side of the patient is favoured as vessel anatomy allows direct access to the superior vena cava/inferior vena cava and provides a shorter and easier route for the practitioner inserting the device (34).

Securement

The CVAD must be secured (26) at the skin insertion point and anchor point (if present) by:

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.1.4 Implanted Venous Port (port/IVP)

Device Selection

- Catheters made of radiopaque silicone rubber or polyurethane are preferred.
- Ports made of various materials including plastic, titanium, silicone rubber, polyurethane, and a combination of these substances can be used.
- The life of the septum is dependent on the gauge of needles used to access the port and the type of needle used i.e. if a larger needle is used, the septum will wear out after fewer punctures than when a smaller gauge needle is used (35).

Site Selection

- Port pocket site selection should allow for placement in an area that provides good port stability, does not interfere with patient mobility, does not create pressure points or interfere with clothing (36).

Securement

- The suture line closing the port should not be located over the septum of the port (36).
- Umbilical catheters are commonly secured using the goalpost method, refer to local guideline or procedures for more information.

3.1.5 Peripheral Artery Catheter

Device Selection

The catheter must be flexible, resistant, as radiopaque as possible, thin walled with a high internal to external diameter ratio (37).

Site selection

- The radial artery is preferred due to its accessibility and good collateral flow, however the femoral, brachial or pedal artery may also be used (1).
- The brachial site should not be used in paediatrics (13).

Securement

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.1.6 Pulmonary Artery Catheter

Device Selection

The catheter must be flexible, resistant, as radiopaque as possible, thin walled with a high internal to external diameter ratio (37).

Site selection

- The preferred site is the right internal jugular vein followed by the left subclavian vein.

The femoral and antecubital veins should be avoided if possible.

Securement

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.2 Confirmation of Tip Position for Central Catheters

- The catheter tip position must be confirmed when a device is inserted, by any of the following techniques prior to use (38, 39):
- ECG CVAD tip confirmation
- Chest x-ray or image intensifier
- Fluoroscopy imaging and Digital Subtraction Angiography (DSA)
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Pressure monitoring of the central venous waveform in operating theatre until formal confirmation post-surgery
- Once the CVAD distal tip position is confirmed via any of the above, the "final Tip position" of the catheter must be documented (the total catheter length and external/inserted length (skin to hub) in the patients' medical record. This then becomes the clinician's primary referral source for written confirmation of tip position.
- This must be completed by the clinician inserting the device, their assistant or delegate for all insertions.

3.3 Standard Precautions (At Insertion)

Standard precautions are the minimum precautions required and must always be applied when caring for patients (4).

- *During an emergency situation (e.g. rapid deterioration and ambulance) time does not always permit use of aseptic technique or full maximal barrier precautions, the clinician should make every effort within their environment to maintain asepsis and adhere to standard precautions. If inserted in an emergency, the IVAD must be replaced as soon as the patient is stable (within 24 hours).*

The precautions outlined in sections 4.4.1 to 4.4.4 are the minimum requirements when inserting a device.

3.3.1 Hand Hygiene

- Perform hand hygiene before insertion procedures, refer to table 2 below.
- Hand hygiene should be performed before and after palpating catheter insertion sites as well as before and after inserting, **replacing, accessing, repairing, or dressing**.
- Palpation of the PIVC insertion site should not be performed after the application of antiseptic, unless non-touch technique is maintained or sterile gloves are used. If you need to palpate the planned insertion site after skin antisepsis to confirm anatomy, repeat the application of antiseptic.

The use of gloves does not eliminate the need for hand hygiene (before putting on gloves and after removal).

Table 2: Hand Hygiene for Device Insertion

Activity		Hand Cleansing Product*	Duration of Hand wash*
Aseptic Procedure	Insertion of PIVC	ABHR*	30-60 seconds
		Liquid antimicrobial soap and running water	40-60 seconds
	Peripheral Arterial Catheter	ABHR*	60 seconds minimum
		Liquid antimicrobial soap and running water	
	Insertion of CVAD, Midline and Umbilical Catheters	Liquid antimicrobial soap and running water	2 minutes
		Alcohol Based Surgical Hand Rub (ABSHR*)	Refer to manufacturer's instructions. Note: Prior to surgical rub, wash hands, forearms and nails using a non-medicated soap and running water.

**Manufacturers recommendations should be followed for the amount of solution and duration*

3.3.2 Aseptic Technique

- All clinicians involved in the insertion of devices must have appropriate training and assessment of aseptic technique, refer to section **2.1 Staff Education and Training**.
- Aseptic technique must be maintained for the duration of the procedure, this includes:
    - Hand hygiene.
    - Maintaining aseptic fields.
    - Once insertion site has been prepped aseptic technique must be maintained and the site must not be touched (unless sterile gloves are worn).
    - Procedures must be performed using non-touch technique protecting key sites and key parts. The cap/cover must remain on the device to maintain asepsis.
    - Personal protective equipment (PPE) must be worn as per standard precautions.
    - Ensure a logic, efficient and safe order of the procedure.
    - Equipment or items dropped on the floor must be discarded (even if there is a cap/cover on) and replaced.
    - Ultrasound transducers used for imaging the vascular system for insertion of venous access devices should be used with a sterile probe cover and sterile gel. The transducer probe must be cleaned and disinfected adequately in between use. Follow manufacturers' instructions for use.
    - A clean environment must be maintained throughout the procedure. Environmental controls to achieve this include; IVAD insertion trolley or procedure tray is to be cleaned, no room cleaning (buffing or polishing) immediately prior to, or during the procedure. The procedure should take place in a closed room or with curtains drawn around the patient zone to minimise air currents.

3.3.3 Personal Protective Equipment

Clinicians should wear appropriate personal protective equipment based on risk assessment and likelihood of exposure to bodily fluids.

Glove Use

- The use of non-sterile examination or sterile gloves will depend on the procedure being undertaken, contact with susceptible sites or clinical devices, the risks involved and the HO guidelines or procedures that are in place.
- For PIVC insertion gloves should be worn immediately after performing hand hygiene.
    - HOs should have in place local guidelines or procedures determining the type of gloves for PIVC insertion based on local needs and clinical risk.
    - Gloves considered in local guidelines or procedures may include; sterile procedural gloves, sterile gloves, non-sterile gloves.
- See below **4.4.4 Maximal Barrier Precautions** for more information (4).

3.3.4 Maximal Barrier Precautions

- Use maximum sterile barrier precautions. This involves:
    - Except for PIVC and arterial line insertions, mask, hair covering including beard if necessary, sterile gown and sterile gloves are required to be worn by all personnel involved in the procedure.
    - PIVC and arterial lines insertion require compliance with asepsis.
    - The insertion site is to be covered with a large sterile drape during catheter insertion.

3.4 Skin Preparation

- Hair at the insertion site should be removed using clippers to improve adherence of the dressing.
- The skin should be physically cleaned with soap and water (if necessary) prior to applying the antiseptic solution before inserting the catheter.
- The same antimicrobial agent must be used for all phases of the patient's skin preparation, to ensure full residual benefit and consistent action (17).
- Palpation of the insertion site should not be performed after the application of antiseptics, unless aseptic technique is maintained.
    - If the health worker needs to re-establish the identification of the vein, the site should be re-prepped with the antiseptic solution and allowed to thoroughly dry (17).

Table 3: Skin Preparation for Adults and Children ≥ 2 months (40, 41)

Skin cleansing prior to ***PIVC*** insertion	0.5-2% chlorhexidine gluconate (CHG) and 70% isopropyl alcohol
Skin cleansing prior to all other device insertions	2% chlorhexidine gluconate (CHG) in 70% isopropyl alcohol
If there is a contraindication to chlorhexidine, povidone iodine 10% in 70% alcohol can be used as an alternative.	

- The application of antiseptic should be a measured quantity and avoid over application. If the site is accessed prior to full evaporation of the product, this can lead to reduced efficacy.
- All solutions must be allowed to dry before beginning insertion, do not wipe or blot.
- Some of the alcoholic chlorhexidine solutions now contain colour to allow easier identification.
- Sterile saline or water solutions alone are not acceptable antiseptic solutions and should only be used to clean the skin of gross contaminants prior to applying antiseptic solution.
- Take care when applying liquid solutions to minimise the risk of eye injury to the patient due to splashes.
- Care should be taken during internal jugular approaches that solutions containing chlorhexidine are not introduced to the ear canal as this can lead to deafness.

4.5.1 Skin preparation in neonates

NSW public health organisations who care for **neonates** must have a local policy or guideline in place for skin preparation and/or antisepsis for pre-term infants. This should consider:

- Using topical antiseptics with extreme caution, particularly alcohol based preparations.
- The risk of chemical burns in premature babies.
- Avoiding Povidone Iodine for skin antisepsis.

4 POST INSERTION MANAGEMENT

4.1 General Information

- If Total Parenteral Nutrition (TPN) is being administered, where possible, health workers should utilise one lumen exclusively for that use (42, 43).
- Consider use of an extension set between an IVAD and needleless connector to reduce catheter manipulation (4).
- Refer to section **2.3 Documentation** for minimum documentation requirements.

4.2 Daily Review for In-patients

- All intravascular devices must be checked (table 4) at each shift for ongoing need and promptly removed when no longer required.
- The insertion site must be visually inspected by the clinician at least hourly with continuous infusion, at least every eight hours if no infusion (15). For further information refer to **Intentional Patient Rounding - Information for Clinicians and Health Professionals (44). For high-risk medicine clinicians should refer to the local protocols or Australian Injectable Drugs Handbook (AIDH) - 7th Edition** (45).
- Ensure medical staff review the need for IV therapy including antimicrobials on a daily basis and switch to oral administration as clinically appropriate.

- Table 4: Daily Assessment

Daily Assessment			
Phlebitis - Erythema - Tenderness - Swelling - Pain - Palpable venous cord - Purulent discharge	Systemic Infection - Rigor - Fever - Tachycardia - Hypotension - Malaise - Nausea/vomiting	Infiltration/extravasation • Insertion Site - Blanched, taut skin - Oedema - IV fluid leaking - Burning/stinging pain • Change in infusion flow	• Catheter position • Integrity of suture • Dressing integrity • Occlusion/patency • Ongoing need for line
For PICCs & Midlines, if limb swelling is suspected, compare the mid-upper limb circumference with the initial value recorded on the CVAD Insertion Record to quantify this. If a significant increase in circumference is confirmed, venous thrombosis should be considered and investigated appropriately.			

- (Source: I-care QLD (15, 17, 28, 36, 46-48)

5.3 Patients in the Community

- All intravascular devices should be checked (refer to table 4) at every clinical visit and removed when no longer required.
- Patients should be educated to visually inspect the insertion site when continuous infusions are running. This must include signs and symptoms of complications and who to contact if needed.

5.4 Transferring and transporting patients with CVADS

- There is an increased risk of CVAD dislodgment and falling out during transfer or transportation of patients.
- Devices should be visually inspected and secured before transfers occur.
- Consideration should be given to the weight of lumen sets and lines must be supported with additional fixation to reduce the risk of unplanned dislodgement.
- If catheter is not in use, check that the catheter is clamped prior to commencing transport.

5.5 Accessing Devices

- To reduce the risk of infection, manipulations of an intravascular device should be kept to a minimum and use a continuous flow system wherever possible.
- Where continuous flow is not possible, then the device should be flushed and locked as per local guidelines and procedures.
- The catheter lumen should be kept sterile and should never be left open to the air.
- Aseptic technique must be maintained at all times.
- Ensure line clamps are used when accessing a CVAD to reduce the risk of air embolism (22).

Table 5: Accessing Devices

PIVC, Midline, PICC, CVC (tunnelled & non-tunnelled), Umbilical Catheters, Pulmonary Artery & Peripheral Artery Catheters, Port	
Aseptic Technique Principles (49), relevant to the procedure. • Sequencing • Hand Hygiene • Environmental control • Maintain asepsis • PPE	**Antiseptic** • 70% isopropyl alcohol swab OR • 0.5-2% chlorhexidine gluconate & 70% isopropyl alcohol **PORT/IVP with needle insertion** • 2% chlorhexidine gluconate & 70% alcohol
Accessing a Catheter • All intravenous access ports should be meticulously cleaned with a large wipe (scrub the hub) for at least 15 seconds generating friction by scrubbing in a twisting motion with a single-use 70% alcohol-impregnated swab or alcoholic chlorhexidine or if allergic 10% povidone-iodine and allowed to air dry prior to accessing the system (50, 51). • The catheter should be accessed with a sterile single-use device. **Accessing a Port** • Only a non-coring (e.g. Huber) needle should be used to access implanted ports. Safety needle is preferred. • Use a new needle for each access attempt. • Needles should be changed every seven days or more frequently for continuous infusions if necessary. • Reinsertion through the immediately preceding needle site should be avoided.	

(Source: I-care QLD (15, 17, 28, 36, 46, 47))

4.3 Blood Collection

- Blood sampling via a CVAD is appropriate for some patient populations based on individual patient risk assessment prior to collection.
- Risks of venepuncture can include anxiety, pain, damage to skin and nearby nerves, and hematoma in patients receiving anticoagulants or with bleeding disorders (4).
- Limit drawing blood from IVADs as it increases hub manipulation and the potential for contamination (4).
- Blood samples from PIVC should not be drawn due to the risk of haemolysis, unless it is directly after insertion.
- Blood cultures should never be collected through a PIVC due to the increased rate of contamination at the time of collection.
- PICC in newborns should not be used for blood sampling or infusing blood products.

- Allow continuous observation of the site and to stabilise and secure the device.
- For patients aged ≥18 years with a CVAD (CVC and PICC), chlorhexidine-impregnated dressings may be used to protect the insertion site from contamination (51, 52).
- Use of chlorhexidine impregnated dressings in infants and children may require individual risk assessment and prescription, should be considered in local guidelines (53-55).
- When the patient is diaphoretic or has excessive bleeding or oozing from the site, use sterile gauze secured with a sterile transparent, semi-permeable dressing until this is resolved (51, 56).
- Umbilical catheters do not routinely use an occlusive dressing over the insertion site, refer to local guideline or procedure for more information.
- When the patient has multiple devices, each should be dressed separately unless the puncture sites are too close together.
- All equipment used for the dressing of the insertion site must be sterile.
- Dressing must be placed so the insertion site is visible for regular inspection, therefore do not place non-sterile or opaque tape directly over the insertion site.
- All dressings must be replaced if it becomes damp, loosened, no longer adherent, soiled, there is evidence of inflammation and/or there is an accumulation of fluid.
-

Table 6: Dressing Change Intervals

Dressing Type	Replacement Intervals
Transparent, semi-permeable, self-adhesive polyurethane	Every 7 days or sooner if the dressing is no longer intact, evidence of inflammation or moist
Gauze	Every 24 - 48 hours or whenever loose, soiled or moist
Chlorhexidine-impregnated	Every 7 days or at each dressing change

(Source (13, 47, 57)

4.4 Needleless Injection Ports

- Removal of a needleless injection port must be performed using aseptic technique.
- Anytime a needleless injection port is removed from the catheter, this is to be discarded and a new sterile injection port should be attached, using appropriate aseptic technique.
- Needleless injection ports that are not bonded to the central line should be changed(17, 42):
    - At least every 7 days (coinciding with administration set changes) OR
    - At the frequency recommended by the manufacturer OR
    - If the integrity of the needleless injection port is compromised (e.g. residual blood remains within the port).

Needleless Injection Ports can also be known as: needleless IV catheter systems, swabable capless valves, swabable capless access device, needleless access ports, needle-free injection port, needleless connector and needle-free connector.

4.5 Arterial Catheters

- Replace disposable or reusable transducers at 96-hour intervals or when clinically indicated. Replace other components of the system (including the tubing, continuous-flush device, and flush solution) at the time the transducer is replaced (13).
- Keep all components of the pressure monitoring system (including calibration devices and flush solution) as a closed system (13).

4.6 Administration Sets

- IV administration sets include both the IV lines and any additional attachments such as needleless injection ports, sideline syringe infusion pumps, three-way stopcocks, multi-flow adaptors and extension tubing that may be added.
- IV administration sets must be attached to the patient so that no tension is applied to the catheter to reduce the risk of dislodgement.
- Ensure all components of the administration system are compatible (including sideline syringe infusion pump or burettes and needleless injection ports) to the devices to minimise leaks and breaks in the system.
    - All connections must be luer-lock.
- Refer to section **2.3 Documentation** for labelling requirements.

Disconnection of Administration Sets

- A continuous circuit should be maintained as intermittent disconnections of administration sets increases the risk of infection.
- All administration sets must be replaced;
    - After being disconnected.
    - If the catheter is changed or
    - After blood has refluxed into the administration set and the blood is unable to be cleared by flushing.
- When an administration set is changed, the IV fluid bag must also be changed.

NB: infusions with blood and blood products and high value medicines, consideration may require on the continuation of the product and a risk assessment should be conducted to assess if product should be discarded and replaced with new lines or continue with existing set. Where an obvious contamination has occurred all lines must be changed.

- Disconnection of administrations sets must be avoided for routine care, such as showering, changing nightwear/gowns. If disconnected, IV lines must be replaced.
- Controlled disconnections where reconnection of the set is immediate may be appropriate in certain situations based on clinical requirements (e.g. changing IV access or infusions in operating theatres, administration of blood products or medical imaging departments).
    - For transient controlled disconnections, aseptic technique must be maintained to prevent contamination of the set.
    - If disconnection becomes more than transient or if the ends become contaminated in any way they must be discarded and replaced.

In-line Filters

In-line filters are not recommended for prevention of BSI, however certain agents such as chemotherapeutic, immunological drugs etc. require filtering for other reasons (15, 17, 46, 58).

Table 7: Frequency of Line Change

Administration Set Use	Frequency of Change
Continuous use (NOT containing lipids, blood or blood products)	Do not need to be replaced more frequently than every 96 hours unless device-specific recommendations from the manufacturer indicate otherwise (51). Change intermittent infusion sets without a primary infusion every 24 hours or whenever their sterility is in question (59).
Blood and blood products	Must be changed when the transfusion is complete, or every 12 hours if the transfusion is not complete (60). The maximum number of blood products as per the manufacturer's recommendations has been reached. Any number of red cell units may be transfused during a 12-hour period, provided the flow rate remains adequate (60). Platelets must be transfused via a new blood administration set. Note: Manufacturer's recommendations defining the maximum number of units per blood administration set must not be exceeded.
Lipid containing solutions and parenteral nutrition	Changed every 24 hours or as recommended by the manufacturer.
Lipid containing medications (e.g. Propofol, Clevidipine)	Changed at minimum every 12 hours or as per the manufacturers' instruction (61).
Chemotherapeutic agents	Remove immediately after use. On completion of infusion including the line flush. The chemotherapy infusion episode may include more than one agent, it is common practice to utilise the same administration set, with line flush in between in order to ensure the full dose has been administered.

4.7 Flushing

- Flushing is recommended to promote and maintain patency and prevent the mixing of incompatible medical solutions. Sterile 0.9% sodium chloride for injection must be used by clinicians, unless the manufacturer recommends flushing with an alternate solution (15-17, 46, 47, 62).
- Clinicians must flush catheters immediately:
    - After placement
    - Before and after each fluid infusion or injection
    - Prior to and after drawing blood
- PIVCs must be flushed at least every 8hrs, for hospital patients or every 24 hours for patients in the community, if not on a continuous infusion.

- CVADs not being accessed must be flushed and locked every 7 days.
- Ports/IVP not being accessed must be flushed and locked every four to six weeks.

4.8 Locking

- Sterile 0.9% sodium chloride for injection should be routinely used to lock a catheter no longer required for continuous infusions, unless the manufacturer recommends catheter lumens be locked with an alternate solution (17).
    - HO's who determine a need to use alternative locking solutions (e.g. heparin, antibiotic, antimicrobial and antiseptic), must have local policy or guidelines to support the appropriate use of these solutions.
- Locks containing medication must be prescribed by a Medical Officer or Nurse Practitioner.
- Refer to NSW Health Policy, **Medication Handling in NSW Public Hospitals** (63).
- Catheters with a medicine 'in situ' to lock the catheter must be labelled as per NSW Health Policy, **User- applied labelling of Injectable Medicines, Fluids and Lines** (7).

4.9 Catheter Migration

- A catheter that has migrated externally must not be re-advanced (64). The treating medical team must be notified immediately if this has occurred.
- If a CVAD is noted to have migrated inwards from the documented marking point, the CVAD must be retracted to the original insertion measurement as documented on the insertion form (65).
    - The medical team must be notified and a risk assessment for infection/contamination should be conducted.
    - This procedure can only be done by a clinician who has achieved CVAD competency. Refer **2.1 Staff Education and Training** for more information.

5 REPLACEMENT AND REMOVAL

5.1 Device Duration

- All devices must be checked at each shift and removed when no longer required or if mechanical complications occur (42).
- Assess any devices in patients transferring from other healthcare facilities who may have a documented or non-documented device in situ. The clinician should inspect for infection, mechanical complications and correct distal tip position. Correct position can be determined through previous documentation and correct external lengths comparison, or via radiological confirmation.
- When adherence to aseptic technique is compromised (i.e. catheters inserted during a medical emergency, ambulance), replace the catheter as soon as possible (e.g. when the patient is stable or within 24 hours) (66-68).
- Devices should be removed based on the following clinical indications:
    - The catheter is no longer required
    - Evidence of systemic infection
    - Damaged catheter
    - Evidence of local infection (redness, swelling, oozing or pain at catheter exit site)
    - Persistent catheter occlusion
    - Confirmation of thrombosis

5.1.1 PIVC

The routine replacement of PIVC may not prevent infection or phlebitis (69, 70). Current research supports replacing a PIVC on clinical indication but the device should not be left in indefinitely and in most cases PIVC dwell time should not exceed 72-96 hours (71). A PIVC should not be used for an extended period. The need for a PIVC beyond short term vascular access should defer to a suitable long term device (refer to section 4.2). The decision to implement PIVC replacement on clinical indication must be based on a formal risk assessment.

Criteria for clinical indication based PIVC replacement

- There is good availability of staff appropriately trained in the insertion and maintenance of devices on each shift.
- There is an assurance that PIVC surveillance in the healthcare facility is adequate, including regular inspection of the site and device, and of PIVC-related Staphylococcus aureus bacteremia (SAB).
- There is consistent documentation regarding device insertion (site ease and date), site appearance and complications experienced with devices.
- Remove PIVC if patient develops signs of local infection, pain or tenderness and follow local reporting guidelines (e.g. IIMS)

Criteria for routine replacement of PIVC

- Replacement is likely to be uncomplicated and the risk is judged to be less than retention.
- May be appropriate in the context of high rates of PIVC related complications
- The PIVC is likely to be needed for another 24 hours.
- The decision should be document in the patient's health record.
- PIVC replacement in neonates and children should be based on clinical indication and ongoing need for the device.

5.1.2 Midline Catheters

- Midline catheters that are inserted at the bedside using sterile technique may stay in place for 2 to 4 weeks (72).

5.1.3 Umbilical Catheters

- This will be determined by the clinical condition of the baby and availability of alternative access (73).
- Remove and do not replace the umbilical catheter if there any signs of catheter-related BSI, vascular insufficiency in the lower extremities, or thrombosis are present.
- An umbilical catheter may be replaced if it is malfunctioning, breaks or splits, and there is no other indication for catheter removal.
- Refer to local policy or guideline for further information.

5.1.4 Peripheral Arterial and Pulmonary Artery Catheters

- Do not routinely replace arterial catheters to prevent infections. Replace only when there is a clinical indication (74).

5.1.5 CVADS

- Do not routinely replace CVADs or haemodialysis catheters. Replacement should be based on clinical indication and need (51, 75).
- Do not remove CVADs on the basis of fever alone. Use clinical assessment to determine whether infection is evident elsewhere or if there is another non-infectious cause of the fever, refer **7 Diagnosis of Infection & Surveillance**.

5.1.6 PORTS

- Ports are a long term vascular access solution.
- The life of a port is limited to the number of needle punctures. The number of punctures varies depending on the gauge of the needle used but is approximately 1000-2000 (follow manufacturers instruction) (76).
- Replace ports based on clinical indications.

5.2 CVAD Guidewire Exchange

- Guide-wire exchanges to replace catheters is not recommended. A small number of patients may benefit from this in exceptional circumstances based on patient assessment, risk and suitable environment. Not advised for haemodialysis and tunnelled catheters.
- Guidewire exchanges must not be performed in the presence of BSI (77).

5.3 Catheter Removal

- Processes must be in place to ensure appropriate authority or order/instruction and written documentation to remove devices. HOs should develop standing orders or local protocols/processes for the routine removal of PIVCs (e.g. nurse initiated PIVC removal).
- Standard precautions and aseptic technique must be used to prevent catheter site infections (4).
- Following device removal, the site must be sealed with a sterile airtight dressing until the site is healed.
    - Umbilical catheters are not routinely dressed on catheter removal, but must be clean and dry.
    - If the patient is being discharged the patient or carer should be educated on the signs and symptoms of infection and complications and advised what to do if symptoms present.
- On removal the clinician should visually check the integrity of the line.
- Routine collection of the tip is not required except in circumstances where infection is suspected. Refer section **7 Diagnosis of Infection and Surveillance**.
- PORT/IVP and tunnelled cuffed CVADs are only to be removed by a Medical Officer or Nurse Practitioner/Clinical Nurse Consultant who has been deemed competent in this skill.
- Ports require surgical removal in theatre or interventional radiology.

Table 8 Requirements for Removal of CVADs

Requirements for Removal of CVADs: To prevent air embolism during CVAD removal HOs must have CVAD removal detailed in their local guideline or procedure.

- Refer to **Clinical Focus Report- Central Venous Access Devices and Air Embolism** (1)
- Removal of CVAD must only be undertaken by trained or supervised clinicians. Refer to **2.2.1 Competency Assessment for CVAD.**
- Removal of the CVAD must be undertaken using an aseptic technique that will minimise the risk of infection.
- The patient is to be positioned supine with head slightly down (if tolerated) during CVAD removal. This is to increase the pressure in the large veins to above that of atmospheric pressure, which reduces the risk of aspirating air into the venous circulation.
- Following CVAD removal, the site must be sealed with an airtight dressing which remains insitu for at least 24 hours to reduce the risk of late air embolism**. Refer to Safety Notice 004/14 Removal of Central Venous Access Devices (CVAD)**. The patient must remain in the supine position (or Semi-Fowlers if supine not tolerated) for between 30 and 60 minutes following CVAD removal (78). At least one set of observations should be done during this period, as well as immediately prior to retrieving the patient to the upright position. Observe for sign of respiratory distress, assess site for bleeding or haematoma and report any changes in status immediately.
- The removal of the CVAD and the presence of an intact tip must be noted in the patient's health record.
- Following removal, the CVAD site will require daily review and dressing until healed.
- Routine observations are to be conducted after the removal of the IVAD.

5.3.1 Removal of Catheter in Suspecting Line Infection

- Do NOT remove a functioning device based solely on temperature elevation (4).
- Remove PIVC if patient develops signs of local infection, pain or tenderness(4).
- If an infection is suspected the treating medical team must be notified and an assessment made for the ongoing need of device, persisting relapse of catheter related BSI, patient deterioration and alternative IV access.
- Patients transferring from other healthcare facilities with a documented device insitu should have the device reviewed upon arrival by a clinician for infection, mechanical complications and correct distal tip position, either through previous documentation and correct external lengths comparison, or via radiological confirmation. Without documentation, consider removal.

6 DIAGNOSIS OF INFECTION AND SURVEILLANCE

6.1 Diagnosis of Infection

- For a suspected catheter related BSI (79), obtain blood cultures (**see 7.1.1**).
- If pus, exudate or erythema is present at the insertion site, swab the site prior to removal of the device and send for culture.
- Catheter tip cultures are not a substitute for blood cultures for the determination of a bacteraemia, a negative tip culture does not exclude infection (79, 80).

6.1.1 Blood Cultures

- Two sets (4 bottles) of blood cultures should be collected in suspected infection for each new episode. This should occur prior to commencement of antimicrobials treatment. If patient is hemodynamically unstable, take 1 set prior to commencement of antimicrobials. Do not delay the administration of antimicrobials in patients with severe sepsis or septic shock.
- Collect one set from the pre-existing device and one set from a peripheral site.
    - If a peripheral set is not possible, a blood culture set from each of 2 or more lumens is required.
- The bottle should be well filled with a minimum 10mL per bottle (for adult patients only)
    - If volume of blood to be collected is an issue, preference should be given to aerobic bottles.
    - In neonates, collect an aerobic blood culture with 0.5-1mL, refer to local policy or guideline for additional information.
- Note the collection site on the request form at the time of collection.
- For further information, refer to local policy or guideline and **Sepsis Kills Adult Blood Culture Guideline, Sepsis Kills Paediatrics Blood Culture Guidelines and Sepsis Kills Neonatal Blood Culture Guidelines.**

6.1.2 Culturing of Tips

- Do not send catheter tips for culture on routine line removal, unless infection is suspected.
- Catheter tips should be cut using an aseptic technique.
- Ensure the site and type of catheter are noted on the request form as well as the appropriate clinical information.

6.1.3 Reporting of Catheter-related BSI

- HOs must have procedures in place for the timely reporting of all positive cultures to the treating medical and infection prevention and control teams.
- Open disclosure should be performed for all suspected or actual catheter related infections, as per the **NSW Health Open Disclosure Policy.**
- For healthcare associated BSIs (Staphylococcus aureus and Vancomycin resistant enterococcus) HO should follow internal reporting and escalation processes and key performance indicator requirements (e.g. IIMS). The NSW health incident management process must be followed for identification, investigation and management of these incidents as SAC 2 (6).

LIST OF ATTACHMENTS

1. PIVC Size & Use Guide
2. Related Documents
3. Additional Resources
4. Implementation Checklist

Attachment 1: PIVC Device Selection Guide

This is a guide for PIVC device selection and should be used whenever practical. However clinical risks and patient characteristics may require a different size to be used (e.g. paediatrics and neonates).

PIVC Size	Use
14G	Trauma patients Rapid, large-volume replacement
16G	Trauma patients Major surgery Intra-partum or post-partum GIT Bleeding Multiple line access Multiple blood transfers High volume of fluids
18G	Blood products Multiple line access Large volume of fluids Major surgery Imaging requiring power injection of CT contrast
20G	General use IV maintenance IV antimicrobials IV analgesia Power Injection
22G	Small or Fragile veins Cytotoxic therapy
24G	Small or Fragile veins Cancer services Day only infusion services Paediatrics
Delivery of Irritant medications: Use the most appropriate cannula size for the vein as use of a peripheral intravenous cannula that is too large for the vein increases the risk of phlebitis. **Refer Safety Notice 009/16 Avoiding thrombophlebitis with intravenous amiodarone (revised 10 Feb 2017).**	

Attachment 2: Related Documents

- NHMRC, **Australian Guidelines for the Prevention and Control of Infections in Healthcare** (3)
- NSW Health Policy Directive, **Infection Prevention and Control Policy (81)**
- **Clinical Excellence Commission, Infection Prevention and Control Practice Handbook** (49)
- Clinical Excellence Commission, **Healthcare Associated Infection: Clinical Indicator Manual version 2.0** (9)
- NSW Health Policy Directive, **Medication Handling in NSW Public Health Facilities** (63)
- NSW Health Policy Directive, **Clinical Procedure Safety** (82)
- ACSQHC, **National Safety and Quality Healthcare Service Standards (second edition)** (83)
- NSW Health Policy Directive, **User-applied labelling of injectable medicines, fluids and lines** (7)
- ACSQHCs, **National standard for user-applied labelling of injectable medicines, fluids and lines (84)**
- Clinical Excellence Commission, **Clinical Focus Report- Central Venous Access Devices and Air Embolism** (1)
- NSW Health, **Health Care Records-Documentation and Management** (5)

Attachment 3: Additional Resources

- Australian Injectable Drugs Handbook (AIDH) - 7th Edition **https://www.shpa.org.au/australian-injectable-drugs-handbook-aidh-7th-edition**
- Cancer Institute NSW, eviQ Cancer Education Online- **Central Venous Access Devices**
- Cancer Institute NSW, eviQ Cancer Education Online- **Clinical Resources, Central Venous Access Devices**
- Clinical Excellence Commission- **Training framework for clinicians new to inserting central lines in NSW**
- My Health learning - **Central Venous Access Devices**
- My Health Learning -**Invasive Device Protocols**
- Intensive Care NSW- **Central venous Access Device Post Insertion Management Guideline**
- NSW Health Multicultural Service- **Patient Information Sheets**
- **Sepsis Kills Paediatrics Blood Culture Guidelines**
  http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/259419/paediatric-blood-culture-guideline.pdf
- **Sepsis Kills Neonatal Blood Culture Guidelines**
- **Safety Notice 004/14 Removal of Central Venous Access Devices (CVAD)**
- Centers for Disease Control and Prevention- **Central Line-associated Bloodstream Infections**
- Health Protection Surveillance Centre- **Central Vascular Catheters**
- Health Protection Surveillance Centre- **Peripheral Vascular Care Bundles**
- Health Protection Scotland- **Preventing infections when inserting and maintaining a peripheral vascular catheter (PVC)**
- The Joint Commission- **CLABSI Toolkit**
- Association for Professionals in Infection Control- **CLABSIs**

Attachment 4: Implementation Checklist

Note: This implementation planner is NOT mandatory – it is a tool for HOs to use to monitor implementation of this policy.

LHD/ Facility:	Assessed By:				Date:
Implementation Requirements	**Not Applicable**	**Not Started**	**Partial Compliance**	**Full Compliance**	**Action Required**
Local guideline or procedures in place for Peripheral Intravenous Catheters (PIVC)	☐	☐	☐	☐	
Local guideline or procedure in place for Midline Catheters	☐	☐	☐	☐	
Local guideline or procedure in place for Central Venous Access Devices (CVADs), including implanted venous ports (ports).	☐	☐	☐	☐	
Local guideline or procedure in place for Umbilical Catheters.	☐	☐	☐	☐	
Local guideline or procedure in place for Peripheral Artery Catheters.	☐	☐	☐	☐	
Local guideline or procedure in place for Pulmonary Artery Catheters	☐	☐	☐	☐	
Roles and responsibilities for each type of clinician involved with these devices is clearly defined in the guideline or procedure.	☐	☐	☐	☐	
Clinicians who insert, manage and remove CVADs have undergone training and formal competency assessment. Assessments are documented and accessible for review	☐	☐	☐	☐	
Facility wide monitoring of clinician CVAD insertion practices to ensure only trained/experienced clinicians undertake or supervise CVAD insertion.	☐	☐	☐	☐	
All staff involved in the insertion, management and removal of devices have completed periodic educational program and assessment.	☐	☐	☐	☐	
Ongoing education is provided to HWs on preventing and controlling infection risks in relation to intravascular devices.	☐	☐	☐	☐	
Patients are provided with infection prevention and control education on their device and this education is documented.	☐	☐	☐	☐	
It has been determined where devices are to be documented in the patient health record. The CVAD Insertion Record or equivalent is completed for every CVAD insertion.	☐	☐	☐	☐	
There is an evaluation method to ensure that insertion sites are assessed and documented daily	☐	☐	☐	☐	

in the patient health record.					
Processes are in place to support and evaluate the appropriate use of alternative locking solutions (e.g. heparin or antimicrobial). Locks containing medication are prescribed by a medical officer or nurse practitioner.	□	□	□	□	
Confirmation of tip position is documented on the central venous line insertion record or equivalent for all central device insertions.	□	□	□	□	
HOs who care for neonates have a local policy or guideline in place for skin preparation and/or antisepsis for pre-term infants.	□	□	□	□	
Criteria for PIVC replacement based on clinical indication has been met by the HO.	□	□	□	□	
Processes are in place to ensure appropriate authority to remove devices.	□	□	□	□	
Procedures in place to investigate positive cultures that are attributed to devices.	□	□	□	□	
All reportable device related BSI events are reviewed at the HO on a case by case basis to identify potential opportunity for clinical practice improvement.	□	□	□	□	
Surveillance systems are in place to monitor adverse events and incidents related to devices.	□	□	□	□	
Compliance with this Policy Directive and Procedures is monitored and reported to the nominated peak committee.	□	□	□	□	

9 GLOSSARY

Administration Set	A tubing set composed of components that is used to deliver infusions.
Air Embolism	The presence of air in the vascular system that obstructs venous blood flow primarily to the lungs and brain (85).
Alcohol Based Hand Rub (ABHR)	An alcohol-containing preparation (gel, foam or liquid) designed for reducing the number of viable microorganisms on dry, unsoiled hands.
Alcohol Based Surgical Hand Rub (ABSHR)	Hand rub performed preoperatively by the surgical team to eliminate transient flora and reduce resident skin flora.
Antimicrobial	A chemical substance , usually a medicine, that inhibits or destroys bacteria, viruses fungi or protozoa (81).
Antiseptics	Antimicrobial substances that are applied to the skin to reduce the number of micro flora (e.g. topical alcohols, chlorhexidine and iodine).
Asepsis	Free from infection or infectious (pathogenic) material.
Aseptic Technique	Aseptic technique consists of a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during clinical procedures. The five essential principles of aseptic technique are sequencing, environmental control, hand hygiene, maintenance of aseptic fields and personal protective equipment (PPE). While the principles of aseptic technique remain

	constant for all procedures, the level of practice will change depending upon a standard risk assessment (81)
Assistant	A trained or experienced clinician who supports or aids a clinician inserting a CVAD.
Arteriovenous Fistula (AV)	Vascular access used to access the blood for haemodialysis treatment.
Blood stream infections (BSIs)	The presence of live pathogen(s) in the blood, causing an infection.
Catheter Exchange	Replacement of existing central venous access device (CVAD) with a new CVAD using the same catheter tract (4).
Central Related Blood Stream Infection (CR-BSI)	A laboratory-confirmed, primary blood stream infection in a patient with a intravascular access device in place, and the BSI is not related to an infection at another site (4)
Central Venous Access Device (CVAD) **Also called a central venous line or central venous catheter (CVC).**	A catheter introduced via a large vein into the superior vena cava or right atrium for the administration of parenteral fluids, medications or for the measurement of central venous pressure, this includes femoral venous catheters. • Centrally- inserted central venous catheters have a skin entry point in the neck or trunk. • Peripherally- inserted central catheters have a skin entry point on a limb or the scalp. • Non-Tunnelled- the catheter insertion and exit points are the same • Tunnelled - the catheter is inserted through one point and then “tunnelled” under the skin to a remote exit point.
Clinician	For the purpose of this policy, a clinician is defined as a medical practitioner (including Locum Medical Officers), nurse or midwife. Experienced Clinician- A clinician with a high level of competence in CVAD insertion and a comprehensive understanding of the management of potential complications. Trained Clinician- Clinician who has completed a training program consistent with best practice for the insertion of CVADs. Untrained Clinician- Clinician who has commenced, but not completed, a training program consistent with best practice for the insertion of CVADs.
Competency	Competence- Capability of the individual to apply knowledge, critical thinking, interpersonal, decision making, and psychomotor skills to intravascular access devices (4). Competence is the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance (86) For the purpose of the guideline, a competent clinician is one who has completed a training program in the insertion of PIVCs or who is in, or has completed, a specialist medical training program Competency- An integration of behaviours in the varied circumstances of the work environment demonstrating the individual’s ability to perform the desired job related activities and tasks (4). Competency Assessment- The process of reviewing and documenting the individual’s demonstrated ability to perform a job, role, specific tasks, or other patient care activities (4).
Electrocardiogram	Is a test that measures and records the electrical activity of the heartbeat

ECG

Erythema	Redness of skin along a vein track that results from vascular irritation or capillary congestion in response to irritation, may be a precursor to or indication of phlebitis (4).
Extravasation	Inadvertent infiltration of vesicant solution or medication into surrounding tissue; rated by a standard tool (4).
Flushing	The act of moving fluids, medications, blood, and blood products out of the vascular access device into the bloodstream; used to assess and maintain patency and prevent precipitation due to solution/medication incompatibility (4).
Guidewire	A long, flexible metal structure, composed of tightly wound coiled wire in a variety of designs; contains safety mechanisms that allow it to be inserted into the vein or artery (4).
Hand Hygiene	A general term applying to processes aiming to reduce the number of microorganisms on hands. This includes application of a waterless antimicrobial agent (e.g. ABHR) to the surface of dry unsoiled hands; or use of soap / solution (plain or antimicrobial) and running water (if hands are visibly soiled), followed by patting dry with single-use towels (81)
Healthcare Associated Infection (HAI)	Refers to infections acquired in healthcare facilities and infections that occur as a result of healthcare interventions and which may manifest after people leave the healthcare facility (81)
Health Organisation	For the purpose of this Policy a Health Organisation is: Local Health District, Speciality Health Networks, Statutory health corporation that provides inpatient services, or Affiliated health organisation in respect of its recognised establishments that provide inpatient service
IIMS	The NSW Health Incident Information Management System
Implantable Venous Port (port/IVP):	Long term CVAD, which is surgically placed under the skin from the insertion site to a separate exit site. The exit site is typically located in the chest, but can be also located elsewhere for comfort and aesthetic reasons (e.g. inner bicep, abdomen and thigh). They can be multi lumen. TIVPs consist of two main parts: the portal reservoir and a catheter. The tip of the catheter resides in either the superior or inferior vena cava. Also known as a port-a-cath or a venous port.
Infection	The presence and growth of a pathogenic microorganism(s) having a local or systematic effect (49).
Infiltration	Inadvertent administration of a non-vesicant solution or medication into surrounding tissue (4).
Intravascular device (device):	Catheters, tubes, or devices inserted into the vascular system, including veins, arteries, and bone marrow (4).
Key Parts	Key parts are those parts of equipment / instruments / consumables that if contaminated by infectious material increases the risk of infection. Contamination may occur by direct or indirect contact with the key site(s), other key-parts, or liquid infusions (81).
Key Sites	The area on the patient that must be protected from pathogenic microorganisms. Key Sites are medical device access sites, surgical sites or open wounds (81).

Locking	The instillation of a solution into an intravascular access device (device) used to maintain patency in between device use and/or reduce risk of catheter related BSI.
Maximum Barrier	Surgical mask, hat (head and facial hair cover), eye protection, sterile gown and

Precautions	sterile gloves. Equipment and clothing used to avoid exposure to pathogens, including sterile coverings for the clinicians and patient: mask, gown, protective eyewear, cap, gloves, large or full body drapes, and towels (4).
Midline Catheter	Catheter used in a vascular access procedure that is inserted inside a major vein for a period of weeks so that blood can be repeatedly drawn or medication and nutrients can be injected into the patient's bloodstream on regular basis
Monitor	To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.
Must:	Indicates a mandatory action
Needleless Injection Port	A device that allows intermittent access to a device with an administration set or syringe without the use of needles (4). Also known as: Needleless IV catheter systems, Swabable capless valve, swabable capless access device, needleless access ports, needle-free injection port, needleless connector and needle-free connector.
Neonate	Pertaining to the first 4 weeks of life.
Non-tunnelled CVAD **Also known as Percutaneous CVAD**	Enter the venous system at the point of insertion and are fixed in place at this site, with the catheter and attachments protruding. Non-tunnelled CVADs are also known as percutaneous CVADs. Non-tunnelled catheters are generally used for short term therapy and in emergency situations. A vascular or nonvascular access device inserted by puncture directly through the skin and the intended location without a portion of the device allowed to remain in a subcutaneous tract (4).
Osmolality	The number of osmotically active particles in a solution (4).
Palpation	Examination by application of the hands or fingers to the surface of the body in order to detect evidence of disease or abnormalities in the various organs; also used to determine location of peripheral superficial veins and their condition (4)
Peripheral Arterial Catheter	An arterial line inserted in radial artery; can be placed in femoral, axillary, brachial, posterior tibial arteries.
Peripherally Inserted Central Catheter (PICC)	A medium to long term CVAD inserted in a large peripheral vein, preferably the basilic vein, and then advanced until the tip rests in the superior vena cava or cavo-atrial junction
Peripheral Intravenous Cannula (PIVC):	A catheter (small, flexible tube) placed into a peripheral vein for intravenous access.
Personal Protective Equipment (PPE):	Refers to a variety of infection prevention barriers and respirators used alone, or in combination, to protect mucous membranes, skin, and clothing from contact with recognised and unrecognised sources of infectious agents in healthcare settings. The equipment worn to minimize exposure to a variety of hazards, including blood-borne pathogens; examples of PPE include items such as gloves, eye protection, gown, and face mask (81) .
Phlebitis	Inflammation of a vein; may be accompanied by pain, erythema, oedema, streak formation, and/or palpable cord (48).

Pulmonary Artery Catheter (PA)	Also known as a Swan-ganz catheter, is a CVAD inserted into a large central vein, with the tip residing in a pulmonary artery. Its purpose is diagnostic and therapeutic; it is used to detect heart failure or sepsis, monitor therapy, evaluate the effects of

	drugs, and infuse medication.
Should	Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action.
Sterile Technique	Is a set of specific practices and procedures performed to make equipment and areas free from all microorganisms and to maintain that sterility
Supervisor	An experienced clinician (also refer to definition of experienced clinician).
Surveillance	Active, systematic, ongoing observation of the occurrence and distribution of disease within a population and of the events or conditions that increase or decrease the risk of such disease occurrence.
Total Parenteral Nutrition (TPN)	The intravenous provision of total nutritional needs for a patient who is unable to take appropriate amounts of food enterally; typical components include carbohydrates, proteins, and/or fats, as well as additives such as electrolytes, vitamins, and trace elements (4).
Tunnelled CVAD	A central vascular access device (CVAD) with a segment of the catheter lying in a subcutaneous tunnel with the presence of a cuff into which the subcutaneous tissue grows to offer security for the catheter; indicates that the skin exit site and vein entry site are separated by the subcutaneous tunnel (4)
Vesicant	An agent capable of causing tissue damage when it escapes from the intended vascular pathway into surrounding tissue.
Visual Infusion Phlebitis (VIP) score	

338(16/08/19)

HIGH VOLUME SHORT STAY SURGICAL MODEL TOOLKIT (GL2012_001)

GL2012_001 rescinds GL2005_076.

The High Volume Short Stay Surgical Model emerged as a model of care from the Surgery Futures - A Plan for Greater Sydney Project (released January 2011). The toolkit provides Local Health Districts with information about the key features of the model, processes for service delivery, staff roles, diagnosis related groups suitable for HVSSS, key success factors, benefits and the steps for implementation of the model.

The Guidelines can be downloaded at
http://www.health.nsw.gov.au/policies/gl/2012/GL2012_001.html

144(19/01/12)

PATIENT IDENTIFICATION BANDS (PD2021_033)

PD2021_033 replaced PD2014_024

POLICY STATEMENT

This Policy Directive supports health services' compliance with the National Safety and Quality Health Service Standards, second edition in particular Action 6.5 relating to patient identification bands. The use of patient identification bands supports the correct identification of a patient within NSW Health.

SUMMARY OF POLICY REQUIREMENTS

Patient identification bands are to be white or clear with a white panel/ insert.

Red patient identification bands are to be used where the patient has a documented allergy to a medicine and/ or a documented life-threatening allergy to a food, or a documented adverse reaction to a medicine. These bands are to be red with a white panel/ insert.

As a minimum, the three approved patient identifiers are to be included on the patient identification band.

Patient identification bands

Health services are to develop local procedures to identify which patients require a patient identification band.

Health services are to develop local procedures consistent with this Policy Directive where technology, such as a patient identifier barcode, is part of, or attached to, the patient identification band.

Patient identification bands are to be destroyed in a way that maintains confidentiality of patient details.

Alert bands

Coloured alert bands must not be used except for yellow bands for patients who have undergone vitreoretinal surgery involving insertion of an ocular gas.

Patient Identification Bands: Procedures.

1 BACKGROUND

The use of patient identification bands supports the correct identification of a patient.

Correct identification of a patient promotes patient safety and minimises the risk of complications such as wrong procedures, medication errors, life-threatening food allergies, transfusion errors and diagnostic testing errors.

Health services are to develop local procedures to identify which patients require a patient identification band.

2 PATIENT IDENTIFICATION BANDS

2.1 Colour

A white identification band or a clear identification band with a white panel/ insert is to be used.

Exception

A red patient identification band with a white panel/ insert is to be used where the patient has a:

- Documented allergy to a medicine and/ or a documented life-threatening allergy to a food
- Documented adverse reaction to a medicine.

The patient's allergy and/ or adverse reaction is not to be recorded on the identification band. Health workers are to refer to the patient's medical record for this information.

2.2 Patient Identifiers

Black text is to be used to record patient identifiers on a patient identification band.

Core patient identifiers

The following three core patient identifiers are to be recorded on the identification band.

- Name: Family name to appear first using UPPER case letters followed by given names in Title case e.g. SMITH, John Paul.
- Date of birth: Standardise the format across the health service e.g. DD/MM/YYYY (26/06/1983), DD-MM-YYYY (26-06-1983), DDMMMYYYY (26Jun1983).
- Medical Record Number.

Exception: Newborns

To minimise the risk of mismatching a newborn and mother, especially if urgent separation occurs for example, newborn requiring admission to a special care nursery/ neonatal intensive care unit, the following identifiers are to be recorded on the newborn's identification band.

- Family name of mother in UPPERCASE then "baby of (given name of mother)" e.g. SMITH, baby of Jane.
- Date of birth.
- Time of birth to distinguish between multiple births.

The newborn's identification band is to be replaced with a new band when the newborn's own Medical Record Number is available.

Confirmation of patient identifiers

The patient's identity is to be confirmed before the identification band is placed on the patient to reduce the risk of misidentification. The patient, or their family/ carer, is to be asked the question "Can you please tell me your full name and date of birth?" The response to this question is to be compared with the patient's identification band and the patient's medical record, admission form, medication charts or request forms.

The information on the identification band is to be confirmed at intervals appropriate for the health care setting. Where the core patient identifiers are missing, inaccurate or unreadable the band is to be replaced immediately.

The identification band is to be disposed of in a way that maintains confidentiality of the patient details.

2.3 Number of patient identification bands

Patients are to wear **one** identification band.

Exception: Patients undergoing procedures

Two or more identification bands are to be placed on a patient undergoing a procedure where a band may be removed or become inaccessible to health workers during the procedure.

During the procedure one identification band is to be visible and accessible to health workers without interrupting the procedure. For example, unstrapping the patient's arm from the table, disturbing the procedural drapes, asking the proceduralist to pause, move or adjust equipment.

Where the identification bands are not visible during the procedure, health services are to develop local risk-based practices to ensure correct identification of the patient during the procedure.

Exception: Newborns

Two identification bands are to be used. An identification band is to be placed on each ankle of a newborn as soon as practicable after birth that is before separation from the mother and before the newborn leaves the birthing room or operating theatre.

If the newborn requires resuscitation the identification bands are to be placed on the newborn while the newborn is on the resuscitaire.

3 COLOURED ALERT BANDS

Coloured alert bands are *not* patient identification bands.

Coloured alert bands *must not* be used.

Exception: Yellow bands and vitreoretinal surgery

A yellow band (picture below) is applied to patients who have undergone vitreoretinal surgery involving insertion of an ocular gas. The bands are to be applied by the surgeon and the surgeon arranges removal.

The gas company supplies the bands. At the time of surgery, the surgeon records the name and contact number of the surgeon/ consultant and the date of surgery. The bands are not to be removed by health workers except for emergency access or if oedema of the limb is present. A new yellow band is to be applied if the band comes off or is removed except as arranged by the surgeon.

The yellow band advises the wearer to:

- Wear the band up to a specific date
- Absolutely avoid nitrogen protoxide anaesthesia
- Absolutely avoid pressure variation (elevation, travel by plane, diving with or without cylinders, hyperbaric chamber treatment).

This information is on the band in six languages.

4 APPENDIX – INFORMATION ABOUT PATIENT IDENTIFICATION BANDS

4.1 Size

Identification bands are to be available in a variety of sizes to fit patients, from the smallest newborn to the largest adult, as relevant to the health care setting. Identification bands are to be long enough for obese patients, patients with lymphoedema, patients with intravenous lines and bandages.

4.2 Comfort for the patient

Use bands that are comfortable to the patient. Ensure no sharp corners, edges, ends or fastenings that can irritate, rub or press into the patient's skin. Due to the tapering shape of infant and toddler's limbs and the absence of a flaring out of the circumference at wrists and ankles, identification bands can fall off. If put on tightly enough to prevent slipping on the infant or toddler sharp edges can irritate the skin and be uncomfortable.

Use material that is flexible, smooth, waterproof, resistant to fluids (e.g. soaps, detergents, gels, sprays, rubs, alcohol cleaning products, blood and other bodily fluids), cleanable, breathable and non-allergenic (e.g. latex free bands).

Check the band does not catch on clothing, equipment or devices e.g. intravenous lines.

4.3 Ease of use by health workers

Use bands that are easy for health workers to:

- Store and remove from storage
- Add, read, check, change or update patient information
- Place on a patient e.g. select the correct size, adjust to the correct length
- Remove from the patient.

4.4 Recording patient identifiers

Standardise the layout, order and style of information across the health service. Use predefined spaces for each patient identifier, a pre-printed format or pre-printed lines. Allow enough space for long names, multiple names and hyphenated names.

- **Printed labels**: use an easily readable style and font size. Ensure the label fits the available space on the identification band. Where possible print labels directly from the client registration database.
- **Handwritten labels**: print clearly in an easily readable size.
- **Write-on identification bands**: only use where a printed band/ label/ insert is not available.

Ensure information cannot wear off and does not require special pens. Inserts are to be sealed to ensure the insert is durable, waterproof, secure and tamperproof.

4.5 Placement of patient identification bands

Placement of the identification band is to be safe and comfortable for the patient and visible, accessible and easily readable to health workers providing care. Care is to be taken to ensure the peripheral circulation is not restricted by the identification band or the band is not causing a pressure injury especially in children. Monitor the size of the band for patients such as premature/ newborn patients who may outgrow their band.

Avoid placing the identification band on a limb with for example, epidermolysis bullosa, burns, an intravenous access, an arteriovenous fistula or graft, a limb to be operated on, or a limb with bandages or compression stockings.

Place bands on the lower limbs of newborns to prevent facial scratching.

Consider how to attach a patient identification band when limbs are not available for example,

- Apply a transparent adhesive dressing/ film over the band and onto the patient's skin in a readily accessible, visible body area. Check for allergies/ adverse reactions to the dressing/ film and check the skin integrity for pressure injuries.
- Attach the band to the patient's clothing or items attached to the patient such as arm boards in a way that is safe for the patient, and visible and accessible to health workers. Re-attach the band when clothing/ item is changed or removed.

WORK HEALTH AND SAFETY – CONTROLLING EXPOSURE TO SURGICAL PLUME (GL2023_018)

GL2023_018 replaced GL2015_002

GUIDELINE SUMMARY

This Guideline provides direction to NSW Health organisations to meet their duty of care under the *Work Health and Safety Act 2011* (NSW) and *Work Health and Safety Regulation* 2017 (NSW) in eliminating and minimising risk associated with surgical plume.

Each NSW Health organisation where surgical plume is created must have systems in place to identify hazards associated with surgical plume and to eliminate or minimise the risks through the implementation of appropriate controls.

KEY PRINCIPLES

This Guideline applies to NSW Health organisations and all other bodies and organisations under the control and direction of the Minister for Health or the Secretary of NSW Health where facilities under their control create surgical plume, such as in operating theatres; surgical clinics and procedural rooms, dental clinics; morgues during autopsy; laboratories/ research and testing facilities.

Surgical plume is generated during operative or other invasive procedures by energy based surgical devices such as electrosurgical (diathermy), ultrasonic and laser units when cutting, vaporising or coagulating tissue. Surgical plume can contain a mixture of hazardous components including ultrafine particulates, noxious and toxic aerosols, cellular debris, bacteria, viruses, gases, fumes and vapours.

Exposure to surgical plume needs to be assessed and controlled as it can cause potential hazards to workers and patients.

Hazard identification and risk assessment, in consultation with workers, must be undertaken to eliminate or minimise the risk of exposure for workers and patients. Surgical plume should be eliminated so far as reasonably practicable.

Plume evacuation systems are the most effective measure to remove plume at the point plume is created. Any plume that cannot be removed using a plume evacuation system should be minimised using additional controls based on the hierarchy of controls.

This risk assessment for worker/ patient exposure to surgical plume must include the physical layout of the area, equipment used for the surgery, surgical procedure being performed (length of surgery, type of tissue disrupted), ventilation of the area, specific risks for the patient and whether a plume evacuation system is installed.

Each NSW Health facility where surgical plume is created must:

- conduct risk assessments in consultation with workers
- implement controls identified through those risk assessments
- review controls at a frequency relative to the level of risk to ensure their ongoing effectiveness.

It is important to identify and procure the most appropriate plume evacuation system for the facility in consultation with workers. The plume evacuation system is to have an appropriate filtration system, alarm monitoring system, capacity to handle plume, and be easy to use without disrupting the surgical view.

The evacuation system must be maintained as per manufacturing guidelines which do not pose additional hazardous manual handling or infection control risks that cannot be controlled. Safe work procedures, checklists and training material must be developed to protect workers and patients based on the risks and controls identified in each facility.

Workers should be provided with information, instruction, training and supervision for the potential risks associated with surgical plume. This includes their role and responsibilities, safe systems of work and the use of equipment including personal protective equipment.

Control measures must be reviewed regularly, in consultation with workers who may be affected by surgical plume to ensure continuous improvement and ongoing effectiveness.

The complete Work Health and Safety - Controlling Exposure to Surgical Plume guideline is available at: **https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2023_018**

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

Patient Matters Manual

CHAPTER 25 – TRAVEL ASSISTANCE / TRANSPORT SERVICES

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TRANSPORT FOR HEALTH - JULY 2006 (PD2006_068)

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Executive Summary

Health services in NSW are major generators of passenger transport demand. Travelling to and from health facilities is often difficult for people who cannot use or have difficulty in accessing public and/or private transport. Transport disadvantaged people are more likely to be those also experiencing the greatest socio-economic and health disadvantage, or who live in rural and/or isolated communities. This in turn affects NSW Health's ability to reduce the gap between those people in the community with the best and poorest health.

NSW Health, *Transport for Health*

Transport for Health establishes a policy framework to assist NSW Health to simplify and improve patient access to health services by:

- responding to the health transport needs of patients in a consistent, strategic and efficient manner;
- developing and maintaining effective working partnerships with transport providers and stakeholders;
- facilitating recognition and consideration of the role and importance of health transport in service planning and delivery within the New South Wales health system.

Transport for Health integrates all non-emergency health related transport service provision throughout the Area Health Services in New South Wales (NSW) into one multifaceted program. These services are delivered by a variety of transport providers with support from a range of NSW government agencies. *Transport for Health* includes the former programs:

- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
- Health Related Transport Program (HRTP)
- Inter-facility transport
- Statewide Infant Screening-Hearing (SWISH) Travel
- Services funded under the former Transport for Health program

Transport for Health is aimed at supporting Area Health Services to be more strategic in identifying, consolidating and integrating a full range of transport services and resources to increase efficiencies and reduce duplication. It will do this by the creation of:

1. Health Transport Units as central point of contact within Area Health Services for responding to health transport issues.
2. Health Transport Networks that will provide a formal channel of communication between Area Health Services and health transport stakeholders in order to achieve better collaboration in the planning and provision of improved patient transport solutions.

Priority of access to *Transport for Health* services will depend on an assessment of how the health of a patient is likely to be affected if transport is not provided or obtained. No eligible person shall be denied access to a service on the basis of inability to pay a requested contribution. Priority is to be given to requests for assistance that will have the effect of:

1. Preventing the further development of a medical condition or,
2. Reducing the chance of an existing health condition becoming more severe.

Individuals who are not eligible for assistance through *Transport for Health* are:
1. People who require transportation by the Ambulance Service of New South Wales.
2. People whose medical condition or behaviour constitutes a danger to themselves, others or property.

Transport for Health, subsidies are available for patients who are disadvantaged by distance and isolation, and need financial assistance to use transport services. *Transport for Health* provides assistance to transport disadvantaged patients by:
- Purchasing or providing direct transport assistance through either brokerage/contractual arrangements or direct service provision.
- Subsidising the cost of patient transport to medical specialists, dental surgeons and, audiologists (for babies screened under the Statewide Infant Screening-Hearing (SWISH) program).

This assistance was provided under the former programs:
- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
- Statewide Infant Screening-Hearing (SWISH) Travel

New provisions for the *Transport for Health - Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)* will commence on 1 July 2006. These will:
- cut the eligibility distance for *Transport for Health - IPTAAS* from 200 kilometres to 100 kilometres; and
- increase the vehicle allowance from 12.7 cents per kilometre to 15 cents.

This is consistent with Australian Health Ministers' Advisory Council (AHMAC) national standards.

Transport for Health, which includes transport service providers and financial assistance schemes, reflects NSW Health's commitment to promoting fairer access to health services and increasing equity in health outcomes. The reforms promoted by this document will provide efficiency gains for Health Services and more effective and equitable delivery of health care to rural and metropolitan communities. Transport for Health will also enable NSW Health to make a valuable contribution to the development of a whole of government approach to better meet the passenger transport needs of communities across NSW.

Part 1: Policy Framework

1. Why transport is important for NSW Health?

Fairer access to health care and increasing equity in health outcomes are key objectives of the New South Wales health system. Two important NSW Health reports (Ministerial Advisory Committee on Health Services in Smaller Towns, 2000 and NSW Health Council, 2000) established that timely and appropriate access to health facilities for transport-disadvantaged people is essential for the cost effective and equitable delivery of health care. These reports highlight that a shortage of affordable transport and the centralisation of specialist medical services were the most significant barriers to achieving this goal.

Transport for Health presents an opportunity to integrate all NSW Health funded non-emergency health transport programs under one umbrella within each Area Health Service. With all key stakeholders working collaboratively to improve the planning, coordination and provision of health related transport services, patients will directly benefit from improved access to the health care they need.

Health related transport demand

NSW Health is a major generator of passenger transport demand. Current public transport services and private transport are often not available or accessible to a significant number of people living in NSW. This can at times result in people experiencing considerable disadvantage in accessing transport. Transport disadvantage is one of many underlying social factors impacting on people's everyday lives that contribute to health inequalities and impacts on NSW Health's capacity to reduce health inequities. The impact of transport disadvantage is often greatest for people who are already vulnerable to the effects of broader social inequalities such as people living in remote communities, housing estates, urban fringes, or Aboriginal or Torres Strait Islanders, the unemployed and those living with a disability etc.

In addition, patients are often required to travel between health facilities to access necessary specialist diagnostic and treatment services. Non-emergency inter-facility transport services have been established at many health facilities to meet this need.

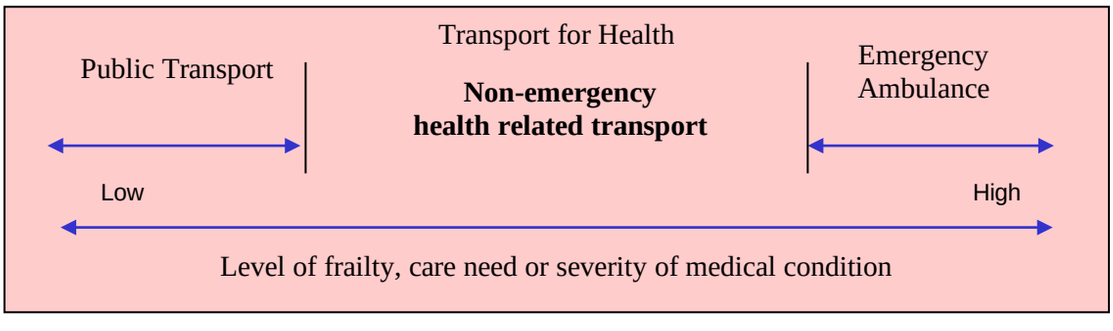
The *Transport for Health* policy provides a guide to the principles of non-emergency health related transport and the steps involved in developing a coordinated and efficient system for responding to patient transport demands.

2. What is *Transport for Health*?

Transport for Health will integrate all non-emergency health related transport into a single streamlined and efficient program in each Area Health Service. It aims to improve patient access to health services across NSW and subsequently to improve health outcomes.

Transport for Health is concerned with demand responsive non-emergency health related transport, which caters for the travel needs of people who cannot reasonably get to or from local health facilities by their own arrangements, and whose condition is not of an acute nature requiring Ambulance transport. The spectrum of *Transport for Health* services is illustrated in the following diagram.

Transport for Health



At the lower end of non-emergency health related transport are people who have a short-term medical condition or a frailty that prevents them from using conventional private or public transport. Many of these people have minimal requirements for assistance and are often capable of using public transport if these services are available at a suitable time, location and cost. Children can also present unique health transport issues including the need to accommodate siblings, secure a transport setting that complies with child protection measures and the fitting of vehicles with appropriate child restraints.

In certain special circumstances such as when a patient has to be transported on a stretcher or requires active (clinical) monitoring or management, the Ambulance Service of New South Wales may provide a non-emergency patient transport service. In some cases an appropriately fitted and monitored Area Health Service vehicle can also provide such services.

Non-emergency health related transport service providers

The needs of transport-disadvantaged patients are addressed by a diversity of transport service providers with support from a range of government agencies. NSW Health is committed to working closely with all key stakeholders to develop integrated solutions that reduce the negative impacts of transport disadvantage upon the health of individuals and communities.

Transport for Health, non-emergency health related transport services include:

- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) - Rural Area Health Services.
- Transport for Health - Rural Area Health Services and South Eastern Sydney Illawarra Area Health Service.
- Statewide Infant Screening-Hearing (SWISH) Travel.
- Health Related Transport Program - Rural and Metropolitan Area Health Services.
- Inter-facility transport services.
- Greater Metropolitan Clinical Taskforce (GMCT) Inter-facility Transport - Metropolitan Area Health Services and Hunter New England Area Health Service.

A significant volume of health related transport is provided by community based non-government organisations funded by NSW Government programs such as Home & Community Care (HACC) and the NSW Community Transport Program.

Aboriginal community controlled health services and Aboriginal transport organisations also provide health transport and in many cases Aboriginal communities are best served by such specialist non-emergency transport services.

Mainstream public transport including taxis, buses and long distance coaches are also an important source of transport for persons travelling to health facilities, and there is potential to significantly increase this sector's contribution to health transport services.

Transport Assistance

Transport for Health - subsidised travel schemes are financial reimbursement schemes for patients who are disadvantaged by distance and isolation and need financial assistance to use transport services to access specialist medical services not available locally.

Transport for Health provides assistance by either purchasing or providing direct transport assistance through brokerage, contractual arrangements, or by direct transport provision by an Area Health Service for example. The program also provides assistance by subsidising the cost of patient transport to medical specialists, dental surgeons and, audiologists (for babies screened under the Statewide Infant Screening-Hearing (SWISH) program).

Transport for Health subsidised travel schemes currently funded by NSW Health include the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) and the Statewide Infant Screening-Hearing (SWISH) Travel.

Non-emergency inter-facility transport services

Non-emergency inter-facility transport services are health related transport services for transporting admitted and/or non-admitted patients between health facilities. This may include stretcher equipped transportation, operated by an Area Health Service.

Non-emergency services provided by the Ambulance Service of New South Wales do not form part of the NSW Health, Transport for Health program.

3. Why a transport policy for NSW Health?

Transport for Health is the key strategy through which NSW Health is working to improve access to health facilities for transport-disadvantaged patients and between facilities for those needing to travel to other sites for health services. The *Transport for Health* (2006) policy recognises that both transport disadvantaged patients and the NSW health system will derive considerable benefit from a comprehensive and consistent approach to non-emergency health related transport service planning across the State.

Transport for Health has been developed to improve patient access to health services by:

- addressing the non-emergency health related transport needs of patients in a strategic manner;
- integrating all non-emergency NSW Health funded or operated transport services or financial assistance schemes (eg IPTAAS, SWISH Travel, Health Related Transport Programs, non-emergency inter-facility transport programs and *Transport for Health*) into a single multi-dimensional health related transport program;
- developing, strengthening and maintaining effective working partnerships with all transport providers and stakeholders;
- facilitating recognition and consideration of the important role of non-emergency health related transport in service planning and delivery within the New South Wales health system.

Transport for Health will play a valuable role in the development of a whole of government approach to meet the transport needs of rural and metropolitan communities in an efficient and cost effective manner. *Transport for Health* is intended to contribute to the process of integrating a range of NSW Health resources and strategies by bringing them into operational alignment, with the broader resources and systems supported by the NSW Government, public transport system and community services sector. Integration of non-emergency health related transport programs will result in improved patient access to health services, better health outcomes, and provide for operational efficiencies in the administration, planning and management of patient care.

Transport for Health recognises the role of the NSW Aboriginal Health Partnership Agreement 2001 in improving the health outcomes for Aboriginal people by promoting cooperation and collaboration between NSW Health and Aboriginal community controlled health services. The *Transport for Health* policy supports and encourages the development of partnerships between Area Health Services and Aboriginal community controlled health services that will promote the provision of culturally appropriate non-emergency health related transport services for Aboriginal people.

4. The policy outcomes

Transport for Health supports whole of government responses to transport needs by supporting a partnership approach between NSW Health and other transport funders and providers. It aims to provide a more efficient use of non-emergency health related transport resources through the improved coordination and integration of transport programs.

The *Transport for Health* (2006) policy aims to improve access to health services for transport-disadvantaged people, particularly in relation to those with the greatest needs, and ensuring a consistent NSW Health approach to this objective. The intention is to support:

1. Consistency and transparency in the processes and standards relating to non-emergency health related transport operations, including eligibility, passenger and service classifications, purchasing decisions, performance management frameworks and quality assurance.
2. Effective utilisation of transport systems and networks to cater to non-emergency health related transport demand.
3. Development of non-emergency health related transport service systems comprising of a mix of service types appropriate to the unique needs of each Area Health Service.
4. Improved information on and understanding of non-emergency health related transport need, levels of service provision, costs and expenditure.
5. Consolidation and integration of Area Health Service transport budgets and programs into a single multifaceted Area based program.
6. A single point of access for clients requiring transport assistance.
7. Statewide dissemination of information on best-practice *Transport for Health* program coordination and delivery.
8. Development of mechanisms for improving the coordination between the scheduling of outpatient appointments, admissions and discharges and available non-emergency health related transport services.
9. Area Health Services being equipped to more effectively identify, consider and address the transport implications of all strategic, service and facility planning and review processes.

5. The core principles

Transport for Health draws on the following core principles.

1. The availability and accessibility of appropriate and affordable transport is a fundamental determinant of a patient's ability to receive timely and appropriate health care.
2. Improved access to health facilities for transport disadvantaged patients is fundamental to achieving the goal of reducing health inequities within the community.
3. Effective and well coordinated non-emergency inter-facility transport is important for patients who need to access health interventions at other sites.
4. Considerable benefits will be derived by establishing a comprehensive and consistent approach to non-emergency patient transport issues across New South Wales.
5. Through effective partnerships NSW Health will add value to and derive value from services funded or provided from other (non-health) sources. This will improve overall system efficiency and community wellbeing.
6. Non-emergency health related transport services should respond appropriately to the cultural requirements of communities and of individual patients in order to facilitate access to health care.

6. The policy objectives

The *Transport for Health* (2006) policy provides a structure to promote the following objectives:

1. Document NSW Health's approach to planning, funding, coordinating, providing and monitoring non-emergency health related transport programs that promote improved access to health care.
2. Describe the role of NSW Health in supporting and funding the planning, development and delivery of non-emergency health related transport programs by Area Health Services.
3. Support NSW Health in establishing and consolidating effective working partnerships with other government agencies.
4. Support Area Health Services in establishing and consolidating effective working partnerships with transport providers, including community based operators.
5. Provide standard approaches to the planning, management and delivery of non-emergency health related transport programs.
6. Facilitate coordination of non-emergency health related transport services and financial assistance schemes within and across Area Health Service boundaries.
7. Maximise opportunities for operational efficiencies across all non-emergency health related transport programs.
8. Provide a standard approach to the monitoring and evaluation of non-emergency health related transport program delivery.
9. Provide clear guidelines for utilising non-NSW Health providers of non-emergency health related transport.
10. Provide stakeholders including health care providers, transport providers, consumers and community representatives, with mechanisms for consultation on and participation in the planning and monitoring of non-emergency health related transport programs.
11. Establish safety and risk management standards relating to non-emergency health related transport services.

7. Roles and responsibilities

This section outlines the roles and responsibilities of the NSW Department of Health and the Area Health Services implementing this policy.

Department of Health

1. Develop and maintain the *Transport for Health* (2006) policy and convene as necessary a statewide *Transport for Health* Implementation Group.
2. Coordinate implementation of the *Transport for Health* (2006) policy and support Area Health Services to implement and develop *Transport for Health* at a local level.

3. Develop in consultation with Area Health Services and other key stakeholders appropriate performance indicators to evaluate program effectiveness.

4. Work in partnership with other agencies to facilitate a whole of government response to the transport needs of communities.

5. Facilitate communications between government and community agencies and industry sectors relevant to *Transport for Health.*

Area Health Services

1. To provide executive support and leadership by the Chief Executive delegating responsibility for *Transport for Health* to a member of their executive management team. These responsibilities include the requirement to:
   - Develop, implement and monitor an Area Health Service, Transport Implementation Plan.
   - Establish arrangements for Area-wide coordination of *Transport for Health* through a Health Transport Unit.
   - Progressively consolidate administration of non-emergency health related transport resources, budgets and funding from internal and external sources into a single, multifaceted *Transport for Health* program.
   - Provide consumers with a single point of access to *Transport for Health* services.
   - Ensure compliance with non-emergency health related transport funding and regulatory requirements.
   - Provide reports to Department of Health on the Area Health Service implementation of *Transport for Health.*

2. To establish a Health Transport Network to facilitate communication between Area Health Service and non-Area Health Service stakeholders, and provide a mechanism to inform the development, operation and enhancement of *Transport for Health* systems and services.

8. Health Transport Units

Functions

Health Transport Units are to provide a means to consolidate the expertise, resources and administrative systems necessary to facilitate access to health services for transport disadvantaged patients. The primary functions of these units are to develop, enhance and sustain an Area Health Service based non-emergency health transport system that includes:

- Health transport services and transport assistance schemes provided by Area Health Services and non-government organisations.
- Spare capacity within transport services funded under other non-health government programs which can cater to health transport need.
- Health transport sourced through mainstream public transport systems.

The Health Transport Units will provide a major coordination role in the Area Health Service for non-emergency health related transport provision and related transport operations within the Area.

Scope of operation

Health Transport Units are to provide a focus for health transport coordination and are responsible for recognising and responding to the needs of key stakeholders including patients, a patient's carer or immediate family, health service staff and transport providers.

This role will involve among other things:

- Managing Area Health Service health transport resources.
- Providing information on health transport assistance.
- Providing information on mainstream public transport services.
- Supporting the implementation of the *Transport for Health* (2006) policy.
- Negotiating with clinical service providers to ensure complementary alignment of appointment or treatment times and health transport operations.
- Supporting efficient discharge planning processes.
- Taking health transport bookings.
- Providing transport referrals as appropriate.
- Administering non-emergency health related transport assistance schemes.

It is the Health Transport Unit's role to ensure effective utilisation of all available resources within and external to NSW Health funded services, in order to maximise the productivity of Area Health Service transport resources and to assist the efficient delivery of health services. The key tasks are to:

- Develop, implement and monitor the Area Health Service, *Transport for Health* Implementation Plan using the NSW Health, *Transport for Health* Implementation Plan Development Guideline as a reference.
- Pursue a whole-of-government approach to addressing the health transport needs of local residents, including improving network efficiencies and economies of scale in service provision across all modes of transport, and sectoral and funding programs.
- Ensure that *Transport for Health* strategies and systems are, wherever possible, aligned to and integrated with the transport coordination initiatives of other government agencies.
- Hold the budget for the Area Health Service transport funding.
- Negotiate and manage contracts and/or agreements for the provision of Area Health Service funded health transport services by non-Area Health Service transport providers.
- Collect and analyse health transport service data in order to account for funding expenditure, identify demand and service use trends, and be able to respond to opportunities for improvement in service coverage or efficiency.
- Establish and maintain links with Health Transport Units in other Area Health Services to ensure appropriate and efficient cross border transport services and to support effective inter-Area networking of health services.
- Maintain a register of health transport services that could be used by transport disadvantaged people within Area Health Service boundaries.

9. Health Transport Networks

Function

Each Area Health Service (AHS) is to establish a Health Transport Network, which will provide a formal channel of communication between AHS and non-AHS health transport stakeholders. These networks are to provide a mechanism to inform the development, operation and enhancement of *Transport for Health* systems and services. Area Health Services that receive *Transport for Health* enhancement funding are required to resource and support a Health Transport Network.

The primary function of a Health Transport Network will be to achieve and maintain better collaboration between the Area Health Service and other health transport providers contributing to the Area's service system. The aim is to facilitate coordination of non-emergency health transport resources to:

- Optimise access to health services for transport disadvantaged patients.
- Maximise the quantity of available health transport services.
- Ensure the quality of health transport services.
- Identify gaps in health transport service provision.
- Identify duplication or over-supply of health transport service provision.
- Ensure health transport services and transport financial assistance schemes are delivered by the most efficient and equitable service mode.
- Identify and address barriers to cross-sector resource coordination.
- Inform the planning, development and delivery of health services and facilities and non-emergency health related transport.

Membership

Health Transport Networks are to include representatives from the following groups:

1. Health transport providers including the Ambulance Service of New South Wales, community transport organisations, taxi operators, bus and coach service operators.
2. Major generators of health transport demand including Area Health Service (AHS) discharge planners, AHS day surgery departments, rehabilitation departments, aged and extended care departments, community health services, oncology departments, renal services departments and Aboriginal Hospital Liaison Officers.
3. Agencies that fund health transport and/or provide financial assistance schemes including the NSW Department of Ageing Disability and Home Care (DADHC) and NSW Ministry of Transport (MOT).
4. Health transport stakeholders including consumer, local government and divisions of general practice representatives, as well as representatives of any significant equity groups within the Area.

Meetings

Health Transport Network meetings should be chaired by the Area Health Service designated *Transport for Health* director and convened at least twice a year. Health Transport Network sub-groups may be established to manage regional or local based issues in Area Health Services covering larger geographical areas. Area Health Services will, where appropriate, convene a reference group with Aboriginal community stakeholders, reporting to the Area Health Transport Network and the Area Health Service designated *Transport for Health* director.

10. Area Health Service - Implementation Plans

As a key element of implementation of *Transport for Health*, Area Health Services will develop a Transport Implementation Plan that describes how the Area Health Service is addressing the *Transport for Health'* (2006) policy objectives. Implementation Plans will focus on the potential to utilise all available transport solutions to meet the non-emergency health related transport needs of the Area's communities. The plan will also demonstrate how NSW Health non-emergency transport funding will be used to complement and enhance existing local and community transport service

systems. Area Health Services will need to liaise with key stakeholders such as the Ambulance Service of New South Wales during this process as changes in transport service systems within the Area Health Service may impact on the workload of other organisations. The *Transport for Health,* Implementation Plan Development Guide (2006) can be used to assist Area Health Services in developing a Transport Implementation Plan. A copy of this guideline is available from NSW Department of Health.

The Area Health Service Implementation Plan is to identify and address the following key issues:

1. The significant demographic, geographic and health service related factors influencing health related transport demand and delivery in an Area Health Service.
2. Current non-emergency health related transport service delivery, including, the services provided by mainstream public transport, local and community transport and other funded transport services.
3. Current provision of health related transport assistance schemes, including IPTAAS, SWISH Travel, non-emergency health related transport programs, Greater Metropolitan Community Transport (GMCT), non-emergency inter-facility transport assistance and any other similar schemes.
4. Gaps in current non-emergency health related transport program delivery and the opportunities to develop services and/or programs. This should include strategies to improve efficiencies through better coordination and integration of existing services and programs.
5. A description of structures and systems either established or planned for the coordination of non-emergency health related transport programs. This may include the identification of key partnerships as well as establishing program development and delivery goals, timeframes etc.
6. Ensure that a risk management plan is in place to ensure patient safety.

Area Health Service, *Transport for Health,* Implementation Plans are to inform and may well be part of the Ministry of Transport's Integrated Transport Plans, Service Planning Guidelines and other instruments developed by the Ministry of Transport such as the recommendations outlined in the *Review of Bus Services in NSW 2004.*

Area Health Services may, where appropriate, develop local operational policy that is consistent with the NSW Health, *Transport for Health* (2006) policy to address unique regional or local non-emergency health transport issues.

11. Monitoring and review

The Area Health Service in consultation with its Health Transport Network is responsible for monitoring the effectiveness of the NSW Health, *Transport for Health* (2006) policy. This includes promoting equitable access to health services to residents. Area Health Services are to establish local mechanisms for the effective measurement of user satisfaction rates and improved patient outcomes within the NSW Health, *Transport for Health* services.

The Department of Health will monitor the effective implementation of the *Transport for Health* (2006) policy by reviewing Area Health Service reports on service delivery and the Area Health Service, Implementation Plans. The *Transport for Health* (2006) policy will be reviewed in consultation with Area Health Services and key stakeholders every three years. Additional requests for review of any specific aspect of the Policy should be referred to the Director, Primary Health and Community Partnerships Branch, NSW Department of Health. The Department will establish a formal mechanism for monitoring the overall implementation of *Transport for Health.*

Part 2: *Transport for Health* - Policy Implementation

1. Eligibility

Decisions concerning priority of access to Transport for Health assistance will be informed by reference to considerations such as the availability of other alternative transport options, a person's eligibility to receive transport assistance from other government programs, their destination and how their health might be affected if transport or financial assistance to the requested destination is not provided or obtained.

The *Transport for Health* (2006) policy provides a framework for Area Health Services to assist people who cannot reasonably gain access to local health services by either public or private transport means, or to assist people who need to access specialist medical or oral surgical treatment services not available locally.

It is also recognised that the incidence of transport disadvantage is considerable and that demand for health transport services is likely to exceed NSW Health's capacity to respond. The policy's eligibility provisions provide a practical guide to help to ensure that the allocation of finite resources is prioritised to those most in need.

1.1 Who is eligible for *Transport for Health* services?

Transport for Health (non-emergency health related transport) services are to be provided on the basis of a patient's inability to reasonably gain access to local health services by either public or private transport, rather than convenience.

The appropriateness of a request for *Transport for Health* services may not always be readily apparent. Expert advice from relevant health professionals or appropriate community representatives may be required to clarify eligibility for services, particularly requests from or made on behalf of mental health patients, patients with disabilities, patients with challenging behaviours, members of specific cultural groups, and day-surgery patients.

Transport for Health services do not include transport services provided by the Ambulance Service of New South Wales.

1.2 Capacity to use private or public transport to access local health services

Persons seeking access to *Transport for Health* services should be encouraged to make use of private transport options or alternative mainstream public transport services where these forms of transport can be reasonably accessed and utilised. The factors that should be taken into account when assessing what is 'reasonable' include:

- A person's ability to physically gain access to a vehicle or service.
- The impact of a person's health condition.
- Distances and duration of travel.
- Waiting times and times of operation, departure and arrival times.
- Number of transfers between services, or different modes involved in making a journey.
- Physical and mental stress involved in organising or making a journey.
- Conditions of roads.
- Availability of suitable assistance or support by a carer or appropriate helper.

- A person's capacity to meet the costs associated with the journey.
- Impact of using public transport on the wellbeing of carers or helpers.
- A person's ability to safely drive to and from the destination.
- The ability of the friends or relatives to safely drive the person both to and from the destination.
- Availability of suitable parking and/or waiting facilities at destination.
- The frequency of a particular journey and the cumulative effect of the above factors involved in multiple journeys.

1.3 Patients who are not eligible for *Transport for Health* services

There are certain categories of patients who are generally not eligible to receive *Transport for Health* services. These groups are:

1. people who may require an Ambulance service because of the acute nature of their health condition;
2. people whose medical condition or behaviour constitutes a danger to themselves, others or property.

1.4 Priority setting for service delivery

A key question is how the health of a person will be affected, if transport to the requested destination is not provided or obtained?

Priority is to be given to requests for assistance that will have the effect of preventing the development of a medical condition or reducing the chance of an existing health condition becoming more severe. Decisions concerning priority of access will also be informed by reference to the availability of alternative transport options including public, local and community transport services, and a person's eligibility to receive transport assistance from other government programs.

1.5 Additional *Transport for Health* eligibility & prioritisation considerations

NSW Health recognises that accommodating cultural needs can significantly contribute to the recuperation and/or overall health and wellbeing of patients. Transport for Health services should, as far as possible, be responsive to the cultural needs of individuals.

The following is a guide for managing requests for assistance from groups that may require additional considerations when determining priorities for transport assistance:

1. A patient's carer, particularly in the case of children, where it is necessary for them to accompany the patient during their journey and/or to remain with them during the period of treatment.
2. Persons seeking to visit relatives or friends staying within Area Health Service facilities who cannot reasonably gain access to those health facilities by either public transport or private transport. Where service capacity is limited, a person who is seeking assistance to attend a medical appointment or treatment will have priority over a person seeking assistance to visit a friend or relative.

3. Every effort should be made to accommodate culturally related requests for particular health transport service attributes (eg drivers of a particular gender). Where a person requests, for cultural reasons, to be accompanied in transit by friends or relatives, and where it is determined that this may impact on their accessing health services, all efforts should be made to accommodate that request. Relevant staff should be provided with appropriate cultural awareness training when dealing regularly with specific groups.

4. The capacity of transport-disadvantaged patients to access transport assistance through other government funding programs such as the Home & Community Care (HACC) Community Transport Program, and the Department of Veterans' Affairs' Booked Car with Driver Scheme, should be taken into account when prioritising a person's access to *Transport for Health* services. Such decisions should also be supported by a local non-emergency health related transport service system that is planned and implemented in partnership with these other programs.

5. Persons whose care and support needs are fully funded from government or private sector sources such as workers' compensation or insurance payments are eligible to utilise *Transport for Health* services. Area Health Services should seek full cost recovery from those funding sources for any service provided.

2. Approved destinations

Ongoing improvements in the organisation and delivery of services by NSW Health means that many aspects of health care that were traditionally delivered in hospital settings are now provided in community or private settings. These services, including primary health care services, remain part of an Area's extended network of health care services and are important in maintaining the health of the community.

Transport for Health reflects NSW Health's commitment to promoting access to health services for residents of New South Wales. Approved *Transport for Health* destinations include any health facility or health care that:

- caters to the needs of Area Health Service residents with acute or chronic health conditions;
- provides a recognised diagnostic, therapeutic (including oral health) or primary health care service;
- provides a recognised service that promotes good health or prevents illness.

The term 'recognised' refers to any health service that is considered to be beneficial to a person's health or wellbeing by a suitably qualified health professional. Where demand for *Transport for Health* services to "approved destinations" exceeds capacity, priority should be given to requests in accordance with the provisions outlined in 1.4 and 1.5.

3. Patient contributions

Transport for Health aims to balance an expectation, promoted by the Australian Government's approach to the Home & Community Care (HACC) program, that community transport services should involve a co-payment with the reality that some transport disadvantaged patients, particularly those with chronic illness, have limited capacity to make a financial contribution towards the cost of the transport they require to access the health services they need.

Income derived from patient contributions can increase the scope and capacity of *Transport for Health* service provision within an Area Health Service. Contributions can also be effective in discouraging inappropriate use of non-emergency health related transport services and might in some cases provide an incentive for patients to pursue alternative public and private transport. There is a need to balance the potential revenue and other benefits derived from patient contributions for use of *Transport for Health* services against the costs of administration and management.

It is important that any approach adopted in relation to personal contributions does not inadvertently preclude a transport-disadvantaged patient from seeking assistance through *Transport for Health* even when no suitable transport alternatives are available.

The following principles aim to support a consistent approach to the use of personal contributions for *Transport for Health* services delivered within an Area Health Service and between different health transport service providers.

3.1 Principles of patient contribution

Health transport providers should seek a financial contribution from patients as currently occurs with the Home & Community Care (HACC) program transport providers but no eligible person shall be denied access to a service on the basis of inability to pay a requested contribution.

1. Providers of health transport services should normally seek a financial contribution from a patient.
2. Patient contributions relate to an occasion of service and do not include donations and bequests that may from time to time be provided to a service provider.
3. The level of a contribution will as far as possible match that applying to comparable non-Area Health Service providers of similar transport service types.
4. No eligible patient shall be denied access to a *Transport for Health* service on the basis of inability to pay a requested contribution.
5. Providers of health transport services may reduce or waive user contributions based on a reasonable and informed assessment of a patient's ability to pay and the effect of payment upon their general circumstances.
6. Health Transport Units and providers of *Transport for Health* services should as a matter of standard practice consider reducing or waiving user contributions for members of identified equity groups such as Aboriginal communities or other very disadvantaged groups.
7. All service providers should make available to any interested party on request a schedule of recommended user contributions and advice regarding provisions for reducing or waiving an individual's contribution.
8. Health Transport Units should in conjunction with Health Transport Networks and through contracts and/or agreements with non-Area transport providers attempt to minimise significant variance in contribution rates for similar service types across the Area's health transport system.
9. Health transport service user contributions will not incur GST as long as the patient is accessing the services of a fully qualified health professional.

4. Health transport purchasing by Area Health Services

Area Health Services should purchase health transport services in a manner that optimises the outputs derived from available funds. The sustainability of service delivery needs to be taken into consideration. Transport services purchased should produce quantifiable outputs, supported by accountable and transparent decision making processes. Financial contributions made by passengers shall be treated as being part payment to the provider towards the full cost of service delivery.

Each passenger trip is comprised of three cost components:
- Administration as a portion or multiple of an hourly rate.
- Vehicle staffing as a portion or multiple of an hourly rate.
- Distance being a multiple of a kilometre rate.

Area Health Services should use the *Transport for Health* Costing Framework (Appendix 3) to:
- Identify accurate output costs for *Transport for Health* service delivery.
- Identify cost differentials between *Transport for Health* services catering to different Passenger Classification levels (see Part 2, Section 5).
- Inform decisions related to purchasing and commissioning *Transport for Health* services.
- Assist in determining the relative merits of in-house or out-sourced *Transport for Health* service solutions.
- Assist in developing service solutions using funding from different government agencies and programs.
- Assist in planning or facilitating service partnerships, where different *Transport for Health* sub-tasks can be carried out by different agencies and the total service payments apportioned to different agencies working in partnership (eg a community transport organisation provides administration, including bookings and data capture, for a *Transport for Health* service and a mainstream bus operator provides the vehicle and driver).

Where non-emergency health related transport is purchased by Area Health Services using *Transport for Health* funds purchased from external sources, the terms should be recorded in contract/or agreement in line with the AHS Procurement Process documented in the Purchase and Supply Manual for Public Health Organisations (January 2006.) Health transport providers should periodically invoice Health Transport Units for services provided under the terms of their agreements and compile invoices using the cost components identified within the *Transport for Health* Costing Framework (see Appendix 3).

It is recognised that some non-emergency health related transport providers, particularly community based services, have developed services and financial systems dependent upon grant funding paid in advance. In such cases, Area Health Services are encouraged to investigate the establishment of volume purchase agreements that provide health transport providers with necessary levels of stability and security, and also allow Area Health Services to align *Transport for Health* funding to units of service purchased at a specified price.

There may be opportunity for Area Health Services to benefit from NSW Ministry of Transport initiatives for regional integration of purchasing strategies across NSW Government agencies in accordance with the recommendations of the 2004 *Review of Bus Services in NSW*. Area Health Services are encouraged to explore strategies for streamlining the purchase of health transport or improving the value of these purchases in partnership with the Ministry of Transport and other NSW Government agencies.

5. Classification Framework

The care and support needs of eligible Transport for Health passengers vary greatly as do the levels of skill, understanding, and ability of health transport service providers to respond to these needs. A service solution that is appropriate and cost effective for one passenger may be unsafe for another.

The care and support needs of eligible *Transport for Health* passengers vary from those who are relatively able-bodied and may simply not have access to public or private transport, to those who are frail or have multiple care needs and require the assistance of skilled and trained staff. Accordingly, a service solution that is appropriate and cost effective for one passenger may be unsafe for another.

There is considerable variation in the levels of skill, understanding, medical knowledge and ability to respond to the spectrum of patient care needs among potential health transport providers. The potential therefore exists for misunderstanding, and for situations where passengers are referred to inappropriate service solutions.

The *Transport for Health* Classification Framework provides a uniform standard for communication and risk management to promote the development of effective and appropriate health transport service solutions. The Framework should be used by all *Transport for Health* stakeholders in order to:

- Ensure that health transport services are appropriate to the care and assistance needs of each patient.
- Minimise risk to patients and health related transport providers.
- Establish a common language used by all *Transport for Health* stakeholders to assist booking, referral, purchasing, planning and monitoring activity.

There are two principal components of the *Transport for Health* Classification Framework.

1. The **Passenger Classification** system is used to assign eligible passengers through a simple screening process to one of three levels of need (low, medium or high) based on their functional ability and care or assistance requirements (see Appendix 2, Table 1). This process, which may be assisted by the use of the Passenger Screening Tool, provides the basis for all decisions made regarding *Transport for Health* bookings or referrals (see Appendix 1).
2. The **Service Classification** system is used to assign *Transport for Health* services to one of three levels (low, medium or high) based on the ability of a service type to appropriately cater for the care and assistance requirements relevant to Passenger Classification System levels (see Appendix 2, Table 2 & 3).

All *Transport for Health* passengers are to be assigned a classification level in accordance with the content of the screening tool. The screening tool may be applied to patients remotely (by telephone) or as part of a comprehensive assessment activity. While the screening tool does not need to be completed for each applicant, all patient classification determinations should be able to be explained in terms of the screening tool's elements.

Transport for Health service providers are responsible for ascertaining any changes to a passenger's classification level each time a booking is made in order to take account of changed capabilities or care needs following treatment. In addition to advice provided by the applicant, information relevant to the screening and classification process should also be obtained, where appropriate, through information or feedback received from drivers and other service staff, health professionals, carers and their immediate family.

Health Transport Units should develop Fitness to Travel Certificates for use by non-Area Health Service *Transport for Health* providers. These documents should be consistent with and incorporated within Area Health Service discharge policy and procedures. They should record the certification of an appropriately qualified Area staff member that a patient is fit to travel on a *Transport for Health* service of a particular Service Classification level after receiving a particular treatment or medical intervention.

Health Transport Networks should aim to ensure that *Transport for Health* service systems contain an appropriate mix of service classification levels to address the full range of patient needs. The NSW Department of Health will work with other government agencies to promote uniform adoption of policy and processes compatible with the Classification Framework across funding programs contributing to *Transport for Health* service systems.

6. Training and accreditation

The Training and Accreditation standards for *Transport for Health* services are linked to the *Transport for Health* Classification Framework and are consistent with the requirements of the *Passenger Transport Act 1990*. NSW Health will work with other NSW Government agencies to streamline, standardise and enhance the availability of training relevant to the provision of *Transport for Health* services. Details of the registration, training and accreditation requirements relating to services operating at the low, medium and high levels of the *Transport for Health* Classification Framework are outlined in Appendix 2, Table 2 and 3.

7. Physical accessibility of services

NSW Health acknowledges its obligations under the *Commonwealth Disability Discrimination Act 1992* and has ensured that these are reflected in all aspects of this Policy Framework. *Transport for Health* service providers should make every effort to ensure that, wherever possible, vehicles providing *Transport for Health* services are equipped with wheelchair/passenger lifts, and that these devices are used in order to minimise manual lifting and handling, and to reduce the risk of falls for passengers with restricted mobility or balance problems. Any *Transport for Health* service providers not utilising accessible vehicles for service delivery should be able to demonstrate clear financial or operational reasons why an accessible vehicle cannot be used.

8. Information and reporting systems

A passenger trip is an international standard for measuring outputs of passenger transport services. It is defined as one-way travel between two points. Commonly an episode of health care delivery will involve two passenger trips: one inbound and one return. All service delivery data must be reported in relation to passenger trips.

NSW Health, *Transport for Health* commitments

1. To work in collaboration with relevant government agencies to develop a common minimum data set for funding programs contributing to *Transport for Health* services.
2. To work in consultation with Area Health Services, government agencies, peak bodies, and other stakeholders to develop a common reporting framework that will be used to monitor and evaluate performance for *Transport for Health* services funded by NSW Health. The reporting system will be designed for electronic data collection and transmission and will be flexible enough to address the breadth of service types and organisations contributing to *Transport for Health* service systems. It will be comprehensive enough to facilitate efficient evaluation of both service and network efficiency at local, Area and State levels.

3. To identify an appropriate computer based *Transport for Health* information management program and support the acquisition of this software by Area Health Services and provide all necessary training in its use to staff.

Principles

The following are principles for guiding the development of an appropriate and effective *Transport for Health* information system:

1. The provision of individual *Transport for Health* services that are safe and efficient requires the efficient management of data.
2. Integrated coordination of *Transport for Health* service systems involves the efficient transfer of specified data between separate service providers and other stakeholders.
3. Effective information sharing, to facilitate cooperative service delivery and planning depends upon the compatibility of the data collected.
4. Effective planning, monitoring, review and enhancement of government funding programs is dependent upon the efficient collation and analysis of accurate and comprehensive service delivery data.
5. Effective cross-program planning and resource coordination, necessary to avoid duplication and yield network efficiencies at local, area and state levels, is dependent upon compatibility of service provision data across government funding programs.
6. Streamlining accountability requirements across funding programs offers considerable opportunity to improve efficiency in service administration by *Transport for Health* providers and to improve upon the effectiveness of integrated coordination of *Transport for Health* service system components.

Area Health Services

Area Health Services have distinct geographic and demographic features, which provide unique challenges and many opportunities for the development of service solutions to meet the needs of transport disadvantaged people and those who need to travel between health facilities for health interventions. These variations will influence and lead to diversity in *Transport for Health* priorities established by each Area Health Service.

Factors that contribute to an Area Health Service's individual needs and service profile are:

- Population demographics including Aboriginal population, health status and socio-economic status of communities.
- Number, nature, size and distribution of health services.
- Geographical area and topographic features.
- Availability of mainstream public transport services and resources.
- Availability and nature of community transport services and resources.
- Nature and levels of non-NSW Health non-emergency health related transport provision.
- Baseline resources for in-house provision or purchasing of non-emergency health related transport services.
- Baseline resources for in-house and external non-emergency health related transport planning and coordination.

- Strategies that reduce the need for non-emergency health related transport such as Telehealth systems.
- Groundwork completed by previous transport development initiatives or projects.

Area Health Services are to endeavour to collect as a minimum the following data in relation to *Transport for Health* services in relation to each passenger trip purchased or provided:

- Name of Passenger.
- Age of Passenger.
- Equity status (ATSI, CALD, disability).
- Passenger Classification Level (for trip).
- Service Classification Level.
- Service mode used (eg. community bus, taxi etc.).
- Date of service delivery (passenger trip).
- Purpose of trip.
- Trip point of origin.
- Trip destination (including information on health facility or hospital department).
- Patient co-contribution.
- Trip cost (if possible).

Assessment and monitoring data

All providers participating in the health transport system will contribute to determining the process for the initial and any ongoing assessment of a person's eligibility under *Transport for Health*. This includes non-health transport providers such as community transport organisations that may determine on an Area's behalf an individual's eligibility to receive *Transport for Health* services.

The collection of a minimum data set including core user data is an essential requirement for the effective planning and efficient delivery *Transport for Health* service systems. It is expected that a person's eligibility will be monitored in order to take account of any changes in their care and support needs. Non-Area Health Service health transport services funded under *Transport for Health* should be able to provide Health Transport Units with relevant patient and service delivery records upon request. The minimum information to be collected for each patient should include:

- Date of initial assessment of eligibility.
- Person and organisation conducting the assessment.
- Assessment eligibility status; and
- Grounds for determining eligibility.

Health Transport Units should also collect and analyse data on unmet non-emergency health related transport demand. This will assist the identification of coordination efficiencies and make valuable contributions to whole of government strategies to improve efficiency and effectiveness of local and community transport networks. Data on unmet demand should include:

- Intended destination.
- Classification of intending passenger.
- Point of trip origin.
- Purpose of trip.
- Frequency of transport requested.
- Representation of a specific disadvantaged group (eg people of Aboriginal or Torres Strait Islander origin, people with a disability, people with a chronic illness and their carers).

The *Transport for Health* - Reporting Framework for periodic reporting to NSW Health is provided at Appendix 3.

9. Effective transport coordination

Effective transport coordination is essential in order to optimise the use of available health transport resources. Effective coordination of health transport will promote:

- Equity of access to health services for transport disadvantaged patients.
- Improved choice, quality and flexibility in health transport for transport disadvantaged patients.
- Health transport demand being met efficiently and cost effectively.
- Balance in responding to the wide range of needs for access to health services.
- Better value being derived from government transport funding programs, coordination initiatives, and transport systems catering to the broader needs of communities.
- Minimise risk to patients being transported.

The core elements associated with effective transport coordination are:

1. Program integration.
2. System-wide coordination.
3. Modal efficiency.
4. Aggregation of patient flows.
5. Demand coordination.
6. Mobility management.

Each of these elements is an essential part of overall effective coordination and should be applied in appropriate combinations based on local context and needs.

9.1 Program integration

Program integration refers to the financial and operational integration and co-location of the range of programs to assist transport disadvantaged patients and those requiring transport assistance to travel between health facilities for treatment or assessment.

9.2 System-wide coordination

System-wide coordination refers to the utilisation of overall health transport capability available through all commercial, non-commercial and community sector resources and service modes. The effective working partnerships required to achieve this objective will be facilitated and supported by the systems and structures promoted in the *Transport for Health* Policy. The main aim of system-wide coordination is to align existing parts of existing health transport programs in a complementary manner, in order to:

- Optimise system coverage and capacity.
- Minimise duplication.
- Reduce the unit costs of provision across the system.
- Increase viability for operators within the system.
- Minimise “silos” of inefficient resource deployment and operation.

System-wide coordination of health transport programs requires Health Transport Units to identify all existing and potential programs and to maximise their use by developing close partnerships with all relevant funding agencies and transport providers.

9.3 Modal Efficiency

Modal efficiency refers to the different service modes within a transport system (volunteer transport, cars, taxis, community buses, public transport buses, charter buses, spare capacity in Area Health Service patient transport vehicles etc) and the need to recognise the relative merits of these modes in responding to different health transport needs. Modal efficiency recognises that:

- Transport modes have different capabilities, limitations, flexibility and operating costs.
- Carrying more passengers in multiple occupancy modes (buses) than in low occupancy modes (cars) reduces the average unit cost of provision.
- The need for flexibility and demand responsive services also means that there is an important, cost effective and ongoing role for low occupancy modes of health transport.

Modal efficiency requires Health Transport Units to identify accurate operational costs for all components of an Area's non-emergency health related transport service system in a format that allows for meaningful comparisons (see Part 2, section 4). It is also important to ensure that there is an appropriate balance between multiple occupancy health transport services and low/single occupancy services, and between high-level and low-level services.

9.4 Aggregation of Passenger Flows

It is essential to develop strategies to aggregate passenger flows wherever possible, and appropriate. This generates greater efficiencies in travelling to and from key destinations within an Area Health Service. Travel arrangements will be generated at specific times of the day and may involve particular transport corridors and/or modes of transport.

Aggregation of passenger flows recognises that certain destinations or groupings of destinations within an Area Health Service will generate regular and predictable volumes of non-emergency health transport demand. Travel to and from these key destinations should be generated at specific times of day and may involve particular transport corridors.

If passenger flows to common destinations are fragmented, then transport will generally occur in low passenger occupancy modes (cars) at a relatively high unit cost. If the flows are aggregated then multiple occupancy mode transport solutions, such as bus services, can be employed at a lower unit cost. Groupings of destinations can be based on locality, rather than purpose such as in attending health services. Flows that accumulate in towns and communities along a transport corridor to a regional centre might mean that patients are only one category of transport-disadvantaged persons that can benefit from a more broadly coordinated passenger transport solution.

9.5 Demand coordination

Demand coordination refers to health services being responsible for ensuring that, wherever possible, appointment and treatment scheduling practices take account of the difficulties that transport disadvantaged patients can experience in travelling. Transport scheduling arrangements need to complement the availability of transport options. This is critical to the aggregation of passenger flows and achievement of modal efficiencies across a service system.

Health facilities can greatly assist the work of Health Transport Units and health transport providers by:

- Identifying patients' needs to access health transport services prior to scheduling appointment or treatment times.
- Setting appointment or treatment times in consultation with the Health Transport Unit or transport provider.
- Setting or altering appointment times to align with the availability of transport.
- Setting or altering appointment times to "smooth out" peak demand times for transport.
- Grouping or prioritising blocks of appointment times for health transport passengers from particular localities to allow them to travel on scheduled services.
- Allocating appointments to allow patients to use existing, scheduled health transport or other transport services.

9.6 Mobility management

The best value that can be derived from NSW Health transport funding and the greatest benefits to be gained by local communities occurs when service solutions are developed that focus upon desired outcomes, rather than inputs.

Mobility management involves matching patient need to the most cost effective and appropriate transport service, rather than the most immediate or expedient, transport solution. This will normally involve referral to an existing transport service but can also include the development or commissioning of new service solutions.

A Health Transport Unit fulfilling a mobility management function becomes a "travel agency" where the destination is a health service or home. It will "shop around" to satisfy each instance of transport need in the most appropriate and cost effective way. It does this by taking into account and considering all available transport solutions. Mobility management applied cooperatively and uniformly by stakeholders across a health transport service system can create a "virtual" one-stop shop for patients. In this situation a patient is seamlessly referred to an appropriate transport solution irrespective of their point of entry to the system.

Key considerations in mobility management are:

- **Patient care and support needs**. The Classification Framework outlined in Part 2, Section 5 provides a mechanism through which patient care and support needs can be identified and matched to appropriate transport services.
- **Cost comparisons**. Service solutions that provide best value for money for both Area Health Service budgets and for patients should be utilised subject to these arrangements being able to appropriately cater to a patient's care needs.
- **Spare capacity** should be utilised wherever possible before allocating or procuring fresh resources to cater to a health transport need. Spare capacity within services that are not necessarily health focused should always be considered.
- **Transfer of passengers needing different levels of care** between health transport services may be examined as an option where appropriate. This can include the transferring of passengers between services or operators.
- **Referral of a passenger to services funded under other programs** that gives priority to the passenger's needs is also an option where appropriate. A frail older person living independently in the community who needs to visit a general practitioner may be a low priority for *Transport for Health* but is eligible for Home and Community Care (HACC) services and may be a higher priority for the HACC transport sub-program.

- **Service partnerships** offer a means to harness the relative strengths of different transport providers. Examples of these partnerships include use of mainstream bus fleet resources supported by the bookings and funding administration systems of local community transport services, and taxi voucher schemes provided cooperatively by local taxi providers and Area Health Services.
- **Standardised coordination** is required in a broad based health transport service system comprising Area Health Service, community based and private sector providers.

10. Subsidised travel

Transport for Health has two former assistance schemes under its jurisdiction these are (1) the NSW Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) and (2) the Statewide Infant Screening-Hearing (SWISH) Travel.

10.1 Travel subsidies to visit medical specialists and oral surgeons includes the *Transport for Health - Isolated Patients Travel and Accommodation Assistance Scheme* (TFH-IPTAAS).

For detailed information on the administrative and procedural requirements of *Transport for Health - IPTAAS*, see the *Transport for Health* - Isolated Patients Travel and Accommodation Assistance Scheme - Procedures Manual available from the NSW Health at http://www.health.nsw.gov.au

The *Transport for Health - Isolated Patients Travel and Accommodation Assistance Scheme (TFH - IPTAAS)* is designed to assist people in rural communities to gain access to specialist medical treatment and oral surgery not available locally.

Transport for Health - IPTAAS provides direct financial assistance to patients to help them meet the costs associated with this travel.

The patient's local doctor plays a key role in applying for assistance under *Transport for Health - IPTAAS*. The doctor makes sure that if specialist treatment is not available locally the patient is referred to the nearest relevant specialist. The patient's doctor is also required to confirm in the application form that the patient meets the eligibility requirements for assistance.

Transport for Health - IPTAAS is not a full reimbursement scheme. The scheme provides financial assistance towards the cost of travel and accommodation where the patient needs to travel more than 100km (each way) to access specialist care. The cost of meals and incidental expenses, such as parking costs and booking fees, are not reimbursable.

Transport for Health - IPTAAS financial assistance can only be used for travel to access specialist medical treatment where the patient is referred by a local medical practitioner. It is not to be used for travel that is undertaken for other reasons.

Residents of New South Wales (including metropolitan areas) who need to travel interstate to access specialist medical treatment that is not available in NSW are also eligible for assistance.

Eligibility for assistance

Assistance under *Transport for Health - IPTAAS* is only available to permanent residents of NSW or Lord Howe Island and applies to the patient's usual place of residence.

Financial assistance may also be provided for an escort where a patient is less than 17 years old or where it is medically necessary for an escort to accompany the patient during the journey and period of treatment.

Aboriginal health

An Aboriginal Health Organisation may claim assistance under *Transport for Health - IPTAAS* if it provides transport for the patient and if the patient is eligible to receive assistance.

Referral to specialists

A patient may only be referred for treatments listed in the Commonwealth Medical Benefits Schedule Handbook, which are not available in their own locality. The referral can only be made by:

- A medical practitioner
- An optometrist
- An accredited dental practitioner

Nearest specialist requirement

Transport for Health - IPTAAS is limited to patients living in isolated areas who need to travel at least 100km from where they live (by the most direct route) to receive specialist health care.

Exemption from the nearest specialist ruling may be granted where referral to a more distant specialist is required due to the waiting time for treatment or the patient's medical condition.

Who is not eligible for assistance?

The following persons are not eligible for assistance:

- Overseas residents seeking specialist medical treatment including residents of other countries that are subject to reciprocal health care arrangements with Australia.
- NSW residents seeking specialist medical treatment outside Australia.
- Residents of Norfolk Island.
- Persons receiving living expenses under Commonwealth, State or Territory Schemes.
- Patients who have been transported under another Government funded program such as the Department of Ageing, Disability and Homecare (DADHC), Home & Community Care (HACC) funded community transport program.
- Patients are not eligible for Transport for Health - IPTAAS financial assistance if the injury or illness is the subject of Workers Compensation or Third Party Insurance Claim. If such patients require interim assistance with travel and accommodation costs prior to the settlement of the claim they should apply to the relevant insurer.

Inquiries concerning residents of Norfolk Island and referrals to or from overseas should be referred to the Australian Government Department of Health and Ageing.

Veterans and War Widows

Veterans and war widows can only claim financial assistance under *Transport for Health - IPTAAS* if they are not eligible to receive assistance to access specialist medical treatment assistance through the Repatriation Transport Scheme (administered by the Australian Department of Veterans' Affairs).

10.2 *Transport for Health - Statewide Infant Screening-Hearing (SWISH) Travel*

The *Transport for Health - SWISH Travel* assists parents with the costs of travel (100km one way) to access diagnostic audiology services associated with the NSW SWISH Program.

Eligibility criteria for obtaining assistance under the Scheme

To be eligible to obtain financial assistance under the Scheme the following criteria apply:

- Distance - travel at least 100km (one way) from their place of residence to the assessment facility.
- Referral a formal referral must be made by the SWISH Area Coordinator to one of the three identified tertiary assessment facilities.

The SWISH program provides screening for all babies within the first few weeks of being born, at their local hospital or community health centre. It enables the early identification of newborns with potentially significant hearing impairment, which requires follow-up diagnostic audiology services.

Travel assistance available under the Scheme

- Wherever possible, the diagnostic assessment facilities should ensure that appointment times for rural patients are scheduled with due consideration given to travelling time, thereby avoiding the need for an overnight stay.

11. Glossary

Aboriginal Community Controlled Health Services	Aboriginal Health Care Organisations that are party to Area Health Service Partnership Agreements reflecting the agreement at a State level between the AH&MRC and the NSW Department of Health.
Accreditation	Systems for quality assurance and regulation of services provided for under legislation and associated regulations.
Ambulance Service	Transport services provided by the Ambulance Service of New South Wales.
Area Health Service Facility	Area Health Service premises (and mobile centres) used for the direct provision of health services including hospitals, community health centres, outpatient clinics and other locations from which Area Health Service funded services are provided.
Area Health Service transport provider	A health transport service that is provided directly by an Area Health Service.
Community Transport	A community based passenger transport service that receives some form of financial operating subsidy either government, non-government or private.
Designated Director	A member of an Area Health Service executive management team, nominated by the Chief Executive with primary responsibility for *Transport for Health.*
Fully qualified health professional	"A fully qualified health professional" would include health professionals with a medical background such as doctors (including psychiatrists, dentists, medical specialists etc), nurses, midwives and allied health professionals such as psychologists, social workers etc.
Health Related Transport Program	NSW Health funding initiative.
Health transport	Non-emergency health related transport primarily catering to the needs of sick or injured persons who are not inpatients and are not eligible for transport provided by the Ambulance Service.
Non-emergency inter-facility transport service	A non-emergency inter-facility transport service is primarily concerned with the transporting of in/out patients needing to attend (a) diagnostic services not available at the referring health facility or (b) those in/out patients who need to be transferred to another health facility for treatment not available at the referring health facility and not requiring the services of the Ambulance Service of NSW.
Non-Area provider or non-Area Health Service provider	A health transport service that is provided by any organisation other than an Area Health Service.
Non-Area Health Service Facility	Premises other than an Area Health Service facility used by health professionals in providing health services, including general practitioners, medical specialist private consulting rooms, diagnostic and therapeutic providers, dentists and other private health care providers.
Not for profit services	Services provided on a non-commercial basis by State government agencies, local government, incorporated associations and other charitable organisations.
Passenger Trip	A standard measure of transport output representing the conveyance of a single passenger one way between two given points eg home and hospital. A trip from home to hospital, followed by a return trip will equate to a total system output of two passenger trips.

Passenger contribution	A contribution made by a passenger towards the cost of a trip (or trips) provided by a community transport service. The transport provider records this for budgetary reporting purposes as a 'service contribution'. It does not include gifts or donations.
Patient Transport Service	A service, usually stretcher equipped, operated by an Area Health Service for inter-facility transport of inpatients.
Service system	A network of individual services and service types working together to jointly cater to a specific area of need or demand.

Appendix 1

***Transport for Health* - Patient Screening Tool**

SERVICE PROVIDER or REFERRAL AGENCY			
PASSENGER NAME		**DATE OF TRAVEL**	

Please tick appropriate answer

QUESTION	YES	WITH HELP *	NO
1. Passenger is alert and oriented to time, place and person			
2. Can walk from home to car/bus			
3. Can manage 2 steps			
4. Can get in and out of a car/bus			
5. Can manage alone during appointment			
6. Carer going and will provide all necessary help			
7. Will need to travel with mobility or personal medical aid**			
8. Reason for transport request - To/from medical treatment			

* "WITH HELP" is defined as any form of non-weight bearing physical assistance the passenger may require.
** mobility or personal medical aid includes wheelchairs, walking frames and portable oxygen equipment but excludes walking sticks or other light weight items.

Question 8 should be linked to a document maintained by Health Transport Units that aligns commonly received medical interventions to levels of post procedural risk relevant to health transport service provision. This document should be regularly reviewed and updated by Health Transport Units and distributed to all registered *Transport for Health* providers within the Area. The Department of Health will assist in ensuring the uniformity of this document across the State.

Appendix 2

***Transport for Health* - Classification Framework Tables**

Passenger Classification

Table 1. Passenger Classification - passenger/service match

Level	Passenger	Service
Low	▪ Requires door to door transport ▪ Requires empathy and reassurance.	▪ From door to door. ▪ Can provide sympathetic and reassuring service.
Medium	▪ As for low level, plus: ▪ Requires some limited (non-weight bearing) assistance to enter/exit vehicle or destination. ▪ Requires some awareness of care needs related to their condition	▪ As for low level, plus: ▪ Can provide limited, non-weight bearing physical assistance ▪ Can provide some assistance to manage/cope at destination.
High	▪ As for low level, plus: ▪ Requires significant (weight bearing) assistance to enter/exit vehicle or destination ▪ Requires trained staff to deal with care needs ▪ May need observation for post procedural complications ▪ ***May require management of challenging behaviour or formal supervision***	▪ As for low level, plus ▪ Can provide weight bearing physical assistance ▪ Can provide trained staff to deal with passenger care needs ▪ Can undertake observation for post procedural complications ▪ Can manage challenging behaviours or provide formal supervision
Very High	▪ Requires a stretcher and appropriate clinical and/or behavioural management	▪ Can provide appropriately trained clinical staff to deal with passenger care needs

Service Classification

Table 2. Service Classification - requirements for providing Low to Medium classification services

Component	Requirements
Services	***1. Registered with the Area Health Service Health Transport Unit***
Operators	1. Satisfy all requirements of the *1990 Passenger Transport Act* and associated Regulations relevant to the service type to be delivered. 2. Apply NSW Health's Transport for Health Classification Framework to assess passenger eligibility for services and carry only passengers who conform to the Classification of the Service type being provided. 3. Not carry any person who is eligible to receive transport from the Ambulance Service of NSW unless specifically approved by the Ambulance Service. 4. Able to demonstrate adequate provision of passenger awareness training appropriate to the care needs or conditions of passengers who are subject to a medium level service.
Drivers	1. Satisfy all requirements of the NSW *Passenger Transport Act 1990* and associated Regulations relevant to the service type to be delivered. 2. Have satisfactorily completed basic training in the capabilities of the Classification of health related transport service being provided. 3. Satisfactorily completed passenger awareness training appropriate to the care needs or conditions of the passengers who are subject to medium level service.
Vehicles	1. Must satisfy all requirements of the NSW *Passenger Transport Act 1990* and associated Regulations relevant to the service type to be delivered.

Service Classification

Table 3. Service Classification - requirements for providing

High classification services

Component	Requirements
Services	***1. Registered with the Area Health Service Health Transport Unit***
Operators	1. Satisfy all requirements of the *1990 Passenger Transport Act* and associated Regulations relevant to the service type to be delivered. 2. Apply the Transport for Health Classification Framework to assess passenger eligibility for services and carry only passengers who conform to the Classification of the Service type being provided. 3. Not carry any person who is eligible to receive transport from the Ambulance Service of NSW. 4. Able to demonstrate the provision of a training program to drivers and other relevant personnel, sourced from a recognised training provider or from a qualified health professional in: ▪ Senior First Aid ▪ Manual lifting and handling of patients ▪ Management of challenging behaviours (excluding those that may constitute a threat to person or property) ▪ Other training relevant to the care needs and health conditions of, or treatments being received by, passengers transported by the service 5. Ensure that drivers and other relevant personnel have attained the competency levels set for satisfactory completion of each of the listed training programs including any requirements for refresher training associated with maintaining currency of competency or qualification.
Drivers	1. Satisfy all requirements of the NSW *Passenger Transport Act 1990* and associated Regulations relevant to the service type to be delivered. 2. Satisfactorily complete basic training in the capabilities of the Classification of health related transport service being provided. 3. Satisfactorily complete training and refresher training as required to maintain qualification or currency of skill, in accordance with point (4) above.
Vehicles	1. Must satisfy all requirements of the NSW *Passenger Transport Act 1990* and associated Regulations relevant to the service type to be delivered.

Appendix 3

***Transport for Health* - Reporting Framework**

The reporting framework will include the number and proportion of trips for patients requiring:
- Cancer treatment
- Renal dialysis
- Other

The reporting frequency is quarterly.

The provisional Key Performance Indicators are as follows:

How much?	How well?
▪ Number of individual people assisted (some people are assisted more than once but are only counted once for the purpose of this measure ▪ Number of trips provided ▪ Number of multiple passenger trips ▪ Number of CALD, ATSI, concession card holders	▪ Proportion of multiple passenger trips ▪ Proportion of CALD, ATSI, concession card holders
Is anyone better off?	
▪ Amount of funding spent on direct patient assistance ▪ Number of patients who find out about TFH - IPTAAS after their trip commences	▪ Proportion of funding spent on direct patient assistance ▪ Proportion of patients who find out about TFH - IPTAAS after their trip commences

A *Transport for Health*, reporting framework template is provided to Area Health Services in the *Transport for Health* Implementation Plan Development Guide.

Definitions

How Much	
Trips	One-way travel between two points by one person
Mode	The type and capacity of vehicle used for a trip usually categorised as either Low Occupancy and Multiple Occupancy

Is anyone better off?	
Number and distance of trips by mode	The number of trips provided by Low and High Occupancy vehicles and the total distance of journeys undertaken in each category
Number of available transport options	Total number of vehicles and available service journeys within each transport mode

Appendix 4

NSW HEALTH

Transport for Health

Service Costing Framework

June 2006

Transport for Health Costing Framework

	Low/Medium Service Classification				High Service Classification			
	Single Passenger		Multiple Passenger		Single Passenger		Multiple Passenger	
	rate/item	charge	rate/item	charge	rate/item	charge	rate/item	charge
Administration	1	2	1	2	1	2	1	2
Driver	3	4	3	4	3	4	3	4
Carer	3	4	3	4	3	4	3	4
Kilometres	5	6	5	6	5	6	5	6
Total service cost		7		7		7		7
Total capacity			8				8	
Practical capacity			9				9	
Contributions		10		10		10		10
Total Invoice Charge		11		11		11		11
Trip Cost		12		13		12		13

Note: Number points below correspond to numbered cells in the table. Bullet points provide general information or comment.

Overview

- This framework is designed to assist Non Emergency Health Related Transport providers develop costings for the delivery of services funded under the *Transport for Health* program and to assist Area Health Services understand how charges for service are calculated by service providers.
- The framework is not intended to be used to cost each unit of service for which an Area Health Service is charged. It should however, be used to provide Area Health Services with information on how providers charge for services and can be used to explain how a charge for a particular service, if queried, has been determined.
- Uniform application of this framework will assist Area Health Services compare the costs of different service providers and service solutions.
- This framework only addresses the delivery of services that commence and conclude within the same day.

Cost Categories

- Two primary categories of service provision are catered to: Low/Medium and High (refer to *Transport for Health* Classification Framework).
- The main difference between Low and Medium level services is experience and training of a volunteer. This is an operational consideration and not necessarily indicative of any major cost difference, therefore the two are grouped for costing purposes.
- Two secondary categories are identified within each primary category: single passenger and multiple passengers. With single passenger services, all costs are attributed to one passenger. With multiple passenger services, total service costs should be shared between the total number of passengers. Cost sharing between passengers facilitates readily accountable multiple funding sources for single services.

Administration Cost Component

The *Transport for Health* program does not support administrative costs being levied on a per kilometre basis. Administrative costs are generally not related to the distance travelled by a particular service. They are represented in this framework as a (relatively) fixed cost per unit of service.

1. The Administrative cost should be based on an ***hourly*** rate for administering a unit of service for a particular type of service. This should include all wage and overhead components. Service providers should be able to break down and account for the components of this cost if required.

2. The total charged for administration of a passenger trip. This should be a portion or multiple of the hourly rate.

    - This cost component provides a means to factor in the overhead cost component of service delivery on a per-booking or per trip basis
    - There is provision for addressing and difference in administrative inputs between service types. Eg. a request that would need to be catered to in single service provided by volunteer car would normally require more administration than a request that could be allocated straight onto a scheduled bus run.
    - In day to day operations, it is assumed that a fixed rate per service would be levied for ease and efficiency of administration. This would be based on an average administrative time per service type request. It is however feasible that a particularly administration intensive request for service could be reflected as an abnormal charge.
    - NOTE: The average admin charge per booking provides a benchmark against which comparisons can be made and improvement targets set.

Variable Operational Costs

A "trip" can be 5 or 500 kilometres. Distance and duration of a trip should, in every case, be the most variable factors in determining the actual cost of the service.

3. It the case of high level services, this would be an hourly wage rate, inclusive of on-costs (for either driver, carer or both). In the case of volunteer services, this may only include an amount for reimbursement of meal or refreshment costs for services above a minimum duration, as set by the service provider.
    - Under the *Transport for Health* model, it is assumed that any paid employee engaged in service delivery will be trained to provide a high level service (in accordance with the *Transport for Health* Classification Framework). Payment for waged staff providing low level classification services should not generally be approved. (Note: this does not mean that a high level service cannot provide transport to a low or medium level passenger.)
    - A high level service may be provided with a volunteer driver, provided that a suitably qualified carer is engaged who is capable of providing level of care and assistance commensurate with *Transport for Health* high level Service Classification descriptors.
    - High Level Services can, particularly in the cases of multiple passenger services, be a cost effective source of health transport for people who conform to the low and medium levels of the *Transport for Health* Passenger Classification Framework. Having a low or medium level passenger classification should not automatically exclude a person from receiving transport on a high level NERHT service.

4. The total charged for personnel costs for the passenger trip. This should be a portion or multiple of the hourly rate noted in 3.

5. The kilometre rate for the service. This should incorporate both fixed costs (insurance, registration etc) and variable costs (fuel, maintenance, depreciation). This amount might be based on historical operational costings determined by the service provider or identified from a source such as the NRMA. This figure should reflect average or projected annual kilometres travelled by the service vehicle/s, as the higher this figure the lower the cost per kilometre.

6. The total service kilometre charge. This will be a multiple of the figure noted in 5. This framework assumes that depreciation is a variable cost factored into the kilometre rate of service delivery.

7. The subtotal of administrative and operational costs. This should represent the final (gross) cost of service delivery.

Costing for Multiple Occupancy Services

8. The total passenger capacity of the service vehicle, eg. 10 seats, 20 seats.

9. The practical passenger capacity of the service or, the number of passengers who are normally carried eg a 20 seat bus may normally carry 10 passengers on a particular service run. To carry more may be impractical for reasons of trip duration, passenger fatigue etc.
Items 8 & 9 commence the difficult process of apportioning the operating costs of multiple occupancy services and attributing them to individual passengers/funding programs by acknowledging that it is virtually impossible, for a wide range of reasons, to fill any service all the time and that it is normal for some spare capacity to exist in a multiple occupancy service.
   - Practical capacity does provide an important measure, or benchmark for of operational efficiency. The higher the practical capacity, the lower the final cost per passenger.
   - The practical capacity can also represent the target capacity for full cost recovery, with additional (above normal operating) capacity being available at marginal cost.
   - An inflated practical capacity figure will disadvantage the operator. A deflated practical capacity figure will disadvantage the Area Health Service. The onus will rest upon operators to ensure that practical capacity figures reflect the operational norm, and that this figure is checked regularly to identify changes in service use trends. Area Health Services will reserve the right to review operational documentation from time to time to ensure that practical capacity figures are reasonable.

Passenger (Fare box income) and a Revenue Guarantee Purchasing System

9. Income received from the passenger/s through contribution.

11. The net cost of the service. The total amount for which the Area Health Service will be invoiced for the trip. This will be the cost of the trip, less the income received from the passenger. This represents the amount the provider will invoice the purchaser. The deduction of passenger income from payment for service supports a **Revenue Guarantee** model for *Transport for Health* model and is consistent with a subsidy based service funding model and policy guidelines which ensure patient entitlement to access services regardless of ability to pay.

Determining cost of Passenger Trip outputs

12. The full cost to the Area Health Service per Passenger Trip (the primary output measure for the service or funding programs) in a single occupancy service, being the invoice charge (cell 11) divided by the number of trips provided (usually two for a return journey).

13. The full cost to the Area Health Service per Passenger Trip (the primary output measure for the service or funding programs) in a multiple occupancy service, being the charge (cell 11) divided by the practical operating capacity (cell 9) divided by 2 (representing a return journey being the norm).
    - The method outlined in 12 is a compromise, which endeavours to achieve efficiency in the financial planning and administration of multiple occupancy services and which recognises the many variable factors in catering to individual health transport needs in such a service mode. It also provides the means to plan multiple occupancy services based on program funding from a range of sources (virtual funds pooling).
    - It is not seen that this approach would prevent or obstruct the collection of real data for actual passengers carried for the purposes of accountability or reporting.

ISOLATED PATIENTS TRAVEL AND ACCOMMODATION ASSISTANCE SCHEME (PD2022_041)

PD2022_041 rescinds PD2019_039

POLICY STATEMENT

NSW Health is committed to ensuring equity of access to timely, high quality health care for people living in regional, rural and remote areas NSW.

This includes ensuring people living in regional NSW are supported to access specialist health treatment that is not available locally. Highly specialised care sometimes requires significant travel for people living in our regional communities and NSW Health recognises the need to ease the financial burden on those who need to travel significant distances to get the specialist care they need.

SUMMARY OF POLICY REQUIREMENTS

The provision of subsidies must be provided within the eligibility requirements and governance framework outlined in this Policy Directive. To support payment of subsidies detailed information on subsidy rates, eligibility, administrative and procedural matters are outlined in the Isolated Patients Travel and Accommodation Assistance Scheme Assessment Guidelines.

Subsidies are to be paid directly to patients or to nominated third party providers to contribute to the cost of accommodation and travel in accessing the nearest eligible specialist health care. Patients must be residents of NSW or Lord Howe Island and be enrolled with Medicare. Patients must travel from their residence for treatment at least 100km (one way), or at least 200kms in a week by making multiple trips to and from the same treatment location to be eligible for the subsidy. Applications must be submitted within 12 months of the hospital discharge or appointment end date.

The Isolated Patients Travel and Accommodation Assistance Scheme is a subsidy scheme, not a full reimbursement scheme.

Local Health Districts that operate Isolated Patients Travel and Accommodation Assistance Scheme offices, are responsible for operation of the scheme at the local level.

Developing and monitoring the Isolated Patients Travel and Accommodation Assistance Scheme Assessment Guidelines and the operation of the scheme is the responsibility of EnableNSW.

The NSW Ministry of Health is responsible for setting Isolated Patients Travel and Accommodation Assistance Scheme policy in line with government direction, providing funding to Local Health Districts and EnableNSW, and monitoring performance of the Scheme.

To access the full Isolated Patients Travel & Accommodation Assistance Scheme Policy Framework please go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_041#

MANAGEMENT OF NSW POLICE FORCE OFFICERS' FIREARMS IN PUBLIC HEALTH FACILITIES AND VEHICLES (GL2013_002)

GL2013_002 rescinds GL2005_035.

PURPOSE

This guideline provides information to staff in public health organisations and in NSW Ambulance about the management of NSW Police Force officers' (**police officers'**) firearms and "appointments" (NSW Police Force terminology for 'Electronic Control Devices' (ECDs), commonly called Tasers, and 'OC Defensive Spray'), in public health facilities and vehicles, including NSW Ambulance vehicles.

KEY PRINCIPLES

Police officers are bound by the legislative requirements of the *Firearms Act 1996* (NSW) (**the Act**) and the policy requirements of the NSW Police Force Handbook to relevantly ensure the safekeeping of firearms and "appointments".

A police officer's decision to remove his or her firearm and/or "appointment" and store it elsewhere is made by the individual police officer taking into consideration operational and environmental circumstances at the time.

Police officers' obligations under the Act override local health facility policies and procedures and NSW Ambulance protocols in this regard. Staff in public health organisations and NSW Ambulance should not make the removal of police officers' firearms and "appointments" a condition of their entry to the facility or vehicle.

USE OF THE GUIDELINE

Public health organisation and NSW Ambulance protocols relating to the management of police officers' firearms and "appointments" must be consistent with this Guideline.

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2013/GL2013_002.html

CHANGE TO IPTAAS DISTANCE CRITERION FOR RENAL DIALYSIS PATIENTS
(IB2010_063)

PURPOSE

To provide information on the change to the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) distance criterion for renal dialysis patients.

KEY INFORMATION

The Minister for Health has determined that from 1 January 2011, a new IPTAAS distance criterion will apply to renal dialysis patients **only.**

From 1 January 2011, patients who have to travel a cumulative distance of at least **200km per week** to access renal dialysis services will be eligible for IPTAAS travel subsidies. Claims from renal dialysis patients for cumulative travel of at least 200km per week undertaken prior to this date are not to be accepted.

The $40 co-contribution for non-pensioners/health care card holders will continue to apply, and is to be levied on the cumulative weekly distance travelled by these patients. Patients in this category are advised to contact their local Health Transport Unit to discuss the effect of the co-contribution on their claim **before** submitting an IPTAAS Application Form - refer to Application Form for Health Transport Unit contact details.

This Information Bulletin is to be read in conjunction with **PD2012_070 Isolated Patients Travel & Accommodation Assistance Scheme Policy Framework.**

Implementation

Eligibility:

Eligibility to access IPTAAS will be on the same basis as other claimants, except that renal dialysis patients will be eligible if they travel a minimum distance of 200km cumulative per week to access their dialysis (compared to 200km per round trip to access specialist medical treatment for other claimants).

Health Transport Units are to calculate the distance travelled by claimants using the standard method set out in the Isolated Patients Travel & Assistance Scheme Policy Framework (**PD2012_070**).

Submission of claims:

1. Submission of a valid form to cover treatment period:
   - Renal dialysis patients claiming under the new rule for the first time must submit an IPTAAS Application Form with all sections completed. As for all patients undergoing continuing treatment over a twelve month period, the referring medical practitioner is not required to complete Section B of the IPTAAS Application Form for subsequent claims. However, a new referral must be provided every 12 months. In the case of renal dialysis, the referring medical practitioner and treating specialist may be the same person.
   - Usually, the treating specialist is required to complete section C of the Application Form for each subsequent claim, as a means of confirming that the treatment took place. However, as renal dialysis is essential and regular treatment, the Travel Diary (available from the local Health Transport Unit) is acceptable as confirmation of attendance **for renal dialysis patients only.**

- Therefore renal dialysis patients making IPTAAS claims only need to submit a new Application Form once every year, unless their personal and/or payment details change, in which case the relevant Section of the form is to be submitted with the next claim made following the change(s).

2. Claiming the subsidy after travel:
   - Claims made by renal dialysis patients are to be paid on a monthly basis. In circumstances where the requirement to claim on a monthly basis causes financial hardship for the patient, payments may be made on a weekly basis.
   - Renal dialysis patients should submit their monthly claims using the single page travel diary, available from their local Health Transport Unit.
   - Claims using the Travel Diary must be submitted in the timeframe on their claim form. If a patient is making monthly claims, they will be able to make twelve of these within the one year validity period of their claim form. The final trip on the last monthly claim for that year must fall within the timeframe for validity of the specialist referral on the claim form.
   - Claims made using the travel diary will only be valid with evidence from the renal dialysis unit to confirm that the patient used private transport to access their care. Evidence includes a signed notation on the diary by the Nurse Unit Manager of the Dialysis Unit, or system printout providing the necessary validation.

Monitoring and Evaluation

All NSW Health Transport Units are to collect data to enable accurate monitoring of the cost of implementing this change to the IPTAAS distance criterion. The data to be collected is as follows:

- Number of claims made by renal dialysis patients.
- Cost of claims made by renal dialysis patients.
- Additional administrative costs associated with the change, expressed as additional Full Time Equivalent staff required to process the additional claims received.

The collected data is to be reported to the Department of Health on a six-monthly basis, commencing with data for the period 1 January - 30 June 2011. Reports should be submitted to the Manager, Primary Health and Equity, NSW Department of Health, Locked Mail Bag 961, North Sydney 2059. A copy should be emailed to **PHCPBmail@doh.health.nsw.gov.au** marked to the attention of the Manager, Primary Health and Equity.

SERVICE SPECIFICATIONS FOR NON-EMERGENCY TRANSPORT PROVIDERS
(PD2023_018)

PD2023_018 replaced PD2018_002

POLICY STATEMENT

NSW Health is committed to ensuring the highest standards of non-emergency patient transport. This Policy aims to ensure that all non-emergency patient transport providers across NSW meet consistent service specifications that support safe, timely and reliable patient transport by means of appropriate vehicles, equipment and staff.

SUMMARY OF POLICY REQUIREMENTS

Non-emergency patient transport providers assist patients who cannot use, or have difficulty using public and/or private transport, and whose clinical acuity does not require a NSW Ambulance emergency vehicle.

Non-emergency patient transport occurs primarily between NSW public health facilities by means of road or air transfer; utilising appropriately equipped vehicles or fixed-wing aircraft. Suitably trained and skilled staff support each transport booking to ensure patient safety and wellbeing.

The Policy outlines minimum service specifications for all non-emergency transport providers in NSW including; vehicle and staff specifications, patient care requirements and clinical governance and record keeping specifications.

There are various providers delivering non-emergency patient transport across NSW. All nonemergency patient transport providers must gain authorisation from the Secretary of NSW Health under Section 67E of the Health Services Act 1997 (NSW) to undertake nonemergency patient transport in NSW.

Vehicles and staff allocated to non-emergency patient transport should be determined based on the patient's clinical condition and requirements during transport.

The vehicle used in non-emergency patient transport must follow minimum specifications which enable the transportation of a patient in a safe, comfortable, and clinically appropriate environment. Staff assigned to each transfer must meet the minimum training, skills and professional registration requirements related to the type of transport booked and act in a manner consistent with the NSW Health CORE values.

Clinical governance requirements are to be in place to ensure staff and patient safety. Nonemergency transport providers must also adhere to requirements for recordkeeping, incident, and complaints management which are open to audit and inspection on request to ensure compliance with the policy.

The full version of the Service Specifications for non-emergency Transport Providers policy is available at: **https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_018**

To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 26 – TISSUE/ORGAN

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Last updated August 2023

ORGAN AND TISSUE DONATION, USE AND RETENTION (PD2022_035)

PD2022_035 rescinds PD2016_001 and PD2020_012

POLICY STATEMENT

Consent must be obtained to proceed with living and deceased organ and tissue donation and transplantation.

NSW Health organisations must follow the requirements for obtaining consent from the intended donor and/or senior available next of kin; a Designated Officer to provide written authorisation for the removal of organ/s and/or tissue after death; and restrictions on living organ and tissue donation from adults and children.

SUMMARY OF POLICY REQUIREMENTS

NSW Health organisations must have local protocols and procedures in place which fit the requirements for both living and deceased organ and tissue donation.

This Policy outlines the process for obtaining written consent, or consent by other manner prescribed, prior to the removal of organ/s and/or tissue for medical, scientific or therapeutic use (apart from diagnostic purposes) in line with the requirements of the Human Tissue Act 1983 (NSW). Where the donor is deceased, and in the absence of their written consent, consent must be obtained from the senior available next of kin or their delegate.

The process for obtaining consent and certification to remove regenerative tissue from a living child for the purpose of transplantation into a parent or sibling, is also summarised.

A Designated Officer must provide written authorisation for the removal of organ/s and/or tissue after death for use for donation and transplantation or for other therapeutic, medical or scientific purposes. Where a family objects to the donation of organ/s from a deceased, contrary to the known wishes of the donor, the requesting clinician must document the reasons for family objection and have this documentation signed by the Designated Officer.

This Policy also summarises the process for assessing requests for the return of tissue to a patient and/or senior available next of kin.

The NSW Health State Forms referenced in this Policy, including those for consent and certification for the donation of organ/s and/or tissue from a deceased patient/senior available next of kin, living adult and/or child, must be used.

The full Organ and Tissue Donation, Use and Retention policy can be downloaded at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_035

USE OF HUMAN TISSUE FOR RESEARCH (GL2023_008)

GL2023_008 resplaced GL2006_021

GUIDELINE SUMMARY

This Guideline represents NSW Health's interpretation of the requirements of the Human Tissue Act 1983 (NSW) for consent to the use of human tissue for research purposes.

It has been developed to assist health professionals, researchers and research support office staff to ensure that research involving human tissue and biospecimens is in accordance with the Human Tissue Act 1983 (NSW), the National Statement on Ethical Conduct in Human Research (2007) and NSW Health Consent Toolkit (2018).

It also provides clarity and consistency for Human Research Ethics Committees assessing research applications involving human tissue.

KEY PRINICIPLES

A person may legally consent to the use of their tissue for research purposes in general or for a limited scope, given the individual is sufficiently informed according to relevant sections of the National Statement on Ethical Conduct in Human Research (2007) (National Statement).

Human tissue removed prior to 1 November 2003 from a deceased person for the purpose of post-mortem examination can be lawfully used for research purposes. Otherwise, consent must be obtained from a person authorised by relevant legislation and a Designated Officer of a hospital.

Human tissue removed prior to 1 November 2003 from a living person as part of standard care procedures can be legally used for research purposes. Access to the tissue for research purposes may require consent according to National Statement Section 3.2.5. Informed consent is required prior to removing human tissue for research purposes.

Human tissue removed on or after 1 November 2003 from a living person as part of standard care procedures can only been used for research purposes if consent has been obtained from that person (or their parent or guardian if they are a child) before or after the removal. If the person passed away without giving consent, consent must be obtained from their next-of- kin.

Human tissue removed on or after 1 November 2003 from a deceased person can only be used for research purposes, written consent to the use of the tissue for research purposes needs to be obtained from their next-of-kin.

Under no circumstances are tissues to be removed from the body of a deceased child who is or was a ward of the state for research purposes, with or without consent.

Human Research Ethics Committees (HRECs) must adhere to legal requirements as well as standards set out in the National Statement when assessing research protocols involving human tissue. Its decision to grant waiver of consent is subject to the legal requirements and must be made according to the requirements in the National Statement.

The *Human Tissue Act 1983 (NSW)* allow the use of lawfully removed small tissue samples to be used for analyses or tests as part of certain quality assurance programs or as necessary for accreditation or the delivery of services at or by certain entities.

The full version of the Use of Human Tissue for Research guideline is available at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_008

LIVING KIDNEY DONATION AND TRANSPLANTATION (PD2022_036)

PD2022_036 rescinds PD2015_041 and PD2017_030.

POLICY STATEMENT

NSW Health supports nationally consistent protocols and standards to be adopted by NSW Health organisations to guide clinicians and institutions in the practice of paired kidney exchange by living donors and recipients.

Health professionals involved in the assessment, management and follow-up of living kidney donors and recipients must understand the standards and conditions for living kidney donation in NSW.

SUMMARY OF POLICY REQUIREMENTS

This Policy applies to all NSW Health organisations involved in the donation of a single kidney by an adult living person for transplantation into another person.

NSW Health staff must comply with the procedures for assessing, consenting and registering donors and donor-recipient pairs to the Australian and New Zealand Paired Kidney Exchange Program.

Informed consent must be obtained from the donor before becoming a living kidney donor. Consent must be given in accordance with the NSW Health *Consent to Medical and Healthcare Treatment Manual* (**the Manual**).

The surgeon who removes the kidney has an independent legal obligation to ensure that the donor has given valid consent and has been informed of risks and alternatives, regardless of whether the medical practitioner who referred the donor to the surgeon also discussed these issues with the donor.

In addition to the signed consent form for surgery, detailed information provided to the donor, including the discussion of risks, must be documented in the medical record.

Detailed information must also be provided to anyone who expresses willingness to become a kidney donor. Information must include, but is not limited to, a full description of the procedure, implications and risks to the donor, and the likely outcomes for the recipient.

The donor may choose not to proceed with donation at any time before surgery, and it is not a foregone conclusion that donation will occur once donor assessment has begun.

Non-directed kidney donation involves a kidney being donated to the “best matched” recipient in Australia or New Zealand (if part of the Australian and New Zealand Paired Kidney Exchange (ANZKX) Program). The non-directed living donor has no say in who will or who will not receive the kidney.

The privacy and confidentiality of each donor-recipient pair must be maintained according to section 37 of the *Human Tissue Act 1983* (NSW).

All non-directed donors must obtain a referral from their general practitioner to a relevant nephrologist, formally associated with a NSW kidney transplant service.

NSW Health organisations must not advertise for, or otherwise encourage individuals, to become non-directed donors.

The assessment of a donor's suitability for non-directed kidney donation must include discussions about allocation to the ANZKX Program or a single NSW recipient.

The NSW Transplant Advisory Committee will initially refer all suitable non-directed donors to the ANZKX Program. It will also facilitate agreement between the donor and recipient treating teams on the most suitable location for surgeries.

The assessment of a recipient must include discussion about the acceptance of a potential donation from a non-directed donor. The recipient must be informed at the time of allocation if they are to receive a non-directed kidney.

The ANZKX Protocols (the Protocols) are the agreed requirements and processes guiding paired kidney exchange in Australia, including assessment, informed consent and registration of donors and donor-recipient pairs in the ANZKX Program.

NSW Health staff must comply with the ANZKX Protocols, and the requirements outlined in this Policy to assess and manage non-directed donors.

The full Living Kidney Donation and Transplantation policy can be downloaded at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_036

ORGAN DONATION AFTER CIRCULATORY DEATH (GL2021_012)

GL2021_012 rescinded GL2020_007

GUIDELINE SUMMARY

The Guideline describes the necessary requirements for health facilities to undertake organ donation after circulatory (formerly cardiac) death in NSW. This approach to organ donation entails retrieval of organs after the patient's death where death is certified according to the irreversible cessation of circulation of blood in the body (rather than according to neurological criteria).

The Guideline outlines the applicable setting for organ donation after circulatory death in NSW, donor referral criteria, patient management (including decision making and consent processes), criteria for the declaration of death, care of the patient and family (before and after the patient's death), the phases of organ retrieval and subsequent organ allocation.

KEY PRINCIPLES

Organ donation after circulatory death provides further donation opportunities for people who wish to be organ donors after their death and is a potential means of increasing the availability of deceased donor organs in NSW within current accepted ethical and legal requirements.

Quality end of life care for a potential organ donor, as with any individual whose cardiorespiratory support is being withdrawn, is the priority and must not be compromised by the donation process.

Once donation has been agreed upon and consented to, efforts should be made to ensure optimal outcomes for the donation. This includes ensuring that the family are fully informed regarding donation processes and that warm ischaemic time for the donor organs is minimised.

USE OF THE GUIDELINE

Chief Executives of local health districts and specialty health networks are to ensure that relevant staff are made aware of this Guideline, and that local protocols to support organ donation after circulatory death are documented and consistent with this Guideline.

The NSW Organ and Tissue Donation Service is responsible for ensuring that organ and tissue donation and retrieval protocols in NSW are consistent with this Guideline, and for facilitating education and training on organ donation after circulatory death for staff as required.

Intensivists, Treating Clinicians and Donation Specialists are to familiarise themselves with the donor referral criteria and management of potential organ donation after circulatory death donors, as outlined in this Guideline (section 2, 3 and 4).

Clinicians certifying death for the purposes of organ donation after circulatory death must do so according to the criteria outlined in the attached procedures and using the proscribed State form (section 2.3.7).

Designated Officers in hospital facilities must ensure that authorisation is provided for the removal of tissue after death for its use for donation and transplantation (sections 2.3.4 and 2.3.7).

Transplant Units who accept organ donation after circulatory death organs for transplantation are to familiarise themselves with the general principles of allocation of organ donation after circulatory death organs (section 5).

To view the Guideline go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2021_012

CONDUCT OF ANATOMICAL EXAMINATIONS AND ANATOMY LICENSING IN NSW (PD2011_052)

PURPOSE

The activity of conducting anatomical examinations is governed by the *Anatomy Act 1977* and regulated by NSW Health.

This document outlines the procedures for the licensing, inspection and regulation of Anatomy facilities conducting anatomical examinations, and provides clear directives to licence holders of acceptable activities and government regulations under the provisions of the licence.

Failure to comply with requirements of the *Anatomy Act 1977* may constitute an offence.

MANDATORY REQUIREMENTS

Anatomy Licences

- The licence is issued to an individual or the holder of an identified position for a specific facility location.
- Anatomy licences are issued by the Director-General, NSW Department of Health, or their delegate, for a 2 year period subject to satisfactory annual inspections. The Director-General may revoke the licence at any time. Once a licence has been granted the NSW Department of Health must be notified in writing of any change to the designated licence holder of an institution.
- Licence holders are required to submit an application to the Director-General, NSW Department of Health, to reapply for their anatomy licence prior to the expiration of their current licence.
- A person wishing to conduct an anatomical workshop or training session as a one-off event is required to apply to the NSW Department of Health for a licence for the specified time period.

License Applications and Inspections

- All applications must be received in writing. An inspection of the proposed facility and subsequent report will be undertaken as part of the licence application process.
- Inspections are conducted by the local Public Health Unit Director or their delegate.
- Licensed facilities will be inspected annually. An inspector can also inspect a licensed premise at any time. The holder of a licence must comply with any terms or conditions included on the licence.

Registers

- All licence holders are required to keep a register of all bodies and/or human tissue in their possession. The register must also be used to contain information relating to the transfer of bodies and/or human tissue from or to another licence holder.
- The licence holder must produce the register to an inspector as requested.
- The register must be retained for at least 5 years from the date of the most recent entry.

Conditions on taking possession of a human body for anatomical examination

- Written consent must be obtained for a body to be used for anatomical examination. Consent is either that of the individual written during their lifetime or received from the senior available next-of-kin after an individual's death.

- If the body of the deceased is at a hospital or forensic institution, a Designated Officer must authorise the use of the body prior to the body being transferred to the licence holder.
- A Designated Officer or a senior next-of-kin cannot authorise the anatomical examination of the body of a person whose death has been reported under the *Coroners Act 2009,* unless a Coroner has consented to the examination.
- A person must not authorise the anatomical examination of the body of a deceased child if the child was, immediately before death, in the care of the State.

Acquisition and retention of donated bodies and human tissue

- Bodies and human tissue specimens can be acquired by a licence holder as either a transfer from another licensed institution (including international institutions) or from a specific body donation program. Minimum standards must be met for information to be included in the donation program information package.
- A transfer of a body or human tissue to another licence holder outside NSW is permitted only with prior approval of a NSW inspector. A licence holder may transfer a body in their possession to another licence holder within NSW without prior approval.
- A body can be retained for a maximum of 4 years. Upon application an inspector may authorise the retention of a body for an additional 4 year period. Generally bodies must be appropriately disposed of within 8 years from the date of death of the deceased.
- Specific provision has been made in the *Anatomy Act* for the permanent retention of tissue (anatomical specimens) where written consent has been given by the deceased prior to death. Where no consent has been given and the wishes of the deceased in this respect are unknown, the senior available next-of-kin may consent to permanent retention of tissue.

IMPLEMENTATION

- Applicants for licences: must ensure that the application includes information as detailed in the attached procedure and that it is accompanied by additional documentation where required.
- Licence holders: must ensure that they meet all legislative requirements of the *Anatomy Act 1977* and relevant provisions of the *Human Tissue Act 1983*, the *Coroners Act 2009* and the *Public Health (Disposal of Bodies) Regulation 2010* or any subsequent regulation made under the *Public Health Act.* Licence holders must satisfy all terms and conditions set by the licence.
- Public Health Unit anatomy inspectors: must undertake inspections as required by this policy or as directed by the Director-General or delegate. Guidelines for facility inspections and the inspection of registers of bodies and human tissue are in the attached procedures.
- Designated Officers in health facilities and forensic institutions: must authorise the release of a body from a hospital or forensic institution for anatomical examination. A body must not be released from a hospital to an authorised licence holder until a Designated Officer has authorised its release. (See following procedures.)

1. BACKGROUND

1.1 About this document

The practice of anatomical examination in NSW is the dissection of a dead human body for the purposes of medical, scientific and educational training and research. This activity is predominately undertaken in university anatomy departments or medical schools for the teaching and training of students and staff and in associated facilities for conducting research.

The anatomical training and research undertaken in facilities would either form part of a university degree or be a specialised training workshop for medical and health professionals.

This document outlines the procedures for the licensing, inspection and regulation of anatomy facilities conducting anatomical examinations, and provides clear directives to licence holders of acceptable activities under the provisions of the licence.

Included in these procedures are guidelines for:
1. Application for a Licence (Attachment 1).
2. Inspection of facilities (including the Inspection Checklist at Attachment 2).
3. Suggested pro-forma for a register of donated bodies and dissections (Attachment 3).
4. Minimum Information to be included in body donor programs.

1.2 Key definitions

Anatomical examination of a body includes use of the body for medical or scientific purposes. However, an anatomical examination does not include a post-mortem examination. Medical or scientific purposes include educational purposes connected with medicine or science. (*NSW Anatomy Act 1977 Part 1 Section 4)*

Anatomical waste in this document means a discarded biologic product, such as blood or other bodily fluid, fat, skin or other small amounts of human tissue removed from a cadaver that is undergoing preparation or dissection for anatomical examination. This waste material may be disposed of as clinical waste according to relevant requirements.

Body in this document means a dead human body. (NSW *Anatomy Act 1977 Part 1 Section 4)*

Designated Officer means a person appointed to be a Designated Officer for the hospital, or a forensic institution. (NSW *Human Tissue Act 1983 Part 1 Section 5*)

Dispose means dispose of the body by burial, cremation or other lawful means. *(*NSW *Anatomy Act 1977 Part 1 Section 4)*

Human tissue means an organ or part of a body. *(*NSW *Anatomy Act 1977 Part 1 Section 4)*

Senior available next-of-kin means the most senior next-of-kin in the hierarchy of next-of-kin within the *Anatomy Act 1977*.

1.3 Legal and legislative framework

Anatomy Act 1977

The *Anatomy Act 1977* regulates the conduct of anatomical examinations in NSW, including the issue of licences, the appointment of inspectors, the conditions of taking possession of bodies or human tissue, the requirements for keeping registers of bodies and human tissue and for the disposal of bodies. In addition the Act outlines general offences. Failure to comply with the requirements of the *Anatomy Act 1977* may constitute an offence.

***Human Tissue Act 1983* - Designated Officers**

Designated Officers are appointed in accordance with Section 5 of the *Human Tissue Act 1983* by the governing body of a hospital or forensic institution. Section 8 of the *Anatomy Act 1977*

states that a Designated Officer of a hospital or forensic institution may, by instrument in writing, authorise the anatomical examination of a body of a person in accordance with the consent given by either the deceased or their senior available next-of-kin.

***Coroners Act 2009* - Coronial Consent**

Section 56 of the *Coroners Act 2009* states that a Coroner has a right to take possession of and retain the remains of a deceased person whenever the coroner has jurisdiction to hold an inquiry concerning the death of the person. This right of the Coroner has priority over any other right to possession such as a potential donation to a school of anatomy.

Once an order for disposal of the remains has been issued by the Coroner, a licence holder may proceed with the potential donation. A copy of the Coronial order for disposal of the remains should be retained with the consent paperwork.

***Public Health (Disposal of Bodies) Regulation 2002* - List A and B diseases**

Anatomy license holders wanting to use donated bodies and human tissue must determine that the body or tissue is not infected with a List B disease as outlined in section 3 (1) of the *Public Health (Disposal of Bodies) Regulation 2002* regarding List A and List B diseases.

1. ANATOMY LICENCES

2.1 General Information

A person in charge of the conduct of anatomical examinations at a university, college, or other tertiary educational institution can apply for a licence to lawfully possess human bodies and tissue for examination purposes at a location specified in the licence.

An anatomy licence is issued in accordance with the *Anatomy Act 1977.* A licence may be issued with additional terms and conditions.

Anatomy licences are issued by the Director-General, NSW Department of Health, or their delegate, for up to a 2 year period subject to satisfactory annual inspections. Re-application is required at the completion of the licence period. The Director-General may revoke the licence at any time.

2.1.1 Applying for an Anatomy Licence

Written applications for an anatomy licence must be submitted to the Director-General, NSW Department of Health. The information required in an application is outlined at attachment 1. Additional information can be included in the written application if desired.

2.1.2 Application inspections

An inspection of the proposed facility specified in the application, will be undertaken as part of the licence application process.

The inspection involves audit of the physical environment of the facility and a review of the policies and procedures of the facility and the register of specimens. The relevant local anatomy inspector conducts the inspection.

On receipt of a written application, NSW Department of Health will advise the inspector to contact the applicant to arrange an inspection. On completion, the inspection report is forwarded to NSW Department of Health with recommendations.

Depending on the report outcomes a licence may be issued with standard and additional conditions.

Applicants can refer to the anatomy licence inspection guidelines [see attachment 2] to gain a comprehensive overview of the inspection process.

2.1.3 One-off licences

A person wishing to conduct an anatomical workshop or training session as a one-off event is required to apply to NSW Department of Health for a licence for the specified time period of the event. The person must, in writing, address each criteria listed in attachment 1 with the exception of providing an ethics committee statement. Bona fide documentation of the event, such as a course program or workshop brochure, must be included with the licence application.

2.1.4 Reapplying for licences

Licence holders wishing to renew a licence are required to submit an application to the Director-General, NSW Department of Health prior to the expiration of their current licence. The written application needs to address the criteria listed in attachment 1. Licence holders should ensure that they submit their application 3 months prior to their current licence expiring.

2.1.5 Re-issue of licence to reflect changes to a licence holder

The Director-General, NSW Department of Health, must be notified in writing of any change to the designated licence holder of an institution. A re-issue of a licence can be requested at any time to accurately reflect changes to staff or duties within the anatomical facility.

A re-issue of a licence should be considered when the current licence holder will be absent from their regular duties for a period of time greater than 3 months.

2. INSPECTIONS

The local anatomy inspector conducts inspections for each local anatomy facility. The facility will be notified of the inspection and must fully cooperate with the inspection. An inspector can inspect any licensed premise at any time.

The inspection audits the physical environment of the facility and reviews the policy and procedure protocols of the facility and the register of specimens. After each inspection a report is sent to the facility that may include recommendations to ensure compliance with licence conditions or the requirements of the *Anatomy Act 1977*. The anatomy inspector will continue monitoring the facility to follow up on the progress of any recommendations.

The inspection is to consist of:

- ensuring the designated holder of the licence is still applicable
- ensuring compliance with any standard and additional licence conditions
- reviewing the register to ensure it conforms with the requirements of the *Anatomy Act 1977* and
- reviewing the anatomy laboratory facility to ensure it conforms to required standards.

NSW Department of Health has developed Anatomy Licence Inspection Guidelines to assist inspectors in undertaking the application audit and assessment (Attachment 2).

3.1 Annual inspections

The anatomy inspector is required to establish an annual schedule for inspection of anatomy facilities within his/her jurisdiction and advise those institutions accordingly.

3. ANATOMY REGISTER

All anatomy licence holders are required to keep a register of all bodies, including human tissue, in their possession. The register must also contain particular information relating to the transfer of bodies and human tissue and the disposal of bodies. An example of a register is attached (Attachment 3). Registers may be in electronic or hard copy format.

The licence holder must produce the register to an inspector as requested. If the register is kept in electronic format it must be accessible to the Inspector during an inspection and able to be printed for signature.

The register must be retained for at least 5 years from the date of the most recent entry.

4.1 Taking possession of a body/tissue

On taking possession of a body, the following information must be entered onto the register:
- the name and address of the person who had lawful possession of the body and who delivered the body into the licence holder's possession;
- the date on which the licence holder took possession of the body; and
- the name, age, sex and last place of abode of the deceased and the date, place and cause of death of the deceased.

4.2 Transfer of a body

When a body is transferred either within or outside NSW, a copy of the particulars contained on the register must also be transferred with the body. The following information must be entered onto the register:
- notification and date of the transfer; and
- the name, address/contact details of person receiving the body.

4.3 Transfer of human tissue

When human tissue is transferred either within or outside NSW, the following information must be entered onto the register:
- notification and date of the transfer;
- the name, address/contact details of the person to whom the tissue was transferred;
- the location where the tissue is to be retained; and
- details of the arrangements regarding the return of the human tissue.

4. DONATION OF BODIES FOR ANATOMICAL EXAMINATION

5.1 General Information

Authorisation for a body to be used for anatomical examination is predicated on the attainment of consent. Consent can be given either via a pre-registered body donation to a licensed

anatomical facility by a deceased person in their lifetime, or after death by the senior next-of-kin of the deceased.

5.1.1 Written consent: hospital or forensic institution

A Designated Officer may authorise the anatomical examination of an deceased adult's body at a hospital or forensic institution if they are satisfied, that the person (during their lifetime) had given their written consent to the anatomical examination of their body after death and that consent had not been revoked. The Designated Officer's authorisation must be in writing. The anatomy facility should ensure that a copy of the Designated Officer's written authority is received at the time the body is transferred to their program. Attachment 2 provides an example of a Designated Officers Authority for donation of a body for anatomical examination.

5.1.2 No written consent: hospital or forensic institution

If there is no pre-written consent by the deceased to the anatomical examination of their body after death, or the deceased is a child, the Designated Officer may authorise the anatomical examination, providing it is:

- established that the deceased had not during their lifetime expressed an objection to an anatomical examination of their body after death;
- ascertained that a senior available next-of-kin has given their consent in writing to the anatomical examination of the deceased; and
- ascertained that there is no senior available next-of-kin of the same or higher order in the hierarchy of senior available next-of-kin who objects to the removal of tissue from the person's body.

The Designated Officer may authorise, in writing, the anatomical examination of the deceased in accordance with any terms or conditions placed on the consent by the deceased or the senior available next-of-kin.

5.1.3 Written consent: not at hospital or forensic institution

If the body of a deceased adult is at a place other than a hospital or forensic institution, and the person had (during their lifetime) given their consent in writing to the anatomical examination of their body after death and that consent had not been revoked, the anatomical examination of that person's body is authorised, in accordance with any terms or conditions placed on the consent.

5.1.4 No written consent: not at hospital or forensic institution

If the body of a deceased person is at a place other than the hospital or forensic institution, the senior available next-of-kin can consent to the anatomical examination of that person's body even if consent was not given in writing during the deceased person's lifetime. The senior available next-of-kin should establish that the deceased had not expressed an objection to the anatomical examination of their body during their lifetime and there is no objection from any other next-of-kin (See 8A(4)(b) *Anatomy Act 1977)*.

5.1.5 Coroner consent

The Designated Officer or the senior available next-of-kin cannot authorise the anatomical examination of the body of a person in respect of whose death a coroner has jurisdiction to hold an inquest under the *Coroners Act 2009* unless a Coroner has given consent to the examination.

The Coroner may set specific conditions to his/her consent. Consent by a Coroner may be given orally and, if so, is to be confirmed in writing as soon as practicable.

5.1.6 Effect of authority

The authority of a Designated Officer or a senior available next-of-kin is sufficient for:

- a person who has lawful possession of a body to cause or permit the body to be used by a licence holder for anatomical examination; and
- for the licence holder to conduct an anatomical examination of the body, at licensed premises, in accordance with the authority, subject to the terms and conditions of the consent.

5.1.7 Children in the care of the State

A person must not authorise the anatomical examination of the body of a deceased child if the child was, immediately before death, a child in the care of the State.

5.2 Taking possession of a body

Licence holders can only take possession of a body for anatomical examination (other than a body transferred from another licence holder) when they have the written authority of a Designated Officer or a senior available next-of-kin.

Licence holders accepting deliveries of bodies from the Coroner must ensure that they also receive the relevant documentation authorising the release of the body.

5.3 Human tissue acquisition

Human tissue can be acquired as either a transfer from another licensed institution or facility (including international institutions) or by a specific body donor or specimen donation program.

Tissue acquisition in NSW is covered by the *Anatomy Act 1977*. Applicants who source tissue from interstate or international institutions are responsible for obtaining statements from the supplying institution that demonstrate that the acquired tissue complies with the consent and other provisions of the Act. It is incumbent upon the facility to ensure that any agreements with interstate/international suppliers of imported tissue clarify the requirements of the original consent regarding the disposal of the tissue. If the tissue is for local disposal the supplier should ensure that it is accompanied by the appropriate documentation to allow disposal in NSW.

If an applicant wants to use body specimens from international institutions they must also ascertain that the body specimen meets the requirements of the *Public Health (Disposal of Bodies Regulation2002)* with regard to List B diseases.

5.4 Transfer of Human bodies or Human Tissues

5.4.1 Transfer of a Body

A licence holder may transfer a body in their possession to another licence holder within NSW without prior approval of an inspector. A transfer to any person in charge of the conduct of anatomical examinations at any place outside NSW is permitted with prior approval of an inspector.

Transfer of a body is not permitted if the licence holder has reason to believe that the transfer would be contrary to the wishes of the deceased or the senior available next-of-kin.

If the body is to be disposed of by the receiving institution it is a requirement that all relevant paperwork (including cremation certificates and medical referee's permit) accompany the body.

5.4.2 Transfer of human tissue

The *Anatomy Act 1977* allows for the transfer of human tissue from one licence holder to another, or to an authorised officer of a NSW hospital, or to a person approved, in writing, by the Director-General within NSW without prior approval of an inspector for use for medical or scientific purposes.

Transfer of tissue will not be permitted if the licence holder has reason to believe that the transfer would be contrary to the wishes of the deceased or the senior available next-of-kin.

The licence holder must ensure that arrangements are made for the return of the human tissue as soon as practicable, and by no later than the end of the period within which the tissue is required to be disposed.

5. RETENTION OF BODIES OR TISSUE FOR ANATOMICAL EXAMINATION

6.1 Extension to retain bodies and human tissue

A licence holder must dispose of a body in their possession within 4 years of the date of death of the deceased.

A licence holder wishing to apply for an extension to retain bodies or human tissue in their possession can do so by writing to the local anatomy inspector. A request for an extension must include the relevant donor details.

An inspector may authorise the retention of a body or tissues for a maximum of an additional 4 year period. All bodies and tissues from those bodies must be disposed of within 8 years from the date of death of the deceased.

An inspector may not give such an extension if it would be inconsistent with the terms of the original consent of the deceased or next-of-kin.

Further authorisation is not required for the retention of tissue slides or tissue blocks or museum pathology specimens in sealed containers.

In granting authorisation, an inspector should consider:

- any conditions placed by the deceased or senior available next-of-kin qualifying their original consent that would prevent extension;
- the purposes for which extended retention of the body or human tissue is sought;
- justification for why the body or human tissue had not been utilised in the four year period; and
- the condition of the body or human tissue.

The holder of a licence must comply with any terms or conditions that are imposed by an inspector in granting an authorisation for the retention of a body or human tissue and must enter details of the authority in the register.

6.2 Permanent retention of human tissue

Specific provision has been made in the *Anatomy Act* for the permanent retention of tissue where written consent has been given by the deceased prior to death.

Where no consent has been given and the wishes of the deceased in this respect are unknown, the senior available next-of-kin may consent to permanent retention of tissues.

No consent is required for the permanent retention of small samples of tissue in the form of tissue blocks and slides.

6. DISPOSAL OF BODIES OR TISSUE

7.1 General Requirements for disposal of bodies

The licence holder is required to dispose of a body in their possession for anatomical examination (including any human tissue from that body) within 4 years after the death of the deceased person, or in accordance with the terms of an authorisation or extension granted by an inspector.

A licence holder, where practicable, should dispose of a body in accordance with the wishes of the deceased or, the wishes of the senior available next-of-kin.

7.1.1 Register

The licence holder, following the disposal of a body, must enter onto the register the:
- notification and date of the body's disposal; and
- the name, address/contact details of the person who disposed of the body.

7.1.2 Disposal of permanently retained tissues

There are many circumstances that necessitate disposal of human tissue separately from the rest of the body from which the tissue originated. These circumstances include where the institution has consent to the permanent retention of tissue that is no longer in a usable state. Decisions on the usable state of such tissues should be taken on a case-by-case basis by anatomy facilities and referred to the local anatomy inspector. If the specimens are to be disposed of the institution should ensure that records detailing the method and reason for disposal are maintained.

Depending on the original consent documentation options for disposal may include:
- contact with next-of-kin to arrange collection of the tissues usually by a funeral director of their choice to make their own arrangements for cremation or burial; or
- appropriate disposal of the tissues by the institution. Dignified treatment and separate disposal are the minimum considerations involved in disposing of human tissue. Arrangements for respectful and sensitive disposal should be made at local level.

These practices should be explained to donors through the donation program information.

7.13. Requirements for the disposal of anatomical waste tissue

Anatomical waste should be managed in accordance with the requirements of PD2005_132 *Waste Management Guidelines for Healthcare Facilities*.

These practices should be explained to donors through the donation program information.

7. BODY DONATION PROGRAMS

It is strongly recommended that body donation programs are overseen by a suitable human ethics committee. Cadaveric material is most commonly sourced from the willed-body donation programs of the schools of anatomy at universities within NSW and interstate. A person may decide in their lifetime to donate their body, after death, to a facility for the purpose of medical training and research. Prospective donors are provided with information about the donation program to which they are considering committing their body once they are deceased. The institution will arrange for prospective donors to complete a consent form to document this decision.

8.1 Written consent

The standard of consent for a body donation program in NSW is written consent. All body donation programs should provide clear consent forms for potential donors that include options for potential donors to specify terms and conditions to their consent [See 8.2].

A body donation program can refuse to accept a body from a deceased person who gave written consent to donate their body. The reasons for non-acceptance of a body should be outlined in the information about the body donation program and a statement as to the possibility of non-acceptance by the institution should be included on the consent form signed by potential donors.

8.1.1 No written consent by the deceased

Generally, programs will not accept body donations from the next-of-kin in the absence of a signed and witnessed consent of the deceased made in their lifetime. There is however, no legislative impediment to consent to body donation from an appropriate next-of-kin, as long as the non-objection of the deceased and other next-of-kin is established. Institutions should provide appropriate forms for next-of-kin consent.

8.2 Consent forms

Donor consent forms developed by body donation programs will vary in content depending on the opportunities offered to the prospective donor to authorise specific activities and place terms and conditions on the use of their body as discussed above.

Consent forms at a minimum should therefore allow the prospective donor to:

- consent or not consent to the use of their body for certain activities, such as sponsored research, educational research; training students or other activities;
- consent or not consent to the transfer of their body to other organisations;
- consent or not consent to the permanent retention of human tissue and allow for authorisation if specific organs are to be retained, including for museum displays; and
- consent or not consent to the release of their prior medical history and/or records to the licence holder or their delegate for the purposes of determining medical suitability of the donation or for research purposes.

In addition the form should contain:

- a statement for the Designated Officer to authorise the donation (for donations from hospital and or forensic institutions);
- a statement as to the reasons why a facility may choose not accept a prospective body donation at the time of death; and
- a statement outlining the screening tests that the donor program may chose to undertake on a donated body and the reason for those tests.

Licence holders should review the range of activities contemplated within their licence and ensure that these activities are reflected in the consent options.

8.2.1 Revocation of consent

A person can change their consent to donation during their lifetime. Body donation programs should include the option of a form for the revocation of consent within their body donation program information.

8.3 Donor information

Information re: body donation programs should provide detail for prospective donors which explain the potential uses of donated bodies and the terms and conditions that a facility may place on the acceptance and use of the donation. It is recommended that the relevant institutional ethics committee or other appropriate governance body review the donor program and its information and materials prior to their publication.

- **Uses of donated bodies/body parts/tissues:** Donor information should contain an explanation of how bodies can have different uses, such as for teaching, research and training, and provide some detail of the meaning of 'anatomical examination' to outline the intended use of a body. Examples of this include where a facility wishes to use the body/tissues from the body for public display in anatomy museums or where other activities such as forensic experimentation may be conducted.

- **Retention:** Donor program materials should include information regarding the length of time a body can be retained, from the date of death, for medical use. Programs should provide an option for permanent retention on their consent forms.

- **Disposal of bodies and tissues and anatomical wastes:** Information on the options for disposal of bodies or tissues should be outlined for prospective donors. This should include information that small amounts of tissue such as body fluids, fat, skin etc may be disposed of as anatomical waste through appropriate clinical waste guidelines. Information should also be provided on the permanent retention of tissue slides and tissue blocks.

- **Public Display:** The fundamental principle of the *Anatomy Act* is the requirement that consent is obtained for the donation, storage and use of relevant material which has come from a human body for certain purposes. It is mandatory that donor consent forms include an option for the potential donor to authorise the use of their body or tissue for particular activities which may be considered by the facility including public display.

- **Use of Images:** The making and displaying of images (including photographs, films and electronic images) requires that facilities put systems in place to ensure suitable practices are carried out. Where licensable activities are concerned this includes ensuring that the dignity of deceased people is maintained at all times. Therefore, facilities need to put in place procedures and systems to prevent the inappropriate use of images of deceased persons or body parts.

- **Transfer of body:** Donor programs should advise prospective donors that their body, body parts or tissues, may be transferred to other organisations for use. It should be specified that transfer can occur both within and outside Australia, and allow donors the opportunity to consent to this use.

8.4 Occupational health and safety and screening of donated bodies or human tissue.

It is recommended that licence holders take steps to ensure that donated bodies or tissue specimens are appropriately screened for blood borne viruses and other pathogens prior to their acceptance of the body/tissue. This may include the use of donor screening tools and/or medical and social history questionnaires and/or the use of specific cadaveric screening tests.

8.4.1 Notification mechanisms

(See: IB2013_010 Notification of infectious Diseases under the Public Health Act 2010)[1]

- Laboratories must notify positive results of scheduled medical conditions in the deceased to NSW Department of Health in accordance with the current NSW *Public Health Act* therefore licence holders **are not** required to undertake notification of results of Infectious disease testing or contact tracing of body donors.
- Licence holders should however have procedures in place for informing the next-of-kin that the donation of either the body or tissues will not be accepted.
- Licence holders can provide the details of contacts of body donors who may be at risk of infection to the local Public Health Unit if required to do so to facilitate contact tracing. Provision of contact details in these circumstances would not be in breach of statutory confidentiality provisions.

LIST OF ATTACHMENTS

1. Application guidelines
2. Example of a Designated Officers Authority
3. Inspection audit checklist and guidelines
   3.1 Examples of Anatomy Registers

[1] Polices will be amended subsequent to the commencement of the *Public Health Act 2010*.

Attachment 1: Application Guidelines.

1. Proposed Licensee(s)
Name
Position
Address
Phone number(s)
Email address

Include all relevant information for both proposed licensees if application is for a joint licence.

2. Location of anatomy facility
This can be the actual or proposed facility.

3. Access to the facility
Specify the types of students and staff who will use the facility and their approximate number per year. Outline the proposed security process for ensuring only bona fide students and staff (as specified) have access to the facility.

4. Proposed anatomical activities
This can be a general statement on the range of activities to be undertaken in the facility. For example, 'The study and practice of anatomy within the terms of the *Anatomy Act* and NSW Health anatomy policy guidelines using tissues for the purposes of anatomical dissection and surgical technique.'

5. Accessing cadaver material
Outline the proposed process for obtaining cadaver material, including details of the facilities where tissue may be sourced from.

6. Registering tissues/specimens
Outline the proposed process for registering all tissue and specimens.

7. Disposal of tissues/specimens
Outline the proposed process for the disposal of tissues/specimens as determined by the requirements of the *Anatomy Act 1977* and NSW Health anatomy guidelines.

8. Ethics committee statement
Where necessary, statements in support of an application from referees and institution ethics committees are to be provided. (NSW Health will advise applicants if such statements of support are required as part of their licence application.)

Lodging Applications:
All applications are to be addressed to:

Director-General of Health
NSW Health Department
Locked Mail Bag 961
North Sydney NSW 2059

Attachment 2: Example of a Designated Officers Authority for Anatomical Examination

Authority by a Designated Officer for the Anatomical Examination and Release of a Body from the Hospital to a Licensed Anatomical Facility

I _____
(Name of Designated Officer)

1. Hereby state that I am satisfied that [Tick where applicable]

   ☐ The above mentioned deceased had given their written consent to the anatomical examination of their body after death and that consent had not been revoked or objected to by the senior available next-of-kin.

   OR

   ☐ The above mentioned deceased had not during their lifetime expressed an objection to an anatomical examination of their body after death and the senior available next-of-kin has given their consent in writing to the anatomical examination of the deceased. There is no senior available next-of-kin of the same or higher order in the hierarchy of senior available next-of-kin who objects to the removal of tissue from the person's body.

2. Hereby authorise anatomical examination and the release of the above mentioned deceased to the:

   _____
   (Name of Licensed Anatomical Facility)
   in accordance with any terms or conditions placed on the consent by the deceased or senior available next-of-kin.

Designated Officer signature: _____

Date: _____

Coroner consent
A Designated Officer or a senior available next-of-kin cannot authorise the anatomical examination of the body of a person in respect of whose death a coroner has jurisdiction to hold an inquest under the *Coroners Act 2009* unless a Coroner has given consent to the examination.

Attachment 3: Inspection Audit Checklist And Guidelines

Body preparation	
Vehicle reception area screened from public view	☐
Wash hand basin; hot and cold water; non-hand operated taps soap and disposable paper towel or air dryer	☐
Slabs, tables, fittings and fixtures in good repair	☐
Adequate sinks with hot and cold water for cleaning equipment and appliances	☐
Hoses fitted with backflow prevention	☐
Refrigerated storage area temperature 1-5°C	☐
Containers for general and clinical waste	☐
Waste disposal	
Different types of waste containers located appropriately	☐
Liquid waste: water authority approval for contaminated waste	☐
Clinical wastes: disposed in accordance with appropriate environmental guidelines	☐
Handling bodies	
Policy for handling infectious bodies	☐
Labelling	
Sufficient systems for permanent non-identifying labelling of bodies and specimens	☐
Sufficient systems to track all bodies/specimens within register	☐
Management of chemicals	
MSD sheets available for easy reference	☐
Satisfactory storage of chemicals	☐
Appropriate mechanical ventilation systems in place	☐
Storage	
Sufficient refrigerated storage compartments at appropriate temperature for the number of cadavers	☐
Adequate Storage of embalmed body parts	☐
Anatomy rooms	
Occupational health and safety policy for the activities undertaken	☐
Appropriate attire and PPE available (e.g. gowns, gloves, masks, glasses)	☐
First aid/Emergency assistance procedures available	☐
Security	
Access only for bona fide staff and students or authorised personnel	☐

Construction of facility

Walls	☐
Floors	☐
Ceilings	☐
Lighting	☐
Ventilation	☐
Toilet and Showering facilities available	☐
Pest Control program in place	☐

General comments on overall standards:

Action required:

Name of inspector:

Signature: **Date:**

Administration management

- ☐ Discussion with head of school/institution overseeing the functions of the facility and licence holder.
- ☐ Discussion on assessment of any complaints lodged with the institution regarding the application and functions of the licence and mechanisms to address those complaints.
- ☐ Evidence of protocols and procedures to ensure all users conduct an anatomical examination in a manner that affords the deceased ongoing dignity between the time of their death and burial or cremation.
- ☐ Copies of inspection reports maintained.
- ☐ Compliance with the time period to make necessary changes identified by the inspection.
- ☐ Compliance with reasonable conditions imposed by inspector (on licence).

Audit of consent forms

- ☐ Evidence of the use of a standard comprehensive consent form that allows terms and conditions to be specified on the consent.
- ☐ Evidence that anatomical examinations are conducted with the written authority of the deceased, or if the deceased did not consent during their lifetime, the written consent of a senior available next-of-kin.
- ☐ Evidence of the inclusion of the wishes of the deceased or next-of-kin relating to the disposal of bodies and/or human tissue.
- ☐ Evidence of written consent for permanent retention of human tissue.
- ☐ Contact details of next-of-kin.

Audit of Register

Minimum requirements of register:

- ☐ Name and address of the person who had lawful possession of the body and who delivered the body into the holder’s possession.
- ☐ Date on which the holder took possession of the body.
- ☐ Date, place and cause of death of the deceased and the sex, name, age and last place of abode of the deceased.
- ☐ Evidence of tracking of any human tissue removed from a body to ensure cross-referencing of all human tissue removed from a specific body.

Retention

☐ Evidence that no body is retained for more than 8 years from the date of death of the deceased.

☐ Evidence that no body exceeds an authorised retention period.

☐ Evidence that no human tissue exceeds the authorised retention period.

☐ Evidence of formal approval for any extension of retention period.

Transfer of bodies and human tissue

☐ Evidence of transfer of a body or human tissue from one institution to another providing it is not contrary to the authority given by the deceased or next-of-kin.

☐ Evidence that when bodies or human tissue are transferred, the following minimum details are entered on the register:
1. the fact that the body or human tissue was transferred;
2. the date on which the body or human tissue was transferred;
3. the name and address of the person to whom the body or human tissue was transferred;
4. the name of the licensed premises, hospital, or other place where human tissue is to be retained; and
5. details of the arrangements made with respect to the return of the human tissue.

☐ Evidence that bodies are only transferred to other licence holders or, with the approval of an inspector, to a person in charge of anatomical examinations outside NSW.

☐ Evidence that human tissue from a body in the licence holder's possession is only transferred to other licence holders, authorised officers of State or interstate hospitals, or persons approved by the Director-General.

☐ Evidence of return of a body or human tissue unless it has been wholly or substantially destroyed.

Disposal

☐ Evidence that bodies are disposed of within 4 years from the date of death of the deceased person unless retained in accordance with an inspectors written authorisation.

☐ Evidence of a Cremation Certificate issued by the attending practitioner pursuant to clause 48 *Public Health (Disposal of Bodies) Regulation 2002*.

☐ Evidence that when bodies are disposed of, the following minimum details are entered on the register:
1. the fact that the body was disposed of;
2. the date of disposal; and
3. the name and address of the person engaged to dispose of the body.

☐ Evidence that bodies are disposed of, as far as practicable, in accordance with any wishes of the deceased.

26. TISSUE/ORGAN **26.25**

- ☐ Evidence that bodies are disposed of, as far as practicable, in accordance with any wishes of the senior available next-of-kin of the deceased if the deceased's wishes are not practicable, or deceased has expressed no such wishes.

- ☐ Evidence that human tissue is disposed of within 4 years from the date of death of the deceased person unless retained in accordance with an inspectors written authorisation or consented for permanent retention.

Attachment 3.1: Anatomy Register Example

NUMBER: _____

NAME OF DECEASED:

SEX: AGE:

DATE BODY RECEIVED:

RECEIVED FROM:

NAME:

ADDRESS

PHONE:

DATE OF DEATH: PLACE OF DEATH:

LAST PLACE OF ABODE:

CAUSE OF DEATH:

REMOVAL DATE FOR CREMATION/BURIAL:

REMOVED BY :

CONTRACTING FUNERAL DIRECTOR (Please PRINT Name, Address & Contact Number):

26. TISSUE/ORGAN **26.27**

DONOR NUMBER	BODY PARTS USED	RECIPIENT	DATE TAKEN	TAKEN WHERE	DATE RETURNED	REASON	DATE OF DISPOSAL	METHOD OF DISPOSAL

DESIGNATED OFFICER (PD2023_012)

PD2023_012 replaced PD2013_002

POLICY STATEMENT

A Designated Officer is responsible for authorising the release of a body for anatomical examination, non-coronial post-mortem examination and the removal and use of organs and tissue from a deceased body for medical, scientific, or therapeutic purposes (including transplant). They must do so in accordance with the Anatomy Act 1977 (NSW) and the Human Tissue Act 1983 (NSW).

SUMMARY OF POLICY REQUIREMENTS

Local health districts, specialty health networks, NSW Health Pathology departments, forensic institutions including NSW Health Pathology must appoint a Designated Officer in any facility where bodies may be donated for anatomical examination, non-coronial postmortems are carried out, or where organ and tissue is removed from a deceased person and used, including donated for transplantation. The licensee of a private hospital appoints Designated Officers for a private facility.

Designated Officers must be appointed in accordance with section 5 of the Human Tissue Act 1983 (NSW) by the governing body of a hospital or NSW Health pathology departments and forensic institutes. NSW Health organisations must ensure that arrangements are in place for staff to easily identify and contact Designated Officers at all times. The appointment of several Designated Officers may be necessary to ensure 24-hour coverage so that one is available when required, particularly after hours. Appropriate staff at NSW Health Pathology departments and forensic institutions including

NSW Health Pathology must have information including 24-hour contact details for Designated Officers for Departments of Forensic Medicine.

Designated Officers must complete mandatory training to become accredited and appointed. To remain eligible for reappointment, Designated Officers are required to successfully complete reaccreditation training every two years.

The Designated Officer has discretionary authority. They are not obligated to authorise a procedure. Designated Officers are obligated to make ‘reasonable inquiries’ before authorising procedures. The

Designated Officer’s authority must be in writing (not orally). This includes authorisation via email, provided that the email clearly states the name and position of the Designated Officer who is providing authority.

The full version of the Designated Officer policy can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_012

MANAGEMENT OF THE POTENTIAL ORGAN AND TISSUE DONOR FOLLOWING NEUROLOGICAL DETERMINATION OF DEATH (GL2023_013)

GL2023_013 replaced GL2016_008

GUIDELINE SUMMARY

This Guideline provides recommendations for managing and delivering standardised clinical therapies to potential organ and tissue donors following neurological death. The goal is to support and optimise organ and tissue function and improve organ retrieval for transplantation.

The Guideline must be read in conjunction with the State Form SMR010517 Neurological Determination of Death (also known as Brain Dead) and the NSW Health Policy Directive Organ and Tissue Donation, Use and Retention (PD2022_035).

KEY PRINCIPLES

The criteria for neurological determination of death are established by Australian and New Zealand Intensive Care Society (ANZICS) and set out in section 1.2 Neurological determination of death in the Australian and New Zealand Intensive Care Society (ANZICS) The Statement on Death and Organ Donation edition 4.1 (2021) (ANZICS Statement).

The management of the potential organ and tissue donor after neurological determination of death aims to support organ function and optimise the number of organs retrieved for transplantation.

This includes frequent clinical assessment of organ function and response to interventions as well as ensuring that the time from determination of death to retrieval surgery is as short as possible.

The recommendations are largely based on physiological rationale, consensus statements and limited clinical research with a non-negligible risk for bias.

Consent is another key principle of all donations as outlined in the NSW Health Policy Directive Organ and Tissue Donation, Use and Retention (PD2022_035).

A valid consent is essential for any donation, refer to the NSW Health Consent to Medical and Healthcare Treatment Manual (The Consent Manual). The hospital's Designated Officer must also have granted authorisation to remove the organ/s and/or tissue.

In NSW the Organ and Tissue Authority's Best Practice Guideline for Offering Organ and Tissue Donation in Australia (Best Practice Guideline) is used to support families make an informed decision about donation and ensures that a Donation Specialist participates in the Family Donation Conversation.

Consent must be in writing or by other manner prescribed as per the NSW Health Policy Directive Organ and Tissue Donation, Use and Retention (PD2022_035) and the NSW Health Consent to Medical and Healthcare Treatment Manual (The Consent Manual).

The full version of the Management of the Potential Organ and Tissue Donor following Neurological Determination of Death Guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_013

ADULT-TO-ADULT LIVING DONOR LIVER TRANSPLANTATION GUIDELINES
(GL2008_019)

This guideline provides guidance to health professionals and additional protection for prospective adult Living Donor Liver Transplantation (LDLT) donors. This guideline is aimed primarily at the jurisdictions that will endorse LDLT, the institutions that will provide LDLT, and the health professionals directly involved in this practice. To the extent that it is adopted by all jurisdictions in line with the particular requirements of their human tissue legislation, and applied in participating liver transplant units, it will promote ethical, lawful and consistent application of quality processes in provision of this complex procedure to donors, recipients and their families.

The full Adult-to-Adult Living Donor Liver Transplanation Guidelines can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2008_019

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