procedure

Policy, Procedure and Guideline - Development, Approval and Implementation System – Framework for Central Coast Local Health District

Document Number	PR2014_039	Publication Date	10 December 2020
Intranet location/s	Corporate: Corporate Governance		
Position	Manager Corporate Governance, Corporate Governance Unit		
Purpose	To define the framework for CCLHD policy, procedure and guideline development, review and implementation system to provide a consistent, transparent and accountable process that meets accepted standards.		
Audience	All staff		
Review due date	December 2024		
Related policy/procedure	PO2005_005 - Policy - Meta Policy PR2020_049 – Standard Operating Practice (SOP) Governance Framework for CCLHD		

1. Scope of Practice

Designation	Requirement
CCLHD staff	All staff involved in the review, development, approval of policies, procedures and guidelines must comply with this procedure

2. Risk Management

Contraindications	▪ **Standing Operating Practices (SOPs**) do not require submission to the Policy & Procedure Implementation Committee. All Directorates/Services developing SOPs need to have an internal endorsement process for their development, review, version control, storage and implementation. ▪ **Standing Orders** (for medications) do not require submission to the Policy & Procedure Implementation Committee. Standing Orders are developed and managed by the specific facility, department, ward or specialty issuing them, and require authorisation by the Drugs and Therapeutics Committee
Alerts	▪ All approved policies, procedures, guidelines will be centrally managed by the Corporate Governance Unit and published on the District's "Policy and Procedure" intranet site ▪ To ensure consistency, transparency and accountability, the "Policy and Procedure" Intranet site is the central repository for all approved CCLHD policies, procedures and guidelines. Directorates/Services wishing to display policies, procedures and guidelines on their intranet sites, must do so by hyperlink to the "Policy and Procedure" site. ▪ Policy, procedure and guideline documents issued for area-wide use in the former Northern Sydney Central Coast Area Health Service will continue to apply to the CCLHD until such time as they are superseded or archived.

3. Procedure

Step 1	▪ **Identify the need** for a new policy, procedure, guideline in accordance with drivers internal or external to CCLHD, or an existing policy, procedure or guideline requiring scheduled review or a change in practice.
Step 2	▪ **Conduct a literature search** – if required undertake a search or utilise formal or informal networks to establish whether there is, or has been, the same or similar work done on the policy topic. For example, library or web search for policies, procedures, guidelines developed in other health facilities in NSW, interstate or overseas.
Step 3	▪ Download the **template** and the **Development and Authorisation Pathway** from the Policy and Procedure Intranet site; **the CCLHD Policy, Procedure Guideline Style Guide** (this must be followed in the development process); and for existing documents under review, contact the Corporate Governance Unit cclhd-AreaPolicies@health.nsw.gov.au to obtain a Word version of the current published document (where possible updates are to be completed using tracked changes)
Step 4	▪ **Develop documents in consultation with appropriate health professionals / divisions and/or expert governing committee/s** (**within the roles and responsibilities articulated in their Terms of Reference) or specialist groups.** Consider if there are: o Work Health and Safety issues (include consultation with WH&S) o Infection Prevention and Control issues (include consultation with Infection Prevention & Control Unit) o Code of Conduct aspects (include consultation with Workforce) o Specific impacts on the health of Aboriginal people (use the formal checklist as per PD2017_034 – Aboriginal Health Impact Statement) o Prescribing, administration or dispensing of medications (approval must be obtained from the CCLHD Drug and Therapeutics Committee following submission to the Drug and Therapeutics Policy and Procedure Sub-Committee) ▪ Policies/procedures/guidelines are to be based on best available evidence and referenced accordingly. ▪ Forms – if there is a medical record form related to the policy/procedure/guideline it must be approved by the CCLHD Forms Committee prior to submission to the Policy and Procedure Implementation Committee. Forms are not to be included within the policy/procedure/guideline – they are to be hyperlinked. If the form relates to prescribing, administration or dispensing of medications the form must first be approved by the Drug and Therapeutics Committee following submission to the Drug and Therapeutics Policy and Procedure Sub-Committee.
Step 5	▪ **Draft for Comment** Authors requiring CCLHD-wide consultation can submit their draft to the Corporate Governance Unit cclhd-AreaPolicies@health.nsw.gov.au for publication on the CCLHD 'Draft for Comment' page of the intranet
Step 6	**Author's submit final draft policy / procedure / guideline plus signed Development and Authorisation pathway** to the Corporate Governance Unit cclhd-AreaPolicies@health.nsw.gov.au to submit to the Policy and Procedure Implementation Committee for review and approval.

Step 7	**Corporate Governance Unit is responsible for**: o Assigning document number o Publication on the CCLHD Policy and Procedure intranet site o Filing documentation in TRIM and managing the records in accordance with the State Records Act and General Disposal Authority GDA21[1] o Notifying staff of the publication via broadcast email communique o Notifying author Division/Service when scheduled review is due
Step 8	**Authors are responsible for:** o Distributing and overseeing implementation of the policy / procedure / guideline in accordance with the approved Implementation plan.
Document Management	
Document Features	**Numbering:** All documents will have a system-generated number consisting of a prefix, year, followed by three digits. The type of document will determine the prefix, the year will be the year first issued and number sequential. Prefixes: PO = Policy, PR = Procedure, GL = Guideline **Naming convention** for the title of the document is to be - noun-verb e.g. Equipment - Cleaning, Equipment - Repair
Mandatory Document Review	Policies, procedures and guidelines will have a mandatory review date of a maximum of four years (or sooner if required due to a change in practice). The review will establish if a document remains active, requires revision or can be made obsolete. Three months prior to a document's Review Date the Directorate / Division / Service will be notified.
Archived Document	When a Policy / Procedure / Guideline becomes obsolete, is rescinded or replaced, the author department notifies the Corporate Governance Unit. The document is removed from the active document lists and placed in archive. The document cover page will indicate the date the document became obsolete and the reason for being obsolete or if replaced the new document number. When a Policy / Procedure / Guideline becomes obsolete, rescinded or replaced, the Corporate Governance Unit will archive it in accordance with the State Records Act and General Disposal Authority GDA21[1].
Interim Document Approval	If expedited approval is required for a policy, procedure, guideline to be published, interim approval can be authorised by the Chair of the Policy and Procedure Implementation Committee either at the meeting or out of session. The document will be submitted to a subsequent meeting for formal approval.

4. Definitions

Policy	**A Policy is a mandatory statement of required action/s** and is a systematically developed document based on legislation, standards, regulations and/or NSW Ministry of Health requirements. Policies apply District-wide and are managed within the central CCLHD policy, procedure, guideline system. Policies: ▪ provide direction on legislative responsibilities or actions required by the organisation ▪ clearly state what will or will not be done; ▪ include WHAT the rule is, WHEN it applies and WHO it covers; ▪ provide reference to any overarching directives, legislation; ▪ identify how it will be monitored and evaluated; ▪ utilise the CCLHD Policy template

Procedure	**A Procedure is a set of approved steps that WILL be followed for a particular act or sequence of acts**. Procedures apply District-wide and are managed within the central CCLHD policy, procedure, guideline system. Procedures: ▪ are based on validated evidence, have a consistent application and inform the reader HOW ▪ direct the practical implementation of related policies; ▪ direct implementation of approved processes unrelated to specific policies ▪ are succinct, factual and generally expressed using specific sets of steps that describe how to achieve the necessary results; ▪ utilise the CCLHD Procedure template
Guideline	**A Guideline is a set of recommended steps that staff SHOULD follow when performing an activity in a standard situation to provide appropriate and necessary care for specific types of patients or patient related activities.** Guidelines apply District-wide and are managed within the central CCLHD policy, procedure, guideline system. Guidelines that communicate best practice can be used to encourage improvements while not officially requiring a change in practice through adoption as policy or procedure. Staff members are expected to follow guidelines and if they do not must be able to justify their actions. Guidelines: ▪ describe and list the key steps undertaken to achieve best practice; ▪ are succinct, factual and generally expressed using specific sets of steps that describe how to achieve the necessary results; ▪ provide reference to any overarching policy/procedure; ▪ utilise the CCLHD Guideline template
Standard Operating Practice	**A SOP is a set of documented steps outlining how staff should perform a specific task within a single facility, department or ward. SOPs can outline a task that may include performing a clinical activity as long as that activity is outlined in an overarching endorsed Procedure, or is within the assumed scope of practice of the person performing the task, e.g. taking vital signs.** ▪ SOPs do not require submission to the Policy & Procedure Implementation Committee. ▪ All Directorates/Services developing SOPs need to have an internal endorsement process for their development, review, version control, storage and implementation. ▪ SOPs must be published on an appropriate intranet site, share drive, or alternate location for relevant staff to access. ▪ All staff required to comply with a particular SOP must be made aware of it by the governing body and, if necessary, provided education/instruction and/or certify having read the SOP. ▪ Staff members are expected to follow SOPs and if they do not, must be able to justify their actions. ▪ SOPs have a mandatory review date of up to four years (or sooner if required due to a change in practice, policy or procedure). The review will establish if the SOP remains active, requires revision or is obsolete.

5. References

(1) State Records Act 1998
http://www.legislation.nsw.gov.au/maintop/view/inforce/act+17+1998+cd+0+N

6. Related resources

Policy and Procedure Intranet Site